



Collaboration Pathways for Infants and Families Affected by Substance Use Disorders: Lessons From New Jersey

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Contact Information

Website: <https://ncsacw.acf.hhs.gov>

Toll Free: 1-866-493-2758

Email: ncsacw@cffutures.org

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Introduction and Overview

In 2009, the state of New Jersey began working with NCSACW on a number of technical assistance (TA) projects to strengthen cross-systems collaboration and improve the lives of families in the child welfare system who are affected by parental substance use disorders. Two of these projects were part of NCSACW's In-Depth Technical Assistance (IDTA) program (see sidebar). For a decade, New Jersey's achievements have encompassed a full range of improvements to linkages among child welfare, substance use disorder treatment providers, and the courts broadly, and then moved to a more targeted emphasis on strengthening agency practices and policies specifically for families with infants with prenatal substance exposure. New Jersey's IDTA initiatives built upon a foundation of prior systems improvements that increased the state's readiness for innovation among agencies and other stakeholders seeking to improve outcomes for children, parents, and families affected by substance use disorders.

About This Case Study

This case study highlights New Jersey's progress and achievements from the vantage point of the New Jersey team and its partners at the intersection of health care, family courts, child welfare, and substance use disorder (SUDs)

NCSACW IDTA Program

Since its initial funding in 2002 by SAMHSA and ACYF, Children's Bureau, NCSACW has provided an array of TA and training to federal grantees and other state, tribal, and local collaborative teams seeking to build stronger linkages among child welfare, substance use disorder treatment providers, and the courts. The most intensive of these efforts is the IDTA program, which has assisted 25 state, county, and local jurisdictions.

In September 2014, NCSACW's IDTA initiative focused on substance-exposed infants (SEI) and their families. The SEI program was developed to help states respond to opioid use during pregnancy, the increasing number of infants entering out of home care, and a lack of coordinated and ongoing services that are needed to support infants, families, and caregivers during the critical postpartum and infancy period. To date, the targeted IDTA-SEI program has supported 12 jurisdictions.*

With senior-level NCSACW staff and consultants assigned to work with a state, county, or tribal interagency team for an average of 18 to 24 months, the IDTA projects have reformed interagency practice and state policy in ways that have improved outcomes and made systems changes in each of these sites. For more information on the IDTA programs, visit the NCSACW website at <https://ncsacw.acf.hhs.gov>.

** The IDTA-SEI program recently changed its name to the IDTA-Infants with Prenatal Substance Exposure program. However, this case study uses the original SEI designation that was employed during New Jersey's project.*

treatment, as well as the NCSACW staff who participated most actively in New Jersey’s work.¹ The case study is not intended to provide an exhaustive, detailed review of all components of the multi-year, multi-faceted TA effort. Rather, it describes the context of New Jersey’s IDTA projects, the accomplishments achieved, the barriers encountered, a set of lessons for further practice, and state and local policy reform in these arenas.

NCSACW believes the lessons from New Jersey provide useful information and guidance to other states and localities seeking similar progress in achieving shared outcomes for all families in their child welfare and other state agency caseloads affected by parental SUDs and especially for infants affected by prenatal exposure. What New Jersey achieved—and what the state partners continue to work on beyond the IDTA projects—has brought considerable progress toward better outcomes for these families.

New Jersey IDTA and IDTA-SEI Goals

New Jersey’s two IDTA projects were linked in significant ways, with the second targeted substance-exposed infant (SEI-IDTA) effort building on the first broader cross-systems improvement effort and because a core group of New Jersey officials were actively involved in both IDTA initiatives.

In 2009, at the outset of the initial IDTA project, New Jersey’s overarching goal was to implement a statewide coordinated plan to work with families involved with the child welfare system and affected by SUDs. More specifically, the state team’s priorities were to develop:

- Capacities for collecting, analyzing, and managing cross-system child welfare and substance use disorder treatment data
- A statewide, cross-systems child welfare and substance abuse training program for child welfare and substance abuse treatment staff
- A recovery support program to be piloted in at least one site

¹ This case study is based on the following major sources of information: (1) a review of more than 1,000 pages of reports that the New Jersey team and NSCACW staff prepared during the IDTA projects, (2) semi-structured interviews with three key New Jersey team members shortly after IDTA ended, and (3) interviews and correspondence with five NCSACW staff most actively involved in the New Jersey IDTA projects.

In 2014, in applying for the second, more targeted IDTA project focused on improving practice and policy for families with SEI, the New Jersey team's stated goal was: *To develop uniform policies/guidelines to address the entire spectrum and improve collaboration to address the multiple SEI intervention opportunities, from pre-pregnancy counseling continuing through a child's developmental milestones and parental treatment.*

The state team refined its IDTA-SEI goals further in 2016 to include the following:

- Increase perinatal SEI screening at multiple intervention points (i.e., the health system, the substance use disorder and mental health system).
- Increase the rate at which women who screen positive for prenatal substance use (using the 4P's Plus[®] validated screening instrument) are connected to assessments through leveraging existing programs and policy mechanisms and establishing formal safety net measures.
- Increase the rate at which women with substance exposed infants and other eligible children receive early support services through leveraging existing programs and policy mechanisms.

