PART ONE

Building Hope for Families Affected by Substance Use and Mental Health Disorders:

A Blueprint for an Effective System of Care to Promote Lasting Recovery and Family Well-Being

National Center on Substance Abuse and Child Welfare

Acknowledgment

The Center for Children and Family futures (CCFF) would like to offer a special Thank You to the ten In-Depth Technical Assistance (IDTA) and Regional Partnership Grant project representatives who were interviewed for this publication. The lessons garnered from these interviews will help further the knowledge and practice of jurisdictions working to improve the lives of, and permanency outcomes for, children and families affected by substance use disorders. The participants were:

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The National Center on Substance Abuse and Child Welfare (NCSACW) created this three-part blueprint to illustrate an effective system of care that promotes lasting recovery, safety, permanency, and well-being for families affected by substance use disorders (SUDs) and mental health disorders.

Part 1 introduces the essential pillars of an effective system of care, built on the lessons of key federally funded programs. It describes policy-level opportunities to support expansion of these policy and practice pillars to achieve lasting systems change on behalf of families affected by SUDs and mental health disorders.

Part 2 describes the purpose, activities, outcomes, and lessons from two federally funded initiatives: the Regional Partnership Grant (RPG) Program and the In-Depth Technical Assistance (IDTA) Program—aimed at improving outcomes for families affected by SUDs and at risk of involvement with child welfare services.

Part 3 provides an in-depth description of the essential pillars of a system of care including rich site examples from the RPG and IDTA programs. It illustrates how sites have implemented collaborative policy and practice strategies to improve equitable access to family-centered services and to enhance family outcomes.

To support development of this blueprint, NCSACW interviewed representatives from 10 RPG and IDTA program sites. To build on previous knowledge gained from many other sites, these interviews provided information about the key lessons, strategies, challenges, and opportunities learned through their collaborative initiatives to improve outcomes for families affected by SUDs and mental health disorders.

Through the three parts of this blueprint, policymakers, state and county administrators, and community partners will better understand the needs of these families, learn strategies to serve them, and gain hope that—with an effective, collaborative system of care on behalf of families affected by SUDs and mental health disorders—*parents do recover, and families and communities do heal*.

Part 1: The Essential Pillars of an Effective System of Care for Families Affected by Substance Use and Mental Health Disorders

BACKGROUND

Tribes, states, counties, and communities have long grappled with parental SUDs and their associated risk to child and family safety, health, and well-being. The opioid epidemic and significant increases in drug overdose deaths in recent years have exacerbated the challenges of serving these families and meeting their complex needs. Opioid overdose deaths have continued to rise in the U.S.—with a 15% increase from 2020 to 2021.[1] Black individuals are disproportionately affected, with the highest rate of overdose deaths from synthetic opioids compared to other races/ethnicities.[2] While opioids have rightfully garnered national attention, methamphetamine overdose deaths have also increased—rising nearly five-fold from 2012 to 2018—with highest rates among American Indians and Alaska Natives (AI/AN).[3] Overdose deaths have contributed to children entering kinship or out-of-home care and led to more complex child welfare services cases.[4]

The percentage of children entering out-of-home care with parental alcohol or drug abuse as an identified condition of removal has continued to increase since 2000.[5] Families involved with child welfare services due to parental SUDs[1] have a lower likelihood of successful reunification with their children if removed; their children also tend to stay longer in out-of-home care.[6,7,8]

Children and families from diverse racial and ethnic backgrounds involved with child welfare services often face further challenges. Black American and AI/AN children are overrepresented in out-of-home care.[9] Children with diverse racial and ethnic backgrounds are more likely to experience longer stays in out-of-home care; less likely to be reunified with their families and find permanency; and more likely to have poor educational, social, behavioral, and other outcomes.[10,11] They may also be less likely to be reunified due to inequitable access to services.[12,13,14]

Infants in particular are entering out-of-home care at increasingly high rates; they accounted for more than 70% of the total increase in entries to care from 2011 to 2018.[15] NCSACW has seen that the largest contributor to infants entering care is identification of prenatal substance exposure with other family risk factors.[2] In response, Tribes, states, counties, and communities have worked to develop a cross-system approach to treating pregnant and postpartum women with SUDs—as well as their infants.

[1] There are differences in reporting and policies about how this data is captured and inputted into state data systems that feed the AFCARS data set. This variation likely contributes to a substantial undercount of children removed with parental alcohol or other drug use as a contributing factor.

[2] For more information on risk factors that may increase the likelihood of child maltreatment, visit: https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html.

This approach includes developing processes for: 1) notifying child welfare services, and 2) creating Plans of Safe Care (POSC) for infants "born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder (FASD)," per the 2016 Comprehensive Addiction and Recovery Act (CARA) amendments to the Child Abuse Prevention and Treatment Act (CAPTA). POSC help families receive the range of services needed to resolve risk factors, increase family strengths, and prevent separation.

