APPLYING AN EQUITY LENS TO COLLABORATIVE PRACTICE WHEN IMPLEMENTING PLANS OF SAFE CARE

Latonya Adjei-Tabi, MPA| Senior Program Associate, National Center on Substance Abuse and Child Welfare

Teri Kook, MSW | Senior Program Associate, National Center on Substance Abuse and Child Welfare

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National Center on Substance Abuse and Child Welfare

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Children's Bureau

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SAMHSA
Substance Abuse and Mental Health Services Administration

National Center on Substance Abuse and Child Welfare

https://ncsacw.acf.hhs.gov | ncsacw@cffutures.org

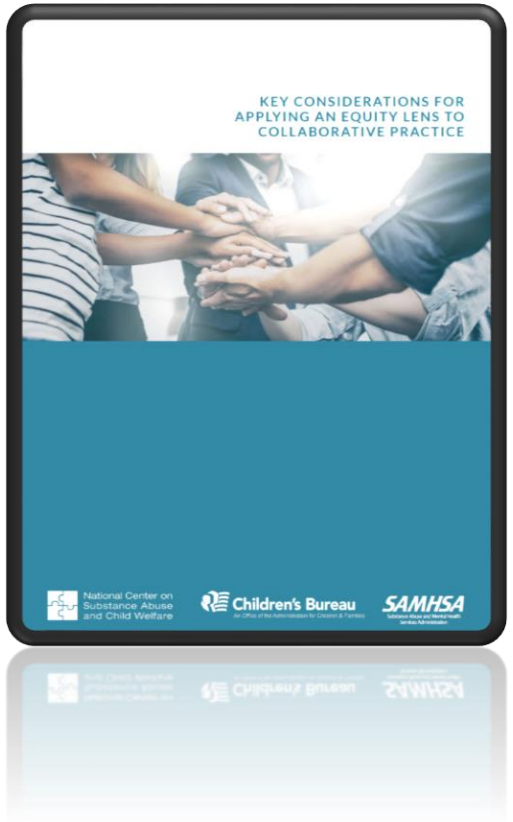
SESSION OBJECTIVES

- Attendees will learn strategies to prioritize work on equity in policy making.
- Attendees will learn how to align collaborative partner's vision and goals to intentionally reduce disproportionality and disparities for families affected by a substance use disorder (SUD).
- Attendees will learn how to utilize people with lived experience to promote equitable access and improve equitable outcomes for all families.

AGENDA

- Why this Work is Urgent
- Disparities in Outcomes
- Options to Improve Collaborative Practice with an Equity Lens

KEY CONSIDERATIONS FOR APPLYING AN EQUITY LENS TO COLLABORATIVE PRACTICE



This brief helps collaborative teams formally **assess existing policies** to determine if and how they **contribute to disproportionate and disparate outcomes for families** being served.

By working through the "*Questions to Consider*", teams begin applying an **equity lens** to collaborative policies and practices.

Available @ https://ncsacw.acf.hhs.gov/files/equity-lens-brief.pdf

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BEFORE WE HEAR ABOUT THE DATA…

It’s important to remember that people can and do recover from trauma and SUDs.

*SUD is a **treatable, chronic, medical disease** that can affect the whole family.*

Healthcare professionals have similar levels of public and structural stigma toward those with a SUD compared to the general population.

75.2% of the public *do not believe* SUD is a chronic medical illness like diabetes, arthritis, or heart disease.

(American Society of Addiction Medicine, 2019); (Shatterproof, and The Hartford, 2021)

Stigma Impacts:

People **seeking** help;

Numbers of families **receiving** treatment;

Quality of treatment;

Likelihood of **staying in active recovery; and**

Resources allocated to prevention and treatment.