Organization and Context of the New Jersey IDTA Efforts

Leadership and Partners

The Division of Mental Health and Addiction Services (DMHAS) within New Jersey's Department of Human Services (DHS) was the lead agency for both IDTA initiatives. The state-based leadership of these two IDTA efforts overlapped significantly, which proved to be an asset in establishing continuity across efforts and a productive working relationship with the NCSACW. The state project liaison from DMHAS had a longstanding relationship with NCSACW.

The primary partnering agencies involved were the State of New Jersey's Division of Addiction Services (DAS); the Division of Child Protection and Permanency (DCPP)² in the Department of Children and Families (DCF); and, for the first initiative, the Administrative Office of the Courts

² DCPP was formerly known as the Division of Youth and Family Services (DYFS). The new division name is used for this case study.

(AOC). These primary partners met monthly and held monthly calls with the NCSACW Change Liaison, with additional calls scheduled as needed. Ad hoc committees were formed to work on specific objectives. Members of the Core Team were also charged with keeping their department's leadership informed about and engaged in the team's progress. State leaders from DCPP, DCF, DAS, and AOC met as needed to discuss the Core Team's work.

In the SEI project, the State Department of Health (DOH) also played an important leadership role, with the sustained involvement of its then Deputy Commissioner throughout the project.³ In addition, the DCF Commissioner recruited a staff member with practice and policy expertise in the intersections of child welfare and SUDs to oversee the SEI-IDTA project. These two individuals, along with the Women's Treatment Manager from the Division of Mental Health and Addiction Services led this initiative. All three were members of the State Opioid Workgroup, which met quarterly and essentially served as the Executive Leadership Committee for the SEI-IDTA initiative. More than 50 people from multiple systems and agencies were engaged over the life of the SEI-IDTA initiative at both state and local levels. DCF staff also included early childhood-focused officials, which deepened involvement on related issues, such as linkages to Head Start and early intervention services. Increased involvement of hospitals and other medical providers also occurred during the SEI-IDTA project, with county-level partners engaged in both IDTA projects. The New Jersey agency partners are listed in [Appendix A: Agencies Represented on the State Team](#).

Related Reforms That Paved the Way for IDTA

The New Jersey team benefitted from earlier reforms and innovation that provided a strong foundation of readiness for the IDTA efforts. Two of the most important efforts were (1) the development of screening and assessment contractual support under the state's Child Protection Substance Abuse Initiative (CPSAI), which strengthened local child welfare agencies' capacity to arrange for timely SUD assessments and referrals to treatment and (2) the innovative statewide implementation of the 4P's Plus prenatal substance use screening tool, which was embedded within the established Pregnancy Risk Assessment instrument, the statewide screening form used

³ In 2018, after the IDTA efforts concluded, the Deputy Commissioner left the state DOH to become Chief Executive Officer of a major New Jersey foundation that is dedicated to improving the health and well-being of vulnerable populations in New Jersey, including a focus on early childhood and sustainable systems reform.

for all Medicaid prenatal care. This foundation was a result, in part, of an earlier separate training in universal screening initiative for healthcare providers conducted by a recognized national expert that predated the IDTA process. Beginning in 1999, the state expanded the training sessions with South New Jersey physicians to include other hospitals, state Medicaid officials, and managed care organizations.

Other Important Contextual Events Affecting the IDTA Projects

The policy context affecting the two IDTA projects included some fundamental issues that most states encounter, as well as issues that were specific to New Jersey. New Jersey accepted Affordable Care Act expansions of Medicaid, and a greater emphasis on managed care also took place during the IDTA efforts. As an early Medicaid expansion state, treatment expansion and access to treatment were major state goals. Medicaid covers a high percentage of births with prenatal exposure, and initial prenatal screening targeted pregnant women who were on Medicaid. As such, engagement of Medicaid and managed care entities played a major role in the IDTA work. Moreover, as the number of newborns with neonatal abstinence syndrome (NAS) was increasing dramatically, with the vast majority of them covered by Medicaid, hospital costs for caring for these infants also increased dramatically. The state team recognized it was to their advantage to work with other partners on identifying pregnant women with SUDs early, connecting them to appropriate treatment covered by insurance, and stabilizing and preparing mothers for the birth event.

During both phases of IDTA, New Jersey's child welfare system was operating under a court order, which resulted from earlier class action suits against the state. The court order emphasized smaller caseloads for child protection workers, more foster homes, and an increase in adoptions. The state established a new cabinet-level DCF in 2006 and adopted a child welfare reform plan in 2004 to respond to

In 2016, New Jersey's child welfare system had 8,264 substantiated cases of child abuse or neglect and 11,019 children residing in out-of-home care.⁴

⁴ Sources: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2018). *Child maltreatment 2016*.

<https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2016.pdf>

and U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2017). *Adoption and foster care analysis and reporting system (AFCARS) Foster Care File FY 2016*. Ithaca, NY: National Data Archive on Child Abuse and Neglect [distributor].

<https://www.ndacan.acf.hhs.gov/>

these issues. The IDTA efforts sought to build on these developments, with a greater emphasis on parental substance use disorders as they affected the child welfare caseload. In 2015, the settlement agreement was modified, recognizing that the state had achieved significant child welfare system improvements and that some of the requirements were not feasible or did not reflect current child welfare best practice. The effects of the court order on the IDTA projects are discussed in Section V: Key Lessons.

