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Practice Summary & Implementation Guidance

Healing, Empowering, Actively Recovering Together (HEART)

The HEART program is a pilot designed to improve outcomes for pregnant/parenting women with substance use disorder (SUD) and their children, who often have neonatal abstinence syndrome (NAS). The HEART program integrated and co-located parenting classes, community resources, and peer support services within the one setting.

Location	Topic Area	Setting
Kentucky	Mental Health/Substance Use	Rural

Population Focus	NPM	Date Added
Cross-Cutting/Systems Building	NPM 5: Safe Sleep, NPM 11: Medical Home	July 2020

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Section 1: Practice Summary

PRACTICE DESCRIPTION

The HEART program is a pilot designed to improve outcomes for pregnant/parenting women with substance use disorder (SUD) and their children, who often have neonatal abstinence syndrome (NAS). The HEART program integrated and co-located parenting classes, community resources, and peer support services within the one setting.

This community-based program was initiated in 2018 based on a community needs assessment that found a significant need for carrying out a plan of safe care in a district with a high and increasing number of NAS cases and a high infant mortality rate. Integration of recovery services with strengths-based parenting support in a "one-stop-shop" model could maximize benefits for participants (Hodgins et al. 2019, Huebner et al. 2019, Kramlich et al. 2018). This program benefits both mothers with SUD and their children.

CORE COMPONENTS & PRACTICE ACTIVITES

This parent-driven and strength-based intervention helps participants build protective factors by providing resources and education. It is based on the Strengthening Families Protective Factors Framework. In order to address the six key protective factors identified by Kentucky Strengthening Families, this program uses six strategies. To build parental resilience, this program focuses on coping strategies. To build social connections, this program is a group experience. To increase concrete supports, participants learn about treatment options and resources. To build social and emotional competence, participants learn how to foster social and emotional skills. To promote nurturing and attachment, parents will learn how to communicate with their babies and read their cues. To increase knowledge of child development, families will learn what to expect as their children grow older and how to deal with it.
The goal of our program was to promote maternal and child well-being by integrating and co-locating services. The core components of the program included parenting classes, information about and connections to services in the community, peer recovery support sessions, and assessment of program practices and participant outcomes.

Core Components & Practice Activities

Core Component	Activities	Operational Details
Parenting Classes	Hold parenting classes	A home visitor, who has been trained in maternal, infant, and early child home visiting, uses Growing Great Socializations™ (Great Kids, Inc., Wausau, WI) and Nurturing Program for

		Families in Substance Abuse Treatment & Recovery™ (Family Development Resources, Inc., Park City, UT) curricula. These group sessions last for two hours each week.
Community Services	Engage community representatives	Make connections in the community with groups who provide education or resources (community college, university cooperative extension office, non-profit organizations, other government programs). Invite representatives to speak to the participants and provide information about enrolling.
Peer Recovery Support	Hold peer recovery support sessions	A certified peer support counselor uses techniques from a variety of program to facilitate one0hour group discussions with participants, while a second counselor holds one-on-one check-ins with participants who may need extra support.
Assessment	Data collection and analysis	Collect data (AAPI-2.1, PFS, BARC-10, and DARS) at intake and 3-month intervals and periodically analyze data. Collect qualitative data from participants and staff about their experiences with the program. Synthesize into program evaluation

HEALTH EQUITY

- Nationwide, the fragmented systems of care and provider shortages in maternity and behavioral health care cause challenges for this population (CMS 2019). Integrated and co-located services are especially rare in rural areas such as the one served by this program, and rural areas are already disproportionately affected by the opioid epidemic.
- This program addresses health equity by serving families where the need is greatest, and resources are fewest. The program serves the disparate population drawn from the designated distressed counties of Appalachia, with the highest rates of drug use, mental health disorders, poverty, unemployment, etc.

EVIDENCE OF EFFECTIVENESS

All participants were non-Hispanic White and had annual incomes of less than $15,000. Most participants had less than a high school education and all but one were unemployed. Nearly half of participants had a history of physical, emotional, or sexual abuse. Participants were in their late 20s and had two children, counting current pregnancies, on average. Most active participants owned or rented housing, but most inactive participants lived in residential treatment facilities (which was often stated as their reason for leaving this program). Participants found and entered the program through a variety of pathways, not necessarily through a formal referral process. Many of the HEART participants reported losing custody of children and having lengthy, frustrating, and confusing experiences with social services. As with custody, living arrangements and housing situations were often in flux. Participants reported accomplishments while in HEART, including completing treatment programs, finding stable housing, obtaining employment, and buying a car. Parents reported that their children had

improved socialization and verbal skills, and said they felt better-prepared to care for their children and address challenging behaviors. Participants reported bonding with their children, reconciling with estranged family, managing anger, communicating effectively, and navigating social situations without drugs. Specific instruments used included: Adult-Adolescent Parenting Index (AAPI-2.1), the Brief Assessment of Recovery Capital (BARC-10), the Devereux Adult Resilience Survey (DARS), and the Protective Factors Survey (PFS).

Section 2: Implementation Guidance

STAKEHOLDER EMPOWERMENT & COLLABORATION

Collaboration partners for this project included:

- **Big Sandy NAS Coalition**-this group identified the need for more comprehensive programs that would address maternal SUD, NAS, and the high infant mortality rate in the region.
- **Local Health Department Director**- the local health department director was enthusiastic about hosting the pilot project and helped ensure the resources were available to support HEART's activities.
- **State Health Department**- provided support and oversight for the program.
- **Local Recovery Center**- provided peer support staff.
- **Local Mental Health Center**- provided a trauma counselor.
- **Local Church**- provided a site for sessions, donated some materials to the program.
- **Local Hospital**- referred participants.
- **Child Welfare System**- referred participants.
- **Courts System**- referred participants.
- **Community Groups (various)-** spoke at sessions and helped participants find resources to address unmet needs.
- **Evaluation Team**- including the epidemiologist and qualitative researchers from external organizations.