(Shatterproof, 2020)

Adverse Childhood Experiences

10 ACEs

Parental Divorce or Separation
Caregiver in Jail or Prison
Caregiver Depression, Mental Illness or Suicide Attempt
Domestic Violence or Threats
Emotional Abuse or Neglect
Sexual Abuse or Exposure
Food, Clothing or Housing Insecurity
Physical Abuse, Hitting or Slapping
Caregiver Problem with Drugs or Alcohol
Felt Unsupported, Unloved and Unwanted

Intergenerational Transmission

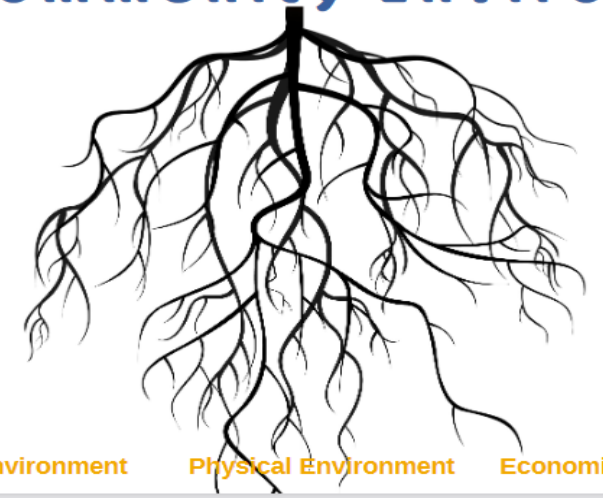
ACEs Being Studied

Placement in Foster Care
Bullying or Harassment at School
Parent or Guardian Died
Separated from Caregiver through Deportation or Immigration
Medical Procedure(s) or Life Threatening Illness
Frequent School or Neighborhood Violence
Treated Badly Because of Race, Sexual Orientation, Place of Birth, Disability or Religion

Source: Center for Youth Wellness, ACE Questionnaire

Adverse Community Environments

Poor Housing Quality and Affordability
Systemic Racism & Discrimination
Deterioration of Physical Environment
Lack of Access to Educational Opportunities
Low Sense of Collective Political and Social Efficacy



Social-Cultural Environment Physical Environment Economic Environment

Intergenerational Poverty

Lack of Opportunity and Economic Mobility
Poor Transportation Services or System
Community Disruption
Damaged Social Networks and Trust
Unhealthy Products
Long-Term Unemployment

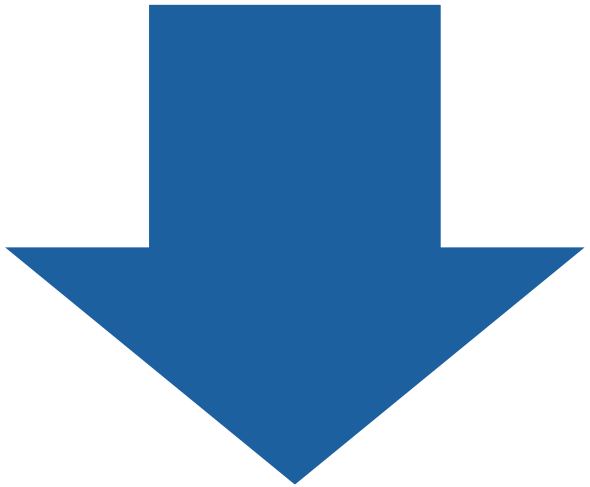
Adapted From: Ellis W. Dietz BCR Framework *Academic Peds* (2017)

Research shows certain groups carry a **greater risk** of experiencing ACEs including:

For Example

- Families of color
- People with less than a high school education
- People who make less than $15,000 a year
- People who are unemployed/unable to work
- LGBTQ+ population

(CDC, 2022)



An individual's exposure to racism and discrimination **increases** the risk of developing toxic stress and ACE-associated health conditions, such as SUDs.