The goals and results of the IDTA-SEI project were also affected by the opioid crisis. New Jersey is among those states most affected by opioid misuse, with overdose deaths statistically higher than the national average in 2016⁵ and significant increases in cases of NAS.⁶ These concerning trends provided a greater spotlight for the IDTA-SEI project.⁷ The Governor at that time chaired the President's Commission on Combating Drug Addiction and the Opioid Crisis, convened by the new federal administration in 2017. He also led a separate state task force to develop policy responses to the opioid crisis in New Jersey, which produced 25 recommendations for action in September 2017. Two of those recommendations explicitly referenced prenatal exposure as requiring immediate action. Other recommendations included increasing the number of recovery coaches in treatment agencies, expanding residential treatment, and expanding supportive housing. All of these recommended changes aligned with the goals that both IDTA projects had identified to address system challenges.

In addition, the state was affected by the passage of the Comprehensive Addiction and Recovery Act of 2016 federal opioid-related legislation and appropriations, including changes in the Child Abuse Prevention and Treatment Act (CAPTA) concerning notification of and response to

⁵ In 2016, the rate of opioid overdose deaths in New Jersey was 23.2 per 100,000, which was statistically higher than the U.S. rate of 13.3 per 100,000. Source: Hedegaard, H., Warner, M., and Miniño, A. M. (2017). Drug overdose deaths in the United States, 1999–2016. NCHS Data Brief, no. 294. Hyattsville, MD: National Center for Health Statistics. <https://www.cdc.gov/nchs/data/databriefs/db294.pdf>

⁶ Between 2010 and 2015, the incidence of NAS among New Jersey hospital births increased from approximately 4.9 to 7.1 per 1,000 live births. Source: New Jersey Department of Health (2017). *New Jersey Birthing Hospitals Survey: Substance exposed infants (SEIs) and their mothers*. The New Jersey Department of Health also reported that from 2008 to 2016, cases of NAS doubled to 685 babies diagnosed in the state (<https://nj.gov/health/news/2018/approved/20180409a.shtml>).

⁷ National Center on Substance Abuse and Child Welfare (2017). *Substance-exposed infants: A report on progress in practice and policy development in states participating in a program on in-depth technical assistance September 2014 to September 2016*. https://ncsacw.acf.hhs.gov/files/IDTA_Executive_Summary.pdf

infants identified as affected by prenatal exposure.⁸ The requirement for plans of safe care for these infants and their families became a focal point in the IDTA-SEI project and in New Jersey's ongoing efforts as of 2016.

Finally, several parallel initiatives were underway within state agencies at the same time as the two IDTA projects. These included expanded home visitation, an early childhood-focused project in three counties, and the development of a child welfare data hub based at Rutgers University.⁹ For the most part, these related initiatives operated separately from the two IDTA projects.

Major Practice and Policy Accomplishments

Through its two IDTA efforts, New Jersey achieved a number of practice and policy improvements to meet their stated goals (outlined in Section I). The major accomplishments of the first round of IDTA included enhanced capacities for cross-systems data collection, analysis, management, and preliminary planning for a recovery support model. In the first round of IDTA, NCSACW worked with DCF to develop a curriculum for child welfare staff on understanding parental substance use. Following the SEI-IDTA initiative, an advisory group was convened to guide the development of a substance use disorder certificate program for the New Jersey DCF Child Protection and Permanency workforce. The certificate program will build capacity for supporting families who are child welfare involved and affected by substance use and co-occurring mental health disorders. This statewide cross-systems training effort is in progress at the writing of this case study with a NCSACW staff member serving on the advisory group as a subject matter expert.

The major accomplishments of the second round of IDTA included a hospital survey of substance use screening practices for pregnant women and the care of infants with prenatal exposure, the development and funding of a case management and recovery support model for

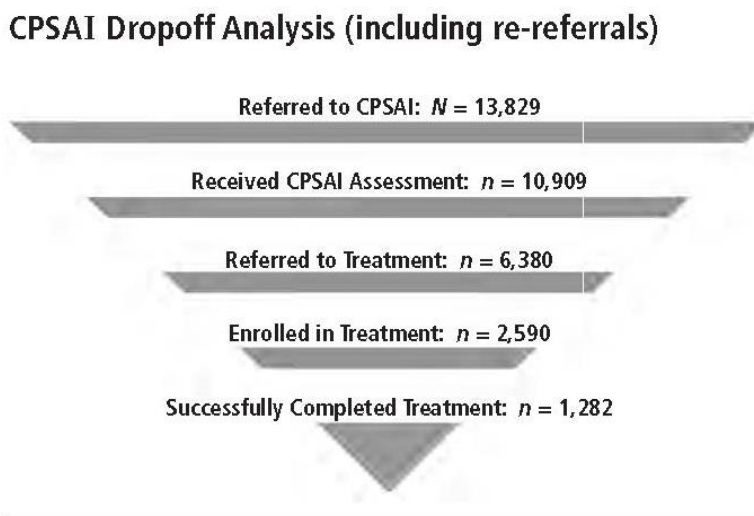
⁸ These changes were included in the Comprehensive Addiction and Recovery Act passed in 2016 in response to the opioid epidemic.