Hope for Family Healing and Recovery

Despite the data, there have been major advances in the past two decades identifying the most effective strategies to safely keep families together so they can heal in unison. Two key federally funded initiatives—the Regional Partnership Grants Program and the In-Depth Technical Assistance Program (described in detail in Part 2 of this Blueprint)—have contributed to this knowledge base while demonstrating key positive outcomes for families. As a result, families have remained safely together, parents have sustained their recovery from SUDs, and innovative policy and practice systems changes are now institutionalized to promote these positive family outcomes for all families.

A great many collaborative teams have noted they could never return to how they operated before; they have witnessed firsthand—through implementing this comprehensive system of care for families—how parents do recover, and families and communities do heal.

THE FOUNDATION: CROSS-SYSTEM COLLABORATION

The foundation of an effective system of care for families affected by SUDs and mental health disorders is a strong cross-system collaborative team drawing on the talents, expertise, and resources of many agencies and individuals with lived experience of SUD recovery and involvement with child welfare services. These diverse agencies include child welfare services, SUD and mental health treatment agencies, courts, public health and health care providers, early childhood education, community-based agencies, and representatives from the recovery community.

> "IDTA site representative: "That's why partnerships work—because everybody comes with expertise. I don't have to be the expert on everything, I just have to know somebody."

Traditional services provided through siloed service agencies do not provide the holistic approach necessary to comprehensively serve these families. Rather, it requires multiple agencies that consistently work together and communicate to provide coordinated, streamlined services for children, parents, and family members. These agencies respond to families' multiple needs as a means to prevent out-of-home placement, keep family members together, and promote parent recovery and family healing.

Building sustainable cross-system collaboration among these diverse agencies who represent the needs of the community takes significant time and involves advancing through stages of collaboration. At the onset, partner agencies may struggle to collaborate, finding it difficult to establish shared accountability through data collection and analysis.

A former RPG program participant, now a current Family Peer Advocate for the program, highlights the system's positive outcomes:

"They taught me how to be independent and vulnerable in a healthy way, showed me I was more than worthy of greatness, and that I could achieve anything I put my mind to. I did just that. I changed into a person once unimaginable for me. Through hard work and dedication from my team and [recovery support network], I was given a second chance at raising my son. He came home with me, and I have never looked back. I believe in RPG so deeply that I decided my heart was into helping people just like me. If I could do it, anyone could do it—and find a new way to live. I am now with RPG as a Family Peer Advocate. Today, not one moment goes by that I don't see how my [past] nightmare is now my fairy tale and how truly grateful I am to be a miracle typing this out today: present, and living my best life!"

Early in the collaboration-building process the focus may be primarily on sharing information about each agency's processes and services and they may just begin to develop joint projects. As they build trust and create shared data systems, joint case planning, and universal protocols, collaboratives can begin to institutionalize policies and practices, and permanently improve how services are provided to families. By standardizing these processes the effects of changes in leadership and administrative priorities as well as staff turnover and workforce development challenges can be minimized.

Many of these challenges (e.g., staff turnover, workforce shortages) intensified during the pandemic.