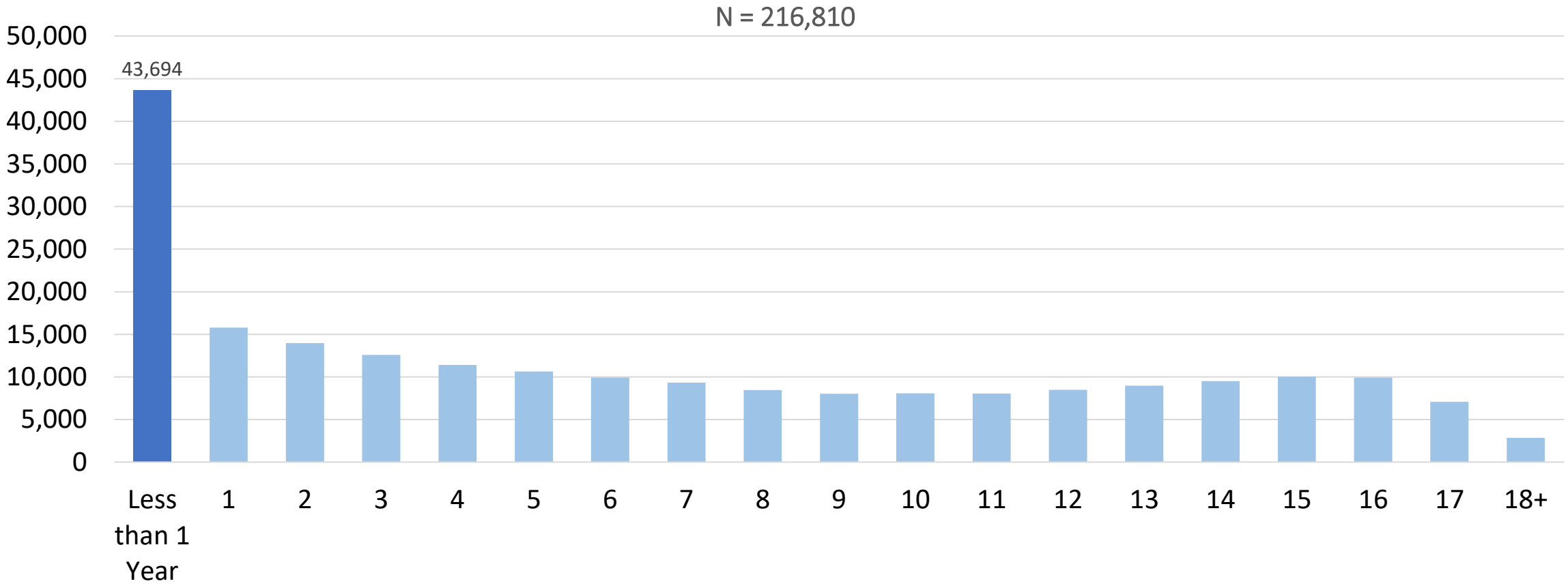
A study of SUD disparities in rural Native American communities found that stress from racism and historical trauma increase the risk of SUDs and is a barrier to recovery.

(Skewes, M. C., & Blume, A. W, 2019)
(ACEs Aware, 2021)