⁹ The New Jersey Child Welfare Data Hub is a collaboration between the New Jersey DCF and the Child Welfare and Well-Being Research Unit at the Rutgers University School of Social Work. The Data Hub seeks to improve the lives of children and families by disseminating New Jersey child welfare and well-being data. More information is available at <https://njchilddata.rutgers.edu>.

opioid-dependent women, changes in regulations regarding the reporting of infants affected by prenatal substance exposure, and more extensive outcomes and cost analyses related to infants with prenatal substance exposure. These accomplishments are discussed in more detail as follows.

Drop-Off Analysis to Improve Treatment Engagement and Retention

A major product of the first IDTA project was a drop-off analysis to assess the points in the systems that families in the child welfare system who are referred for a substance use disorder assessment and subsequent treatment services either do not engage in or drop out of services. As the figure below illustrates, the analysis of data from fiscal year 2009–2010 indicated that more than 13,800 child welfare cases referred to substance use screening agencies resulted in 2,590 entries to treatment and 1,282 completed treatment (not including those still in treatment). Importantly, the drop-off analysis also showed that 41 percent of those referred to treatment entered treatment.¹⁰



*Some clients are still in treatment and may yet successfully complete treatment.

State staff described the importance of the drop-off analysis as “helping us to see things differently.” They indicated that this graphic depiction showing the gradation from clients screened to those completing treatment was a helpful way to assess engagement and retention of

¹⁰ Data were drawn from two administrative datasets—the CPSAI database and the New Jersey Substance Abuse Monitoring System—which are linked by a common identifier.

parents from the child welfare system in SUD treatment, following screening and referral from the CPSAI contract agencies. The New Jersey team used this drop-off analysis tool to guide and manage system improvements such as more face-to-face outreach and engagement during the preliminary stages of the child welfare investigation and assessment process. The team's efforts were featured in a 2015 article in *Child Welfare's* special issue on families in child welfare affected by substance use.¹¹

The New Jersey team also conducted a cross-system data inventory, which enabled team members to gain a better understanding of the data being collected by the various partner agencies other than their own. The data inventory process identified limitations with the data and challenges with access, including a need for legal staff in state agencies to develop data use agreements to facilitate sharing of data across agency boundaries.

Statewide Substance Use Disorder Training for Child Welfare Workers

As a result of IDTA, the New Jersey team developed and incorporated SUD education into the training for new child welfare workers. This initial training evolved into four 1-day training modules that are still provided to new workers and are in the process of being updated. In addition, subsequent to IDTA, New Jersey is currently developing a more in-depth training program for existing staff.

Case Management and the Recovery Support Model

During the initial IDTA effort, the recovery support model was developed but did not reach full implementation as planned due to leadership changes and resource limitations. However, major features of the model were incorporated in the IDTA-SEI effort. During IDTA-SEI, the Camden-based team, which had been involved in earlier hospital-based SEI-linked reforms, sought to develop a continuum of care—including increasing shared communication—for pregnant women with SUDs and their infants. The team completed a walkthrough of their county's system (medical, substance use, and child welfare) for pregnant women. The walkthrough illustrated the

¹¹ Traube, D. E., He, A.S., Zhu, L., Scalise, C. and Richardson, T. (2015). Predictors of substance abuse assessment and treatment completion for parents involved with child welfare: One state's experience in matching across systems. *Child Welfare*, 94(5), 45–66. <https://www.ncbi.nlm.nih.gov/pubmed/26827464>

gaps between service systems and challenges that women experienced obtaining services. The Camden team identified initial goals for building collaborative practice.

The larger New Jersey state team used Camden’s experience to develop a request for proposals for the Maternal Wraparound Program (M-WRAP), issued through DMHAS, to provide intensive case management, wraparound services, and recovery supports for pregnant and postpartum women with opioid use disorders. Using state funding from DMHAS and DCF, including funds from the now-current Governor’s opioid initiative, M-WRAP has been implemented statewide in six regions.

Statewide Hospital Survey of Screening Practices and Related Data Analysis

During the second round of IDTA, the New Jersey team conducted a survey of the state’s 50 birthing hospitals regarding their practices for screening pregnant women for substance misuse or abuse and their identification and care of substance-exposed infants ([Appendix B](#)). The team also surveyed 200 outpatient pediatric care providers working in the birthing hospitals regarding assessment and care of infants with NAS. The survey, which was completed in 2017, was an exemplary effort to document current screening protocols and practices. This survey also documented NAS treatment practices, billing codes used for NAS treatment, and hospital discharge practices. The New Jersey team made a sustained effort to gain representative responses through professional associations’ endorsement of the survey and encouragement to the hospitals and other medical professionals. The team also addressed DMHAS’ data-sharing confidentiality concerns and obtained institutional review board approval.

The purpose of this survey was to gain a better understanding about protocols and practices used by New Jersey birthing hospitals and providers in the care of SEIs and their mothers. Despite the recommendations put forth by the American Academy of Pediatrics to manage SEIs, it is unclear whether these guidelines are being used widely or consistently.