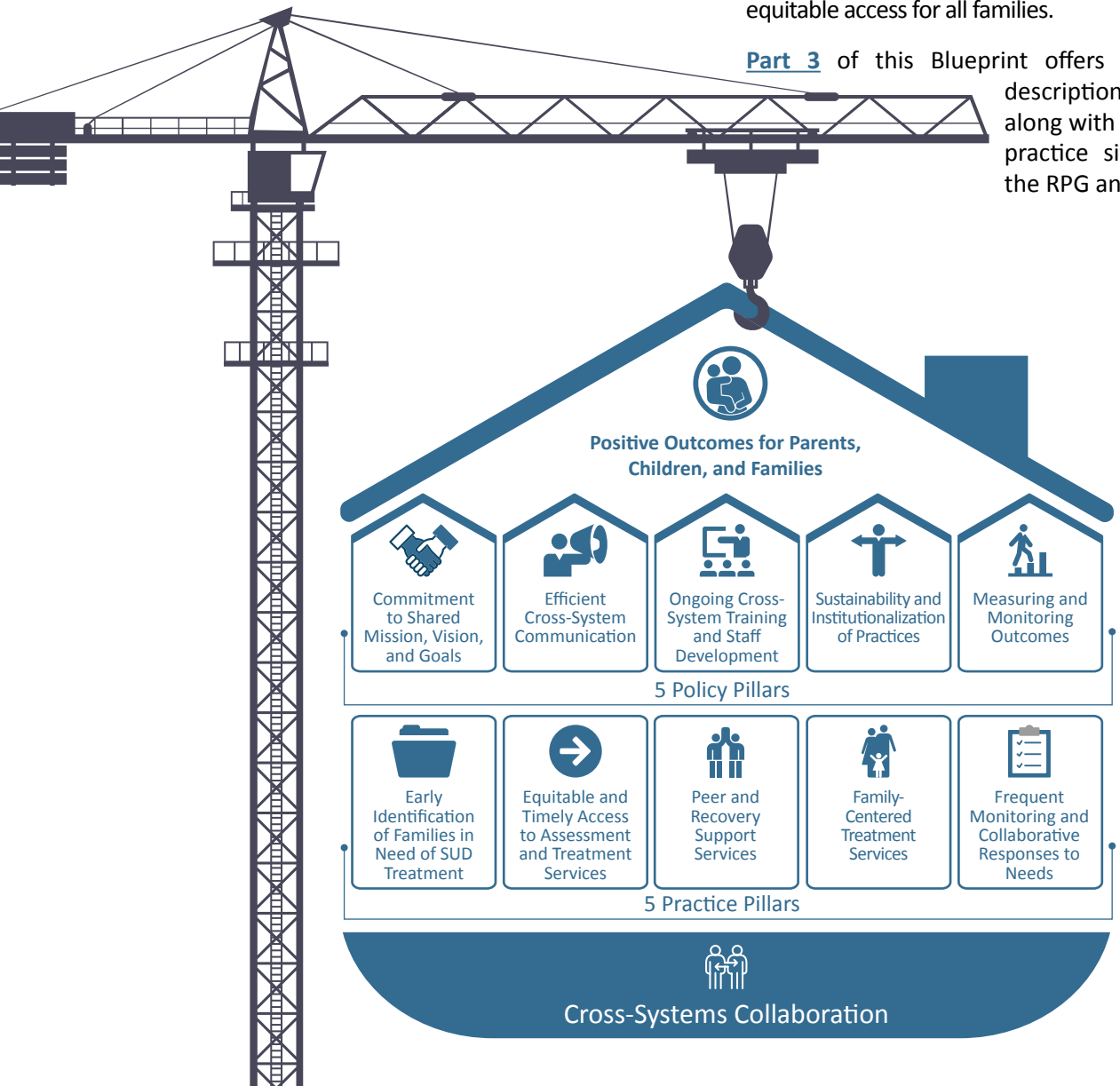
Ultimately, after years of dedication and investment of resources and time, collaboratives can establish and sustain an effective system of care that promotes positive outcomes for all families, as well as the agencies and professionals that serve them.

THE ESSENTIAL PILLARS OF THE SYSTEM OF CARE

With cross-system collaboration at the foundation, an effective system of care for these families develops though 10 essential pillars known to promote positive outcomes. These pillars originate from Children and Family Futures' (CFF) *Comprehensive Framework to Improve Outcomes for Families Affected By Substance Use Disorders and Child Welfare Involvement*.

The pillars include *five system-level policy efforts*. These efforts, in turn, strengthen a multidisciplinary, collaborative approach to sustaining *five key practice strategies and innovations* that improve outcomes for families. Each of these pillars can be implemented individually; however, when cross-systems collaboratives construct them in unison, this effective system of care creates true sustainable systems change on behalf of families. By reviewing data at the onset of an initiative, collaborative teams can then better assess how to increase the scale of their initiative, enhance services across the continuum, and improve equitable access for all families.

Part 3 of this Blueprint offers a more thorough description of the pillars along with detailed policy and practice site examples from the RPG and IDTA programs.



System-Level Policy Pillars

There are five policy pillars essential to building a strong, multiagency collaborative team. These pillars can be put in place first to best implement and sustain the innovative practice strategies.

- **Commitment to Shared Mission, Vision, and Goals**

  United commitment to shared mission, vision, and goals remains the cornerstone of a strong collaborative team. Tensions may appear early in the development of an initiative; partner agencies often come to the table with: 1) differing opinions and values related to the mission and priorities of the work, and 2) diverse viewpoints of parents with SUDs. Collaborative teams benefit when they take time to develop an understanding of partner agencies' processes and priorities, clarify any misunderstandings, develop a shared common language, and clearly define both a mission and goals for the project. This process requires leadership to devote ample time to plan meetings and establish a formal governance structure that promotes engagement from all involved partners with all levels of staff—from the executive level to the front line.

Through their completion of the Collaborative Values Inventory, one RPG program found a significant bias against pregnant and parenting mothers with SUDs among some health care professionals, especially those working with infants. In response, they developed an eLearning session on stigma for health care professionals, *Stigma Associated with Addiction*, which reviews the disease model of addiction and features patients' experiences of interactions with the health care system.

- **Efficient Cross-System Communication**

  Developing cross-system information sharing agreements and protocols allows local partners to collaboratively monitor families' progress toward goals as well as evaluate the success in achieving the initiative's mission. This process requires development of clear administrative policies and protocols so that confidential information remains protected and properly exchanged to: 1) protect participants' rights, and 2) allow partners to trust that information will be shared appropriately. At the local level, information sharing among the child welfare agency, SUD and mental health treatment agencies, court, and other partners allows them to jointly identify problems that families are experiencing, detect unmet service needs, and adjust treatment or case plans accordingly.