WHY THIS WORK IS URGENT

DATA AND RESEARCH
REGARDING INFANTS WITH PRENATAL SUBSTANCE EXPOSURE
AND THEIR FAMILIES

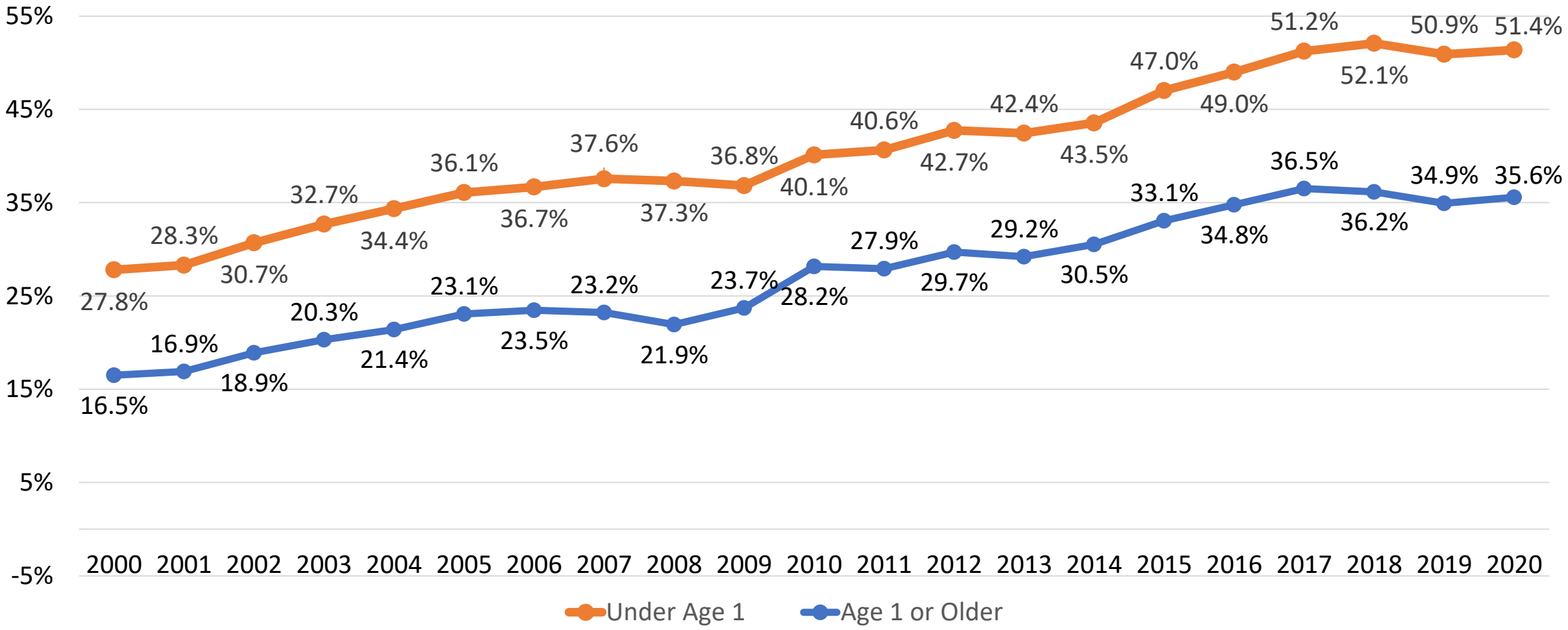
NUMBER OF CHILDREN WHO ENTERED OUT OF HOME CARE, BY AGE AT REMOVAL IN THE UNITED STATES, 2020*



*Note: Estimates based on **children who entered out of home care** during Fiscal Year*
**2020 Estimates may be influenced by the COVID-19 pandemic*

(AFCARS Data, 2020 v1)