The survey results regarding prenatal and postpartum practices contributed in part to the state’s development of M-WRAP. State staff pointed out how this information also laid a foundation for their ongoing work to prepare for implementing plans of safe care as required by CAPTA. The survey also revealed that while 94 percent of responding hospitals said they were very or extremely confident in their effectiveness at identifying and managing prenatally exposed infants, there was substantial variation and a lack of consistency across hospitals in how they

screened for and identified prenatal substance exposure. Moving forward, the interagency team plans to use the hospital survey findings to establish standards for best practices for screening and reporting.

In addition to conducting the hospital survey, the New Jersey team assembled data on Medicaid costs of hospitalizations related to NAS and reviewed Medicaid prenatal screening and referral data to map the frequency of screening across the state.

Overall, the team found high utilization (over 80 percent) of screening using the 4P's Plus tool by private physicians and hospital staff

serving pregnant women on Medicaid. Still, the mapping enabled the team to identify and target low utilization areas to increase prenatal screening for substance use. Moreover, the mapping identified that no data were being collected on positive screens to determine if women who were assessed as needing treatment actually entered treatment. The New Jersey team noted that the state's managed care organizations now require prenatal screening for substance use in order to collect reimbursement for prenatal care. The team intends to eventually link Medicaid data with substance use treatment data to learn about the frequency of mothers with positive screens accessing treatment.

The New Jersey IDTA efforts were able to build on the successes of prior screening reforms and carry that momentum forward. The latest data available from the statewide hospital survey and Medicaid sources indicates that the 4Ps Plus screening tool is used in a sizable majority of all prenatal care funded by Medicaid in New Jersey. This represents the furthest expansion of use of a validated prenatal screening tool in any state known to NCSACW.

Implementing Plans of Safe Care for Infants With Prenatal Substance Exposure and Their Families

In the year following the IDTA-SEI engagement, a workgroup with team members that included pediatricians specializing in neonatology and child abuse and neglect, child and adolescent psychiatrists, and child welfare nurse care managers¹² to respond to the federal legislative language in the CAPTA amendments concerning the definition of infants “affected by substance abuse.” DCF has begun counting notifications from the hospitals that match these new

¹² DCF's Nurse Care Management Program is operated through a memorandum of agreement with the Rutgers State University School of Nursing.

definitions. Prior to the 2016 Comprehensive Addictions Recovery Act, New Jersey did not have state laws related to reporting infants identified as affected by substance abuse. However, in January 2018, DCF and DOH jointly issued new regulations setting forth criteria for hospitals to define and notify DCF of substance-affected infants, to provide service to parents of such infants, and to bring New Jersey into compliance with CAPTA requirements.¹³ A recommendation is currently pending for the executive team that oversees CAPTA implementation to continue with the IDTA-SEI efforts. At present, the executive team is focused on maternal mortality and morbidity, with SUD treatment for SEI-related problems as a priority within that overall emphasis.

As part of the IDTA-SEI effort, the New Jersey team also conducted a separate comparative analysis of child welfare outcomes of infants and children with prenatal exposure compared to those without prenatal exposure. The analysis focused on differential rates of child removal, reunification, and re-entry to out-of-home care. State staff found that infants and children with prenatal exposure had higher rates of removal, a longer time to reunification, and higher rates of re-entry than those of non-exposed children. These findings were an important factor in gaining support for the interagency team's efforts to respond to prenatal exposure through implementing plans of safe care. Work continues in the Camden site where efforts are underway to link the implementation for plans of safe care to the county's existing cross-systems collaborative efforts.

Institutionalizing Change

The New Jersey team is well positioned to sustain its practice and policy changes with the expressed commitment of state agencies for continued cross-systems training, funding of M-WRAP implementation of plans of safe care, and expanded and enhanced data collection to monitor progress. For example, beginning July 1, 2019, Medicaid will reimburse providers for case management and recovery coach services in the SUD treatment system.

¹³ New Jersey Administrative Code. § 8:43G-2.13 Child abuse and neglect and substance-affected infants. Amended by R.2018 d.018, effective January 16, 2018. See: [50 N.J.R. 283\(b\),s](#)

Challenges to Systems Change

The progress that the New Jersey team made was not without its challenges, described as follows.

Barriers to Systems Change

During the course of its efforts, the New Jersey team encountered specific barriers that are commonly seen in large-scale collaboration efforts. These challenges included reorganization of state agencies, turnover in the Governor's office with new senior agency leadership, challenges to data sharing across agency boundaries (in part due to confidentiality concerns and variable data collection and reporting processes), and an emphasis on separate innovations and reforms that were part of the court order in the state's child welfare system.

Tracking Outcomes Data That Adequately Reflects Progress

As outlined in Section III, the New Jersey team made substantial progress on collecting and analyzing new and existing administrative data on SUD screening practices for pregnant women, child welfare outcomes for infants with prenatal substance exposure, and the Medicaid costs associated with hospitalization of infants diagnosed with NAS. These data helped inform the team's policy and practice improvements.

Yet, these data alone do not adequately reflect the deeper impact that the IDTA efforts may have had on improving outcomes for children, parents, and families affected by SUDs. Obtaining comprehensive outcomes data can be challenging—for any site—and requires sustained commitment from all partners to systematically collect and share needed outcomes data on the families involved in multiple service systems.

The IDTA timeframe of 18 to 24 months does not allow for measuring long-term outcomes for children, parents, and families. However, states can identify the outcomes they want to measure and begin to collect and report system outcomes.