An RPG recipient developed a Progress Exchange Form into which SUD treatment providers enter monthly treatment progress notes. They upload the form to the child welfare family case record within the state child welfare data system, which child welfare case managers may easily access. SUD treatment providers may also access child welfare case information from this system to further enhance cross-system information sharing.

- **Ongoing Cross-System Training and Staff Development**

  Developing and maintaining an ongoing cross-system training program encourages partner agency staff to understand the holistic needs of families affected by SUDs and mental health disorders while gaining knowledge of the practices, processes, and roles of the partner agencies in meeting those needs. Collaborative partners come to the table with expertise and knowledge within their own service systems; still, they often lack a complete understanding of the evidence-based practices, processes, and service needs of families beyond their own area of focus. Ongoing and consistent training programs ensure that all partner agency staff are on the same page, help to combat stigma related to working with families affected by SUDs and mental health disorders, and encourage sustainability of policy and practice changes amid administrative and staff turnover.

In one RPG program, peer recovery specialists conduct 30-minute trainings on Recovery-Oriented Systems of Care at every monthly meeting. This work has improved partners' understanding of SUD treatment and recovery while also elevating the voices and expertise of persons with lived experience.

- **Sustainability and Institutionalization of Practices**

  Successful program sustainability involves shifting focus from simply how to keep an individual project funded, to permanently changing the system to reflect a new way of doing business across organizations.

These efforts need to begin early in the life of a collaborative initiative; thus, collaborative teams need to ensure all of the partner agencies remain involved and invested in finding coordinated ways to access the range of funding resources from multiple systems. Formal sustainability plans involve strategizing potential funding streams to expand, replicate, or institutionalize the policy and practice changes proven effective. Sustainability relies on measuring and monitoring outcomes to demonstrate the initiative's success when garnering support for future funding.

An IDTA site developed a program in one region of the state that provides intensive case management, wraparound services, and recovery supports for pregnant and postpartum women with opioid and other SUDs—and their families—for up to 1 year following birth. At first, it was jointly funded through the state SUD treatment and child welfare agencies for implementation in three regions in the state. Key state-level leaders elevated the program's outcomes at the state-level opioid committee meetings such that the message of its success reached the governor's office. The governor then announced funding from the state's opioid initiative to expand the program to the entire state.

- **Measuring and Monitoring Outcomes**

  Measuring and monitoring family outcomes allow collaborative teams to: 1) develop joint accountability across systems in the pursuit of the goals of the initiative, and 2) examine the program's progress toward improving child, parent, and family outcomes. Early in the initiative, partners need to agree upon a set of performance measures to monitor comprehensive family outcomes—such as safety, permanency, and well-being for children—along with SUD treatment completion and recovery measures for parents. Teams can develop and maintain effective information systems to accurately measure the agreed upon goals. This may involve linking administrative data sets to match parents in treatment with children involved with child welfare services—allowing them to jointly monitor cases and track family outcomes based on the identified performance measures. Collaborative teams benefit from regularly reviewing data via a data dashboard or report card to share progress and identify any needed program and practice modifications.

> "RPG recipient (who integrated evaluation and service teams): "The close relationship between service and evaluation really is essential. It's relationship; it's partnership. Data drives our decisions."

Practice Pillars

These practice pillars include innovative and effective strategies that lead to positive outcomes for families affected by SUDs and mental health disorders.

- **Early Identification of Families in Need of SUD Treatment**

  One of the most integral steps to keep families safely together and prevent out-of-home placement is the early identification of parents in need of SUD and mental health treatment through universal screening practices. As a best practice strategy, it is recommended that child welfare workers universally screen all parents with cases of suspected maltreatment for SUD and mental health disorders since parental substance use—and the effects on child and family safety—are not always evident upon an initial report. The World Health Organization recommends that health care providers universally screen all pregnant women for alcohol and other substance use as early as possible in the pregnancy and at every follow-up visit.[16] Universal screening practices may help reduce racial biases and discrimination that might otherwise cause families from underrepresented groups to be screened at a disproportionate rate. Implementing universal screening requires collaborative teams to select appropriate validated screening tools, provide ongoing training on screening processes, ensure consistent sharing of results among partners, and ensure effective referral for assessment and treatment services for all members of the family.

An IDTA program disseminated a statewide Birthing Hospital Survey to understand how pregnant women and infants with prenatal substance exposure are identified, treated, and triaged. Results from the survey informed development of statewide best practice guidelines for screening, as well as cross-system models to ensure these families receive the services they need. For example, they developed an intensive case management, wraparound, and recovery support program for pregnant and postpartum mothers and their infants that requires contractors to screen mothers for SUDs using an evidence-based screening tool, such as the 4P's Plus.