INCIDENCE OF PARENTAL ALCOHOL OR DRUG ABUSE AS AN IDENTIFIED CONDITION OF REMOVAL IN THE UNITED STATES, 2000 TO 2020*

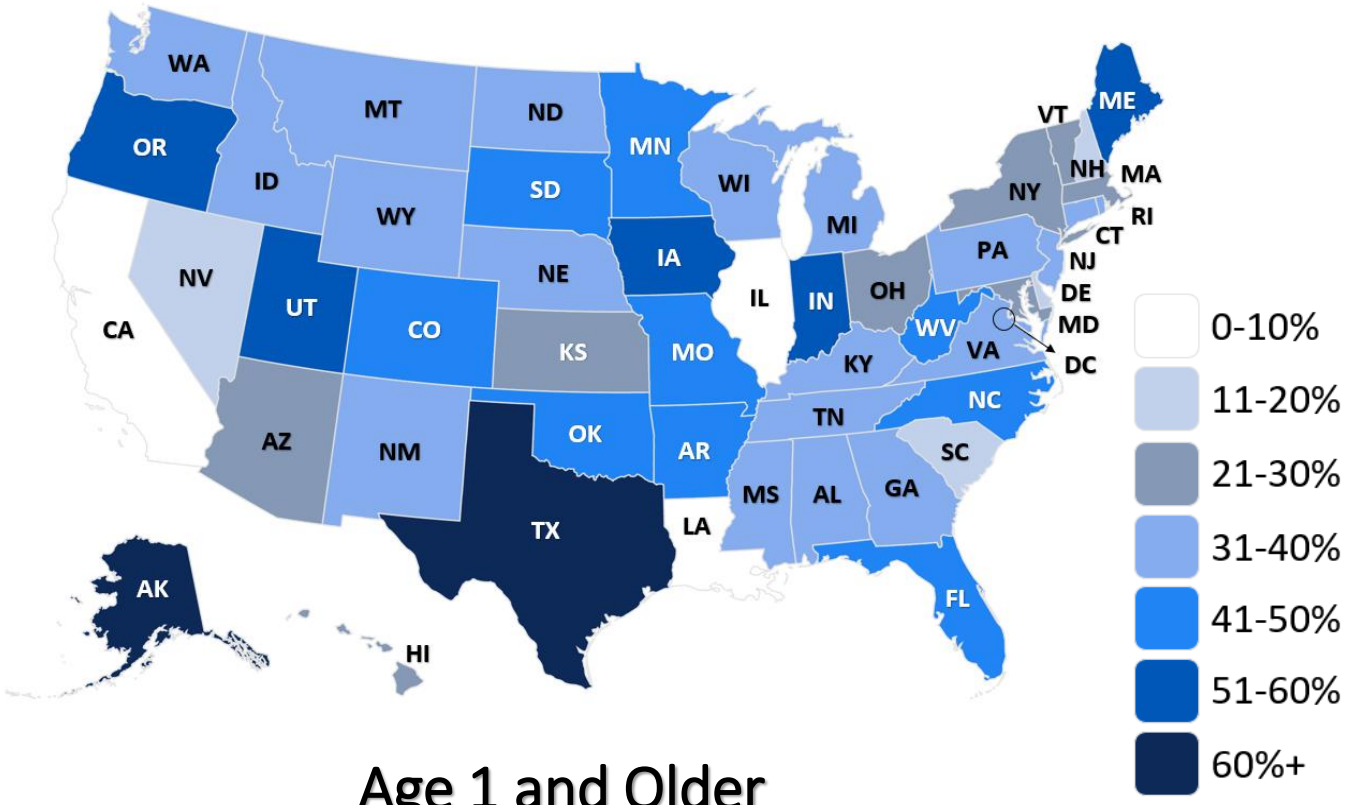


*Note: Estimates based on **children who entered out of home care** during Fiscal Year*
**2020 Estimates may be influenced by the COVID-19 pandemic*

(AFCARS Data, 2000-2020)

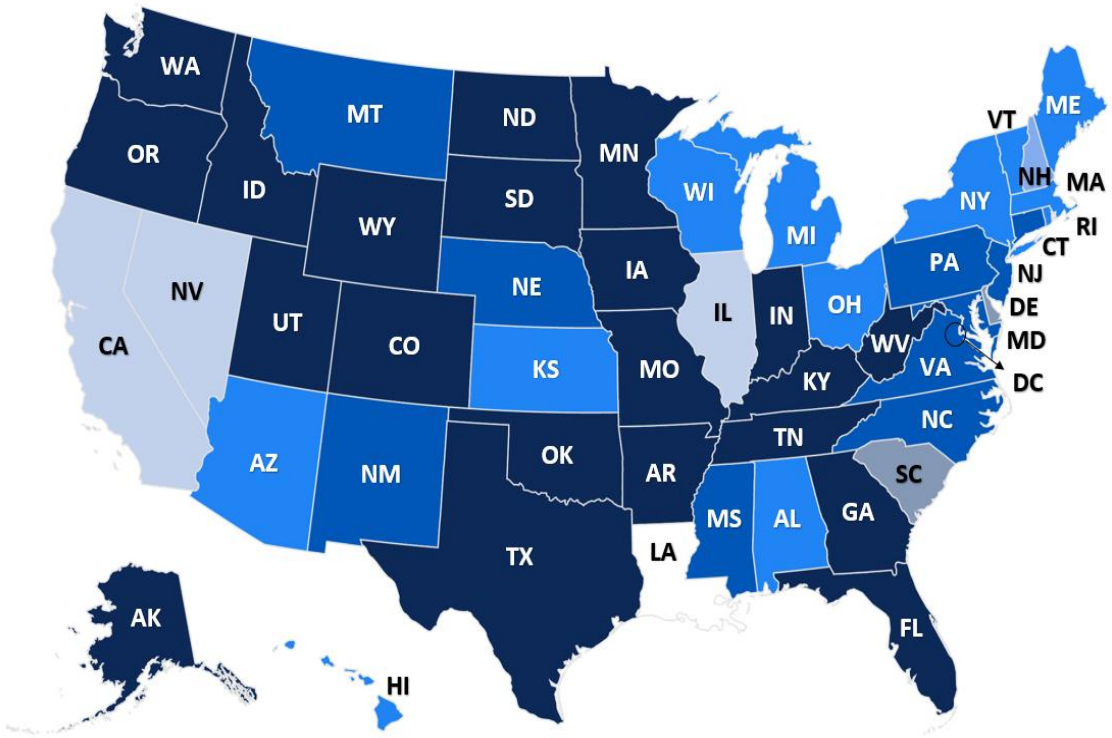
INCIDENCE OF PARENTAL ALCOHOL AND DRUG ABUSE AS AN IDENTIFIED CONDITION OF REMOVAL FOR CHILDREN BY AGE, 2020*