As the New Jersey team continues its efforts and the initiatives further mature, indicators the team should strive to track to more adequately measure the state's success might include:

- Earlier and expanded identification of substance use during pregnancy through prenatal screening
- Improved engagement and retention in treatment for parents in the child welfare caseload affected by SUDs
- Increased admissions of pregnant and parenting women in treatment over baseline levels
- Expanded engagement of parents with substance abuse issues in home visiting programs
- More consistent hospital notifications to child protective services
- Increased referrals by hospitals and child welfare services to early intervention services (IDEA Part C agencies) for infants affected by prenatal substance exposure
- Reduced lengths of stay in the neonatal intensive care unit for infants affected by prenatal substance exposure

Key Lessons

A set of lessons emerged from the New Jersey IDTA experience that NCSACW believes are of value to other jurisdictions seeking to implement state-based practice and policy reforms to better serve families affected by parental SUDs and, in particular, infants with prenatal substance exposure. These lessons, discussed as follows, center on four key areas: contextual barriers, leadership, data and outcomes, and the interconnected nature of change components. This section concludes with a fifth and final lesson from NCSACW staff about the process of providing intensive TA to jurisdictions engaged in systems improvement initiatives.

1 Context matters in change efforts and requires a proactive response

A state's or community's context always matters when implementing systems improvements. Shifts in the fiscal, legal, and leadership arenas as well as parallel reform initiatives almost always affect efforts to change practice and policy—sometimes positively, sometimes negatively. Yet, many sites do not always identify and tackle the adverse effects of contextual issues head-on in planning, either because focusing on barriers may seem overly negative, or

because barriers may be seen as outside the control of the site team. As a result, collaborative teams often deal with barriers reactively rather than anticipating and handling them proactively. In addition to contextual issues, certain *individuals* or “blockers” may also act as barriers to systems improvement efforts. Blockers can come from one or more partner agencies—attorneys, judges, treatment agencies, child welfare workers, and managed care. Effective leadership that builds trusting relationships can help the team identify barriers and blockers early and clearly enough to develop strategies to overcome or reduce such obstacles.

In New Jersey, the lead site team members knew state agencies well enough to be able to anticipate issues likely to recur from prior reform efforts, including information sharing and a lack of data on key processes and outcomes. They also had well-established personal and professional networks that enabled them to work with potential blockers over time. The lesson for other jurisdictions is the importance of the interagency team anticipating barriers explicitly and addressing them proactively.

Persistence also matters in responding to contextual barriers. The legal complaint against New Jersey’s child welfare system was initially settled in 2004, but monitoring continues under the Sustainability and Exit Plan. New Jersey officials attribute some of the most important practice changes during this time to the settlement and the state’s continuing efforts to strengthen services to children in the child welfare system. However, the primary focus of the court order and monitoring was on the array of services (e.g., provision of mental health services) and outcomes for children in foster care, and not on issues related to parental SUDs and infants affected by prenatal substance exposure in the child welfare system specifically. An unrelated 2017 report on infants and toddlers by a statewide advocacy agency did not include prenatal substance exposure. Subsequently, New Jersey identified the need to engage in IDTA-SEI, prioritizing early identification of pregnant women with SUDs, expanding wraparound services to support engagement in treatment, and increasing the awareness of the state opioid workgroup on the effects of prenatal substance exposure on infants. It is noteworthy that in 2014, DCPP hired a Director of Clinical Services, who was a critical member of the IDTA state team, to focus on substance use disorder issues in the child welfare system.

2 Committed and consistent leadership is essential to affect systems change

The New Jersey IDTA efforts were greatly aided by the active engagement and commitment of two state officials from DMHAS (within DHS) and DCPD (within DCF) with deep experience in interagency collaborative efforts to respond to the needs of children and families involved with child welfare due to parental substance use disorders. These individuals:

- Were highly skilled in identifying and framing difficult issues that the team needed to respond to (with the strategic help of NCSACW staff as needed);
- Were able to convene key stakeholders as needed to increase awareness about the prevalence of the problem, identify barriers, develop strategic plans, and implement practice changes;
- Had a deep understanding of the challenges facing state agencies that seek to work together more effectively across agency boundaries;
- Recognized the importance and necessity of engaging independent community systems outside state government—such as hospitals, maternal and child health, and managed care—to effectively serve families;
- Had access to the top officials in their agencies and were able to secure their support and leverage resources when needed;
- Had extensive knowledge and understanding of both the child welfare and treatment systems from many years of cross-systems’ experience;
- Were effective “connectors” in that they did not always take the lead in making the case for change, but ensured that the stakeholders and agency leaders who could make change possible were in the room at the right times; and
- Were able to devote significant time to the IDTA efforts, while handling their other agency responsibilities at the same time.

As previously mentioned, state leadership both within and outside of the IDTA efforts was significant in advancing New Jersey’s reform agenda. For the IDTA-SEI effort, for example, the Governor had a visible national role on some important elements of the IDTA-SEI agenda. The Deputy Commissioner of Health also was a genuine agency leader, a pediatrician who understood SEI issues in considerable depth and who brought great credibility with professional

peers in the private sector. His efforts to establish links to the Medicaid staff and the results of the NAS cost study resulted in more emphasis on cost issues than in most states. His leadership in ensuring that costs were part of the discussions may have contributed to the managed care organizations' policy change to reimburse for comprehensive care that includes required prenatal screenings for substance use.