- **Equitable and Timely Access to Assessment and Treatment Services**

  Parents with SUDs and child welfare involvement often face many obstacles in accessing and remaining in treatment; children and families from diverse racial and ethnic backgrounds often experience further barriers. Equitable and timely access to SUD and mental health assessment and treatment services remains a critical component to the effective system of care since a parent's successful engagement in treatment and transition to recovery are essential to positive child welfare and court outcomes.

  Collaborative teams use a variety of methods to improve timely access to services, such as offering family members care coordination or program navigators to ensure warm handoffs and smooth transitions between service providers, using motivational enhancement techniques such as Motivational Interviewing (MI), and implementing POSC for pregnant and postpartum women with SUDs and their infants that promote early access to prenatal care and SUD treatment and services. Equitable and timely access to assessment and treatment services requires a strong relationship between child welfare services and local SUD treatment providers, as well as agreed upon information sharing protocols that promote communication regarding treatment progress.

An IDTA program created an approach—rooted in community public health—to developing prenatal POSC for pregnant mothers and their infants. For pregnant mothers actively engaged in their treatment plan or following a physician-prescribed course of treatment—absent other risk factors—the medication-assisted treatment (MAT) provider or the birthing hospital develops and manages prenatal POSC. Managing these plans outside of the child welfare system helped to increase timely access to prenatal care and SUD treatment services by removing any parental fear of automatic referral to child welfare.

- **Peer and Recovery Support Services**

  Recovery support services—provided by persons with lived experience of SUDs and child welfare involvement, or by professionally trained recovery specialists—help parents receive the assessments, treatment, and support services they need to be successful with their treatment and child welfare case plans. These peers or specialists may serve as the support person who prepares the parent for SUD treatment assessment and may even assist with transportation or attend the assessment with them. Persons with lived experience, in particular, serve as trusted allies for parents as well as positive role models of recovery, with support that extends beyond the reach of clinical SUD treatment. Peers and recovery supports, within the context of child welfare services, help coordinate services to achieve cross-agency goals of: 1) fostering adult recovery and parental capacity, 2) strengthening adult and child bonding, and 3) promoting child safety and permanency in the caregiving relationships.[17] Implementing recovery support services requires collaborative teams to: 1) clarify the roles and responsibilities they intend for persons with lived experience to fulfill, 2) secure funding for paid positions, and 3) ensure ongoing training and coaching.

> "RPG program participant: "Working with [the person with lived experience] made me feel like I had someone on my team who understood what I was going through. I felt like he understood me better than even my therapist because he had a similar story; he is a great example of being able to turn things around."

- **Family-Centered Treatment Services**

  Parental SUDs and mental health disorders affect the entire family; they can interfere with a parent's ability to take care of and bond with a child while also disrupting family health and well-being. A comprehensive system of care for these families relies on delivery of family-centered services that provide a comprehensive array of clinical treatment and related support services to meet the needs of the children and each member in the family—not just the identified client.

  Family-centered interventions seek to build parental capacity, enhance family relationships, and improve family functioning.[18] Ideally, families receive evidence-based, multigenerational programs and parenting curricula designed for parents in recovery. Family-centered treatment needs to also be trauma informed; culturally responsive; and tailored to the individual's race, gender, cultural identity, and sexual orientation.

It is critical that all partners reflect an understanding and responsiveness to the fact that parents and children live within the context of a larger family system, and families exist within the context of their community and culture.

An IDTA program promotes a family-centered approach to supporting pregnant and postpartum women with SUDs and their infants and families through expanding the use of Family Care Plans. Family Care Plans ensure families receive comprehensive family-centered treatment and auxiliary services not only for pregnant or postpartum women, but also the infant, children, and other family members. As of 2023, all state-contracted SUD treatment providers are required to develop Family Care Plans for pregnant and postpartum women with SUDs.

- **Frequent Monitoring and Collaborative Responses to Needs**

  Parents with SUDs and mental health disorders in early recovery require much more frequent contact, support, and oversight than typically provided through routine child welfare and court cases. Enhancing the monitoring and ongoing support for families can happen through a number of approaches, such as increasing the number of administrative case reviews, facilitating collaborative case planning, ensuring regular family team meetings, and implementing family treatment courts (FTCs). Consistent oversight ensures that if the parent needs an adjustment to their treatment plan, the entire team will be aware and make timely, appropriate changes to ensure continued recovery for the parent and permanency for the children. Oversight also includes setting clear expectations and providing therapeutic, motivational responses to parents' behaviors such as contingency management and MI.

An RPG project serving pregnant and postpartum women with SUDs and their infants encourages program participation and fosters positive behavioral change in a voluntary setting without the use of judicial/court oversight. Their multidisciplinary clinical care team provides supportive oversight to monitor parent progress and meets regularly to discuss collaborative responses to any unmet family needs. They ensure that all messaging and information to parents is consistent and clear across providers.