Total Number of Removed Children with Parental Alcohol and Drug Abuse = 83,516



Age 1 and Older

National Average: 35.6%



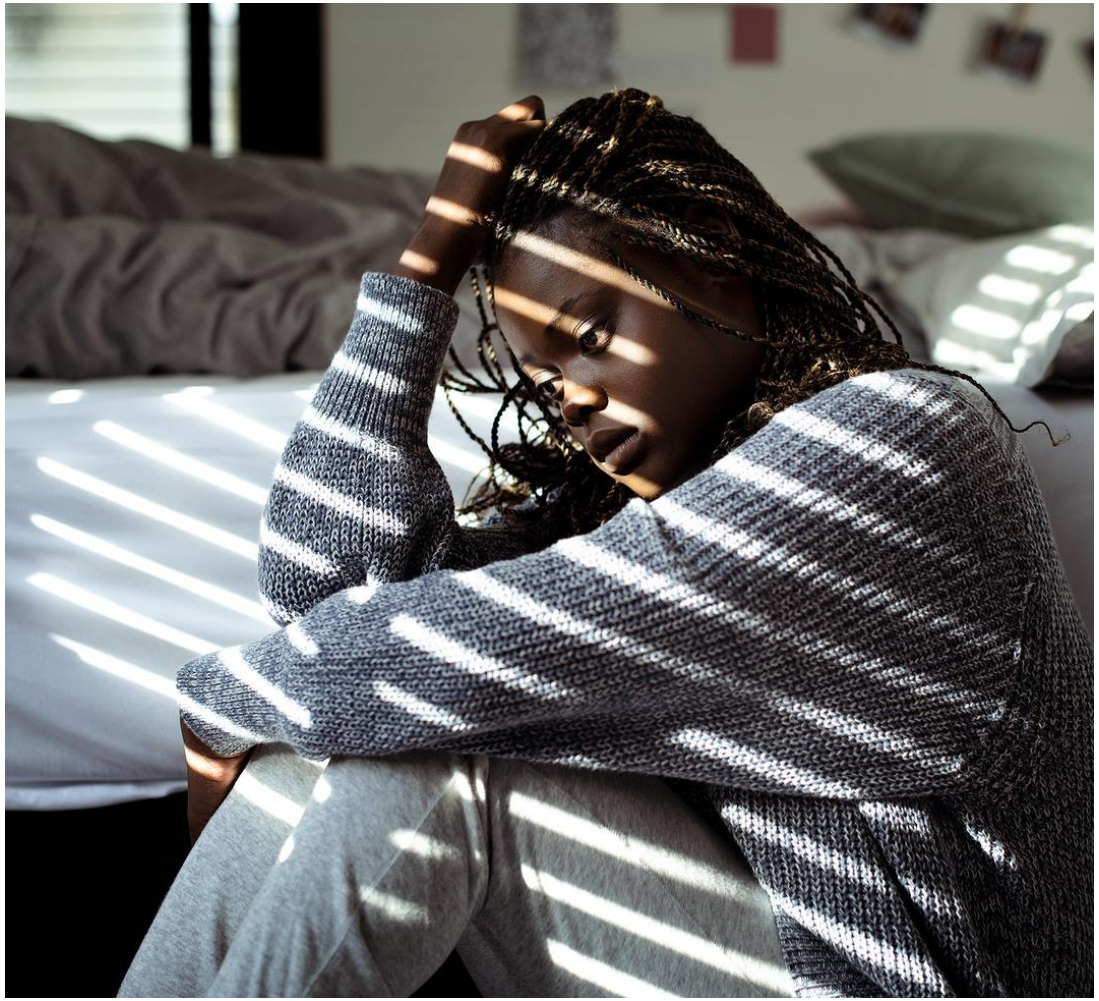
Under Age 1

National Average: 51.4%