3 Institutionalized outcomes data are needed to adequately assess results

As this case study has highlighted, the New Jersey IDTA team made great strides in collecting and using existing and new data to document the prevalence of SUDs in the child welfare caseload and current practices for identifying and responding to infants with prenatal substance exposure. However, one-time, ad hoc collection of data on prevalence or practice differs substantially from routine, institutionalized data sharing and analysis that tracks improvements in outcomes over time to make the case for needed practice and policy changes.

In the most recent reporting of Adoption and Foster Care Analysis and Reporting System data for 2016, New Jersey staff identified to child protective services higher levels of child removals associated with parental substance use (40.5 percent) than the national average (34.5 percent).¹⁴

Changing the process of agency interactions is hard; keeping final outcomes and net resources in view throughout the process is harder. Any statewide reform initiative will likely need new data on outcomes and baselines to learn how to target resources better. It may also need to establish better connections among agencies and other partners to improve the team's collective capacity to track how many families successfully move from one system to another—or how many do not. In New Jersey's case, the drop-off analysis helped to build such capacity. Measuring child welfare and treatment outcomes would close the loop on such an analysis and is essential to understand the impact of related process improvements (e.g., earlier identification and screening).

¹⁴ Source: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. 2017. *Adoption and foster care analysis and reporting system (AFCARS) Foster Care File FY 2016*. Ithaca, NY: National Data Archive on Child Abuse and Neglect [distributor]. <https://www.ndacan.acf.hhs.gov/>

In New Jersey, a set of performance measures to assess the impact of their innovative practice changes is still emerging. The IDTA initiative introduced a data template with specific data points that could establish baselines and measure long-term outcomes. Their next phase (post-IDTA-SEI) is to move toward a dashboard of the most important measures of impact that is institutionalized and reviewed on a regular basis by senior officials. That critical task needs to continue, recognizing that measuring the results of statewide implementation of systemic practice and policy changes over time must be sustained beyond the duration of any given TA initiative. Achieving interagency review of shared outcomes will require team members to achieve clear consensus around interpretation of 42 CFR confidentiality requirements.

4 The various components of systems change are interconnected

The lessons from the New Jersey IDTA initiatives indicate that systems change to improve outcomes for families served among multiple human services agencies is rarely about a single, isolated part of the system. Data components, training components, funding, and the changes in practice all interact in complex patterns. Yet, often, a site team may focus on only one of these within their respective system without examining how they interact. In New Jersey's case, the state team learned from the drop-off analysis that screening of parents for SUDs did not necessarily link to treatment entry or completion. The team's progress in the form of better screening and engagement at the front end of the child welfare system led to a demand for changes at the front end of the treatment system (i.e., contracted peer specialists who are co-located in child welfare offices) to further improve client engagement. Subsequent changes to improve treatment access (and quality) resulting from better screening are emerging. The M-WRAP funding efforts will add to the capacity of family-centered treatment for the 240 women it serves. The team is now focused on efforts to ensure collaboration among the SUD treatment and early childhood systems. An ongoing challenge for New Jersey will be to make these links explicit and develop measurement systems to track their impact over time.

5 IDTA tools and processes help teams drive change

In reviewing the role of NCSACW staff in providing TA and how they worked with the New Jersey team, state officials mentioned guidance on developing and implementing plans of safe care consistent with guidance from the Children’s Bureau Information Memorandums and Program Instruction. Additionally, NCSACW and CCFF TA tools, the drop-off analysis and the systems walkthrough were especially helpful

The TA is helping us move forward some significant projects (e.g., hospital birth survey, a community pilot program, a statewide RFP for the Maternal Wraparound Program) providing us with many resources that will capture all elements for a best practice model.

New Jersey team member

IDTA process improvement strategies. A system walkthrough is a proven process designed to assess the effectiveness of the system in achieving its desired results or outcomes, such as family reunification, successful treatment completion, and child safety by ensuring that children are living in safe and stable environments. Participants conduct a virtual walkthrough of the identified system, providing all key stakeholders with: (1) a good understanding of the system as it currently exists; (2) identifying any problem areas (e.g. inconsistency of referrals, delays in accessing treatment, lack of services/involvement from critical stakeholders, problems with engagement and retention, and lack of communication across systems); and (3) generating ideas for improving organizational processes. The system walkthrough conducted in New Jersey highlighted different identification and treatment practices occurring at prenatal care providers and hospitals across the community. It also highlighted the lack of information sharing about substance use and treatment engagement during the pre- and post-natal periods.

One team member commented, “We did not feel that the NCSACW came in and told us what to do, but entered into problem-solving with us.... Implementing the Plans of Safe Care would be very difficult without the help we received from the NCSACW staff.”

The New Jersey team also provided useful advice for future TA directions and methods. Their suggestions included:

- Increase the number of onsite visits to help build relationships between core team members, increase face-to-face dialogue between partners, and help facilitate practice change.
- Ensure that individual IDTA project periods are for at least two years.
- Develop a web-based discussion forum in which states can ask and respond to questions.