POSITIVE OUTCOMES: HOW DO FAMILIES BENEFIT FROM THIS SYSTEM OF CARE?

Results from several multisite evaluations—as well as individual studies of innovative programs serving families involved with child welfare and affected by SUDs and mental disorders—show that implementing this system of care promotes equitable outcomes in the following domains:[19,20,21,22,23,24,25,26,27]

EQUITY in ACCESS and OUTCOMES

All outcomes disaggregated by race, ethnicity, gender, and other key demographic characteristics.

RECOVERY
Parents access treatment quicker, stay in treatment longer, and decrease substance use.

REMAIN AT HOME
More children remain at home throughout program completion.

REUNIFICATION
Children stay fewer days in out-of-home care and reunify within 12 months at a higher rate.

REPEAT MALTREATMENT
Fewer children experience subsequent maltreatment.

RE-ENTRY
Fewer children re-enter out-of-home care after reunification.

Part 2 of this blueprint provides individual outcome data from the RPG and IDTA programs.

POLICY OPPORTUNITIES TO EXPAND THIS SYSTEM OF CARE

Now that there is clear evidence of the most effective policy and practice strategies for serving these families, the next step is ensuring Tribes, states, counties, and communities can continue implementing these strategies and expanding their programs to serve all families affected by SUDs and mental health disorders. NCSACW interviewed RPG recipients and IDTA sites to understand the policy barriers and challenges they face as well as the related opportunities and investments that would support them as they continue this work.

One interviewee noted an example of an organization whose model offers support to families in child welfare by persons with lived experience. The organization faced challenges in their efforts to become a Medicaid provider in their state. Another state noted challenges with billing peer support services through Medicaid as rates are low and vary based on county. Two states noted that, while their peer support programs demonstrate positive outcomes for families, they have difficulty developing the rigorous evaluation studies necessary to build the evidence base for these programs that might support their continued funding.

- **Increase Funding for Support Services by Persons with Lived Experience**

  Barriers and Challenges: Tribes, states, counties, and communities consistently report that SUD recovery support by persons with lived experience is one of the most crucial components of a comprehensive system of care for these families, and fundamental for ongoing recovery for parents. RPG and IDTA sites note that securing funding for these services continues to be a challenge, particularly for states without Medicaid expansion.

  Policy Opportunities: Tribes, states, counties, and communities can customize the way that funds can be accessed to support peer and recovery specialist programs, based on individual community needs. States can apply for Medicaid expansion to offer peer support services as a comprehensive mental health and SUD service delivery system. To include support by persons with lived experience in the state Medicaid plan, they need to: 1) have a mental health professional, as defined by the state, as a supervisor, 2) coordinate peer support with an individualized recovery plan with measurable goals, and 3) complete training and certification as defined by the state.[28] Jurisdictions are encouraged to explore Medicaid expansion efforts in their state and to seek technical assistance from NCSACW and other organizations to support their funding efforts.

  States can also invest in building the evidence base for programs offering support by persons with lived experience through federal, state, and philanthropic resources. Demonstrating program effectiveness can help to secure future funding.

  The Family First Prevention Services Act (FFPSA) also provides a significant opportunity to enhance this system of care for families since it expands how Title IV-E of the Social Security Act can connect families to SUD treatment services and keep children safely with their parents during treatment.[29] See the **Children's Bureau website** as well as *Planning Title IV-E Prevention Services: A Toolkit for States* for more information regarding funding prevention services.

- **Extend Health Care Coverage for Postpartum Care**

  Barriers and Challenges: Tribes, states, counties, and communities need consistent intensive support for families in the postpartum period to reduce rising rates of maternal overdose and mortality, particularly for women of color. One in three pregnancy-related deaths occur between one week and one year after childbirth.[30] In 2019, the maternal mortality rate for non-Hispanic black women was 2.5 times the rate for non-Hispanic white women and 3.5 times the rate for Hispanic women.[31] Further, risk of relapse and overdose among women with opioid use disorder who recently gave birth is highest 7 to 12 months postpartum.[32] Several RPG and IDTA sites noted that a lack of funding for postpartum care (including substance use and mental health treatment) and infant healthcare beyond 6 months postpartum is a barrier to families' health, safety, permanency, and well-being.

  One interviewee described their community's challenge related to women only receiving Medicaid coverage until 60 days postpartum and the effect on child welfare outcomes. The interviewee stated that in cases where a mother loses custody of her infant after this 60-day period, there is a lack of health care coverage for her continued SUD treatment.