Note: Estimates based on ***children who entered out-of-home care*** during the Fiscal Year

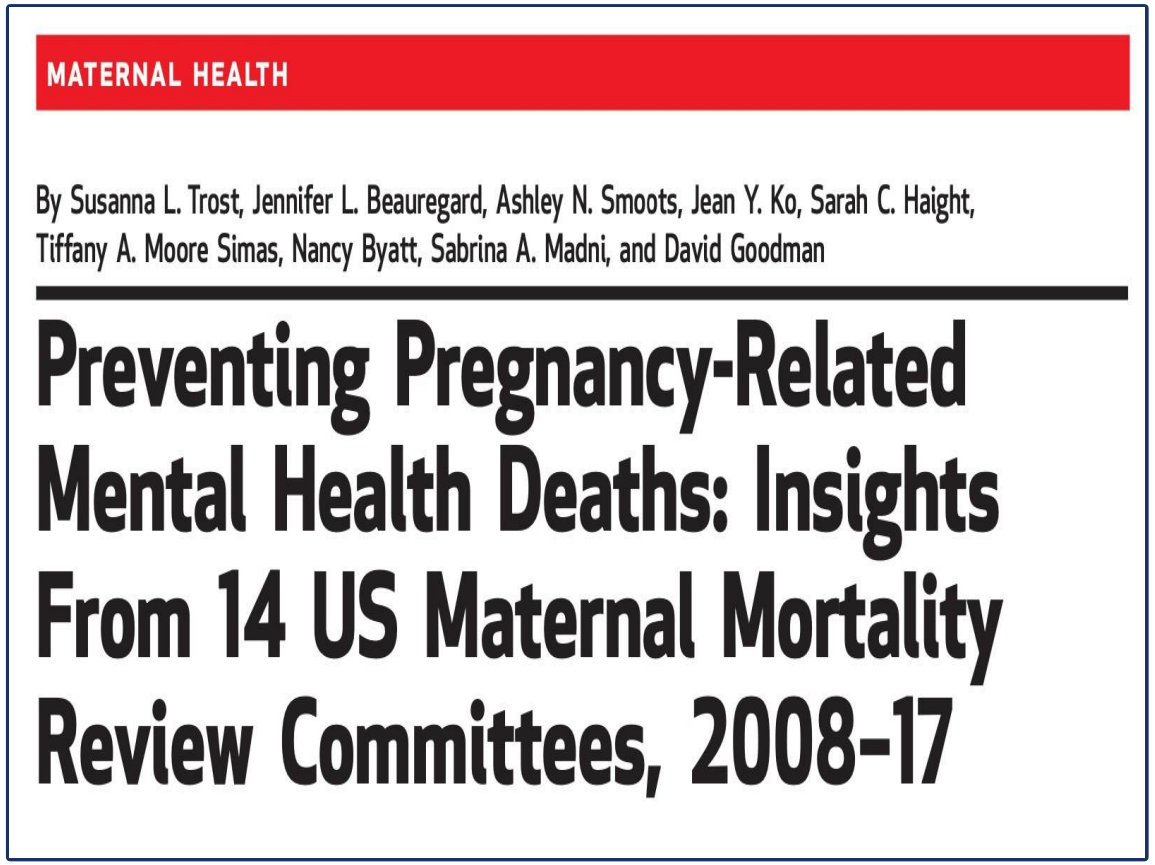
*2020 Estimates may be influenced by the COVID-19 pandemic