REPLICATION

This practice has not yet been replicated. Plans to replicate in a nearby county by 2020 were placed on hold due to the effects of COVID-19.

INTERNAL CAPACITY

Onsite personnel included:

- A local program coordinator, who has a background in social work and a history of working with the child welfare system and families affected by SUD.
- A parent education specialist employed by the public health home visiting program.
- Two peer support specialists from a local SUD treatment center, who have state-issued certifications in peer support.
- Enough childcare providers to watch the infant and toddler children of participants during sessions.
- A licensed trauma counselor from a local mental health care center.

At the state department for public health, supporting personnel included:

- The Early Childhood Development Branch Manager provided support with budgeting and grants management.
- The Early Childhood Mental Health Program Administrator provided technical assistance with program design and implementation.
- An epidemiologist evaluated the program and provided technical assistance with developing data collection methodologies.
- The Title V Director provided oversight and guidance in design and implementation.

PRACTICE TIMELINE

Phase: Planning/Pre-Implementation		
Activity Description	**Time Needed**	**Responsible Party**
Program Design	**Fall 2017-Summer 2018** **250 hours**	**Title V Director, Early Childhood Mental Health Program Administrator**
Staff recruitment and onboarding	**Summer- Fall 2018** **250 hours**	**Local Health Department Director**

Phase: Implementation

Activity Description	Time Needed	Responsible Party
Participant Enrollment	Fall 2018- Present 2 hours/week	Program Coordinator
Parenting Classes	Fall 2018- Present 3 hour/week	Parent Education Specialist
Community Services	Fall 2018- Present 2 hours/week	Program Coordinator
Peer Recovery Support	Fall 2018- Present 4 hours/week	Peer Support Specialists

Phase: Sustainability

Activity Description	Time Needed	Responsible Party
Assessment	Fall 2018- Present 1 hour/week	Program Coordinator, Epidemiologist
Evaluation	Spring 2019- Present 250 hours	Evaluation Team

PRACTICE COST

Below was the first-year budget. Actual first-year costs came in substantially under budget, at $110,000, but new programs should use the higher figure as their guide in planning.

Budget			
Activity/Item	**Brief Description**	**Quantity**	**Total**
Coordinator/Regional Director	Includes direct and fringe	1 FTE	$120,000
Parenting Group Leader	Paying for home visiting staff	1 Leader for 42 sections	$44,100
Peer Recovery Coach	Time donated in-kind by local recovery centers	2	$0
Trauma Counselor	Time donated in-kind by local mental health center	1	$0
Child Care providers	Paying for childcare during sessions each week	4	$26,880
Training	In-kind, provided by the state department for public health	*N/A.*	$0
Supplies	Consumables, Pack & Plays with sheets, gas cards	*N/A.*	$24,000
Incidentals	Meals, snacks for participants and their families	*N/A.*	$3,920
		Total Amount:	**$200,000**

LESSONS LEARNED

In the evaluation report, the following were listed as successes for the program: improved participant self-esteem, continued progress toward recovery, positive outcomes or impacts for children of participants, improved parenting skills, improved relationships between participants and others, involvement of fathers in the

program, the provision of services and referrals for additional resources, the staff's skills, the format and content of the peer support, and changing community perceptions of SUD.

The program did encounter some challenges, which were addressed through recommendations in the program evaluation report. Participant safety was a concern due to individuals being present during the sessions who were not participants; the evaluators recommended implementing protocols to address participant and staff safety. Parents who did not have custody of their children felt that they did not have enough time in visitation; the evaluators recommended finding strategies to allow parents in HEART more time with their children to practice parenting skills. Some parents with several children felt that the curriculum was too basic; the evaluators recommended including information that would apply to older children and children with different developmental needs. Transportation and scheduling were the biggest barriers to attendance; the evaluators recommended looking into flexible scheduling options and partnering with community groups that could provide transportation to sessions. During the interviews, it became apparent that fathers were less involved in the program; the evaluators recommended that the program make some formal decisions about the role of men in the program. Based on participants' descriptions of the medication-assisted treatment programs, the evaluators recommended assessing what services are currently offered in the community and ensuring that HEART does not duplicate services. Staff burnout is also a concern due to workload and the emotional burden of the work, so the evaluators recommended hiring additional program staff (such as a care coordinator) who could handle duties currently covered by other staff as well as expanding the training and support available for Beyond those recommendations, there were several other lessons learned. Those included improving the screening processes to better identify needs and serve participants, and expanding service offerings (WIC, family planning, immunizations, toxicology screenings, etc.). The evaluators also recommended formalizing all program protocols (referral, eligibility, intake, curricula, data collection) in order to promote quality and consistency.

NEXT STEPS

During COVID-19, program sessions have been offered online, with content tailored to the individual participants' needs and reformatted for a virtual setting. This transition was a learning process for HEART but could help the program be sustainable in coming months. The program is scheduled to expand to a second site in coming months, but that plan may need revisited based on social distancing guidance. HEART staff have been addressing some of the evaluation recommendations, specifically related to formalizing protocols. However, turnover in program staff has made ensuring consistency a challenge.

RESOURCES PROVIDED

- N/A.

APPENDIX

- N/A.

REFERENCES

Centers for Medicare and Medicaid Services (CMS). (2019). Maternal Opioid Misuse (MOM) Model. https://innovation.cms.gov/initiatives/maternal-opioid-misuse-model/

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