Policy Opportunities: The American College of Obstetrics and Gynecology recommends extending Medicaid coverage to at least one year postpartum.[33]

This ensures continued care for postpartum women with substance use and mental health disorders, as well as their infants, while improving child and family outcomes. For example, an interviewee described how Medicaid expansion in Oklahoma has allowed the state to offer the Parent Child Assistance Program, an evidence-based home visiting program that supports pregnant and parenting mothers and their infants affected by substance use until 3 years postpartum.

The American Rescue Plan Act of 2021 allows states to elect to provide 12 months of extended postpartum coverage to individuals enrolled in Medicaid and the state Children's Health Insurance Program (CHIP). See the *Center for Medicaid Services State Health Official Letter* for guidance to states on implementation of this new option.

- **Promote State Legislation that Protects Children and Remains Responsive to the Needs of Whole Families**

Barriers and Challenges: Many Tribes, states, counties, and communities report that state laws and child welfare policies, which they interpret as punitive, hinder their ability to comprehensively serve families affected by SUDs, particularly pregnant and postpartum women with SUDs and their infants.

Policy Opportunities: The American Academy of Pediatrics promotes supporting pregnant women with SUDs with primary prevention efforts and access to comprehensive prenatal care and SUD treatment through a trusting provider-patient relationship—referred to as a public health approach—rather than punitive measures through the criminal justice system.[34] This approach is described in more detail in the following section.

A related policy opportunity is to allow key child welfare, SUD treatment, and public health leadership—and those who work at the ground level—to review proposed state legislation and offer insight into the potential effects on families affected by SUDs and child abuse and neglect. These leaders can also educate policymakers, district attorneys, judges, law enforcement, and other legal professionals on the benefits of a family-centered, preventive approach to protecting infants and children while promoting parental recovery. While they might not be able to immediately change existing legislation, this opportunity allows states to ensure future legislation adequately responds to the needs of families and develops collaborative approaches to holistically serve families within existing laws.

In two of the states that were interviewed, women who use substances during pregnancy may be arrested and criminally charged. Interviewees stated that these practices may instill a sense of fear in pregnant women, creating a reluctance to seek prenatal care and SUD treatment services during pregnancy. These practices also may cause health care providers to avoid screening and reporting substance use in pregnancy due to fear of women being penalized.

- **Develop Community Partnerships that Support Preventive Approaches to POSC**

Barriers and Challenges: Many Tribes, states, counties, and communities acknowledge the need for child welfare services to develop community partnerships with health care, SUD treatment, home visiting, and other community providers to encourage preventive approaches to POSC and mitigate the need for child welfare involvement. It is ideal for pregnant women with SUDs to be engaged in a community-based voluntary POSC prior to the birth of the baby to promote positive outcomes; child welfare services is not always the agency to lead this preventive approach.

An interviewee shared that their state child chemical endangerment law creates a gap in services; child welfare does not have jurisdiction to intervene or provide services until the child is born, yet pregnant mothers may be criminally charged for using substances during pregnancy. Child welfare is working to build partnerships with healthcare providers to move into this gap and engage pregnant women in prenatal care and SUD treatment prior to birth with a prenatal POSC.

Child welfare services agencies note the challenge of responding to cases of prenatal exposure in which the mother is already engaged in SUD treatment or MAT and there are no other family risk factors—these cases might not necessitate a report and response from child welfare services, but a response may be legally required.

Policy Opportunities: Tribes, states, counties, and communities can establish community partnerships that allow for preventive POSC to be implemented outside of the child welfare system. Community-based agencies and health care providers can lead development of POSC in the prenatal period to engage pregnant women and their families in SUD treatment, prenatal care, and other supportive services prior to the birth of the baby as a way to keep families together and prevent out-of-home placement. For families with minimal to no child abuse or neglect risk factors, community-based agencies or health care providers can oversee POSC and coordinate services to meet these families' needs. Some communities have found ways to differentiate between notifications and reports to CPS for prenatal substance exposure.

Some communities have established multiple pathways for POSC development and implementation for cases that do not involve other risk factors for child abuse and neglect in which POSC development and follow up is led by community-based agencies. There is an opportunity to make state legislative and child welfare policy changes that support a preventive approach to POSC.

New Mexico recently passed **HB230**—state legislation aligned with the federal CARA amendments to CAPTA. This law promotes a non-punitive approach by not requiring an automatic referral to child welfare services based solely on the finding of prenatal substance exposure. The law supports New Mexico's shift in approach to serving pregnant women with SUDs—and infants with prenatal substance exposure—from a child welfare-led response to a public health effort.

NCSACW's *How States Serve Infants and their Families Affected by Prenatal Substance Exposure: Identification and Notification* highlights innovative ways states and local communities monitor and report on infants and families affected by prenatal substance exposure without an open child welfare case.