Looking Ahead: Next Steps and Ongoing Initiatives for the New Jersey Team

The New Jersey team is poised to continue and expand the progress it has made in several ways:

- **Expanded Training.** A post-IDTA-SEI follow-up training project was launched in March 2018 to develop a certificate program for groups of 25 DCF staff at a time that would equip them to work more effectively with SUD treatment agencies and professionals. The advisory group formed to develop the training curriculum emphasized the need for staff to be more trauma-informed, understand the stigma attached to SUDs, effectively and appropriately share information (within the limits of confidentiality requirements), and understand how court timetables operate.

New Jersey's prevalence of removals of infants under the age of 1 year is headed in the right direction, but still needs improvement. Data show removals declined from a peak of 23.5 percent in 2009 to 20.9 percent in 2016. In contrast, the national rates increased from 16.5 percent to 18.0 percent during that same timeframe. State staff are continuing to work to improve these numbers, based on further analysis of the hospital survey findings and prenatal screening data.¹⁵

¹⁵ Source: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. 2017. *Adoption and foster care analysis and reporting system (AFCARS) Foster Care File FY 2016*. Ithaca, NY: National Data Archive on Child Abuse and Neglect [distributor]. <https://www.ndacan.acf.hhs.gov/>

- ***Sharing and Using Hospital Survey Data to Further Improve Practices.*** The state has requested additional TA from NCSACW to further analyze and interpret the findings of the hospital survey and use those data to support the development and implementation of Project ECHO (Extension for Community Healthcare Outcomes). The goal of ECHO is to continue responding to the causes and effects of prenatal substance exposure through statewide adoption of best practice clinical care and community-based interventions to support infants affected by substance exposure and their parents.
- ***Ensuring the Provision of Medication-Assisted Treatment.*** In 2015, New Jersey was awarded a 3-year SAMHSA grant for their Medication Assisted Treatment Outreach Project.¹⁶ The state team identified pregnant women with opioid disorders and veterans as their priority populations. The state team intends to use the grant to focus on effective outreach and engagement strategies to ensure that these two target populations access needed services.
- ***Garnering New State Leadership Support.*** As the newly elected Governor took office in 2018, new state agency heads were appointed, including the head of DCF, who had prior experience in New Jersey and with the first IDTA project. The new DCF commissioner was active in earlier child welfare reform efforts and has expressed her support of the goals of the SEI-IDTA project. The funding of a request for proposal for the M-WRAP project and the potential for opioid-specific treatment funding under the 21st Century Cures Act are also seen by state staff as positive signs of executive leadership support.

Conclusion

The New Jersey IDTA efforts set in motion changes with impressive breadth. Over time, as these changes become institutionalized, they will affect thousands of infants and children, and thousands of families in the child welfare, maternal and child health, and private medical care systems. The changes in practice and policy sought by these TA efforts also raise the possibility that professionals in dozens of agencies will change their daily operations and practice.

¹⁶ This grant was under SAMHSA’s Medication-Assisted Treatment—Prescription Drug and Opioid Addiction grant program.

Such widespread systems changes will not result simply from multiple meetings across agency lines, or the issuance of documents explaining how to implement changes that respond to the causes and effects of prenatal substance exposure. Achieving such progress takes time; infusing these changes throughout state agencies and among other key stakeholders' practices will require more time to move from an isolated project to institutionalized statewide policy. Successful large-scale systems change further requires patience and persistence, along with leadership that possesses both, aided by a clear vision of how systems can change to improve the lives of children and families. NCSACW has been privileged to be able to work with such leaders in New Jersey and around the nation, and we are grateful for what we have learned from and with them.

Appendices

Appendix A: Agencies Represented on the State Team

<p>New Jersey Department of Human Services (DHS)</p> <ul style="list-style-type: none"> • DHS Office of Program Integrity & Accountability • Division of Mental Health and Addiction Services • Division of Family Development • Office for the Prevention of Developmental Disabilities Child Welfare • Division of Medical Assistance and Health Services 	<p>New Jersey Department of Children and Families (DCF)</p> <ul style="list-style-type: none"> • Division of Family and Community Partnerships • Office of Early Childhood Services • Office of Clinical Services • Division of Child Protection and Permanency
<p>New Jersey Attorney General’s Office</p>	<p>Administrative Office of the Courts and Legal Services</p>
<p>New Jersey Department of Health</p> <ul style="list-style-type: none"> • Maternal Child Health Unit • Office of Licensing • Division of Family Health Services 	<p>Substance Abuse Treatment Providers</p> <ul style="list-style-type: none"> • Jersey Shore Addiction Services Healthcare • Family Guidance Center: Family & Children’s Services • Organization for Recovery Health Services
<p>Other Healthcare Members</p> <ul style="list-style-type: none"> • Weisman Children’s Rehabilitation Hospital • Central Jersey Family Health Consortium • South Jersey Perinatal Cooperative • Rutgers Fetal Alcohol Spectrum Disorders (FASD) Training Center • Rutgers School of Nursing, Maternal Child Health Services • FASD Clinical and Educational Representative 	

Appendix B: New Jersey Birthing Hospital Instructions and Surveys

- [Instructions for Healthcare Provider Survey](#)
- [Survey for Hospital Obstetric Leadership](#)
- [Survey for Hospital Pediatric Leadership](#)
- [Survey for Pediatric Primary Care Provider](#)