- **Require Multiagency Engagement as a Component to Funding for Initiatives Serving this Population**

Barriers and Challenges: Tribes, states, counties, and communities recognize that building cross-systems collaboration is a critical component to improving policies and practices on behalf of families affected by substance use and mental health disorders. RPG and IDTA sites consistently state that one of the key elements to their success is that they had engagement from multiple agencies that serve these families. However, building sustainable collaborative partnerships in which partners have a true stake in the work and consistently commit their time, resources, and expertise to the collaborative effort can be a major challenge.

> "Several interviewees credited the RPG program and IDTA application's explicit requirement that teams include representation from multiple agencies for ensuring this actually happened. One site representative noted: "We will stay siloed if you let us stay siloed."

Policy Opportunities: As noted by RPG and IDTA program representatives, one way to encourage engagement from multiple agencies is for all future federal and state funding to include a requirement that the project engage multiple systems and agencies. Further, requiring a planning period as part of the grant or other funding mechanism also encourages collaborative teams to lay the groundwork on which the initiative can be built. It urges teams to take the time to engage key invested partners, establish governance structures, come to consensus on shared mission and goals, establish communication pathways, and more. This process was the key to success for many RPG and IDTA programs. Federal and state funders may now encourage future initiatives to take this same collaborative approach to serving families. NCSACW's *Building Collaborative Capacity Series* offers strategies for states and communities to establish cross-systems collaborative teams.

- **Establish Cross-Systems Administrative Data Sharing and Agreed Upon Performance Indicators**

Barriers and Challenges: Tracking and monitoring data allows collaborative teams to measure program effectiveness, monitor comprehensive family outcomes, make data-driven program improvements, and promote program sustainability. RPG projects are required to evaluate their programs, submit common measures of their performance, and participate in a national cross-site evaluation as a component to the project. RPG project performance measures are used to analyze implementation and operations, develop reports to Congress on the RPG program progress, and advance local evaluation efforts.

Despite a requirement to establish data sharing agreements, RPG projects report difficulties gaining access to child welfare and SUD treatment administrative data, which hinders their local and cross-site evaluation activities. Some RPG projects report not being able to fully contribute to the cross-site evaluation due to difficulty obtaining data sharing agreements and limited access to data.

In addition, RPG projects identify the challenge of customizing the performance indicators beyond the required elements of the cross-site evaluation to meet their own program evaluation goals and fully measure SUD recovery and child welfare outcomes.

An RPG project noted that in their first round of RPG, it was a challenge for partners to consider sharing data across systems. There was a feeling of ownership over the data and a distrust for how it would be used. They emphasized that this has really shifted as they have built relationships through subsequent rounds of RPG.

An RPG project shared that their collaborative team determined that there were additional data indicators that they needed to measure to more fully understand how children, parents, and families were progressing toward program goals and objectives. They developed a matrix that identifies the levels of client success at discharge on twenty objectives across four goals.

Policy Opportunities: Commitment to cross-systems administrative and other data sharing requires a level of trust among partners that the information will be shared accordingly. Building trust among collaborative partners takes time and requires a dedicated planning period in which partners identify and commit to common values and goals as well as understand the roles, responsibilities, and operations of partner agencies. This process also helps collaborative teams to identify and establish joint outcome measures and performance indicators to accurately measure and monitor comprehensive outcomes, such as safety, permanency, and well-being for children, along with SUD treatment completion and recovery for parents. RPG and IDTA projects have had success developing data and evaluation subcommittees to ensure that program evaluation and data sharing among partner agencies remain a priority, and have created communication pathways to assure steering committees and executive leadership has needed information to support long-term sustainability.

The RPG Brief *Practice-Level Strategies to Create Systems-Level Change: Results* describes how collaborative teams can use cross-systems data to create shared goals and outcomes to inspire long-term practice and systems-level changes.

SUMMARY

Part 1 of this Blueprint described the need for Tribes, states, counties, and communities to create a collaborative system of care implementing proven policy and practice strategies that keep families safely together, encourage family-centered treatment for SUDs and mental disorders, and promote lasting recovery. It introduced the 10 policy and practice pillars that lead to positive child, parent, and family outcomes and provided site examples from communities implementing these pillars. Interviews with representatives from RPG and IDTA programs illuminated that Tribes, states, counties, and communities are facing real barriers in serving these families—such as accessing funding for peer support programs and extended postpartum care for mothers and infants; responding to state legislation that criminalizes substance use during pregnancy; developing proactive, preventive approaches to supporting families affected by prenatal substance exposure; and developing and maintaining collaborative partnerships. There are clear policy opportunities that Tribes, states, counties, and communities can pursue to reduce these barriers and promote continued expansion of the system of care to promote parents' recovery, and family and community healing.

In Part 2 of this blueprint, learn more about the federally funded initiatives—Regional Partnership Grants and the In-Depth Technical Assistance Program—that made important contributions to learning what works best when serving families affected by SUDs and mental disorders. In Part 3, dive deeper into how to implement the 10 policy and practice pillars, and read detailed RPG and IDTA site examples that highlight effective strategies.

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