(AFCARS Data, 2020 v1)



MATERNAL MORTALITY

1 IN 9 MATERNAL DEATHS ARE DUE TO MENTAL HEALTH CONDITIONS: 100% ARE PREVENTABLE


MATERNAL HEALTH

By Susanna L. Trost, Jennifer L. Beauregard, Ashley N. Smoots, Jean Y. Ko, Sarah C. Haight, Tiffany A. Moore Simas, Nancy Byatt, Sabrina A. Madni, and David Goodman

Preventing Pregnancy-Related Mental Health Deaths: Insights From 14 US Maternal Mortality Review Committees, 2008–17

More than two-thirds of people with a pregnancy-related mental health cause of death had a history of or indications of current substance use

(Health Affairs VOL. 40, NO. 10, 2021)

CONNECTING THE DOTS: MATERNAL HEALTH AND CHILD WELFARE

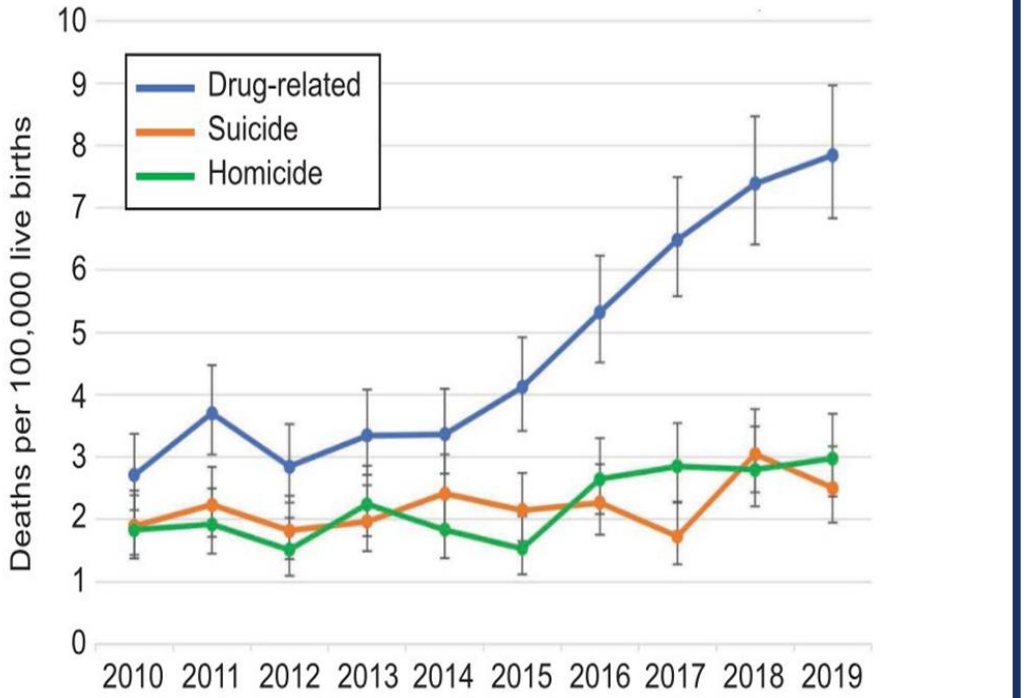
History of or current substance use (with or without diagnosis of SUD) was present in 67 percent of deaths.

Common life stressors included:

- Medication instability (39%)
- Previous suicide attempt(s) Removal of a child from the person's custody or CPS involvement (24 %)
- (22%)

(Health Affairs VOL. 40, NO. 10, 2021)

PREGNANCY-ASSOCIATED DEATHS DUE TO DRUGS, SUICIDE, AND HOMICIDE IN THE UNITED STATES 2010–2019



22.2% of all Maternal Deaths are due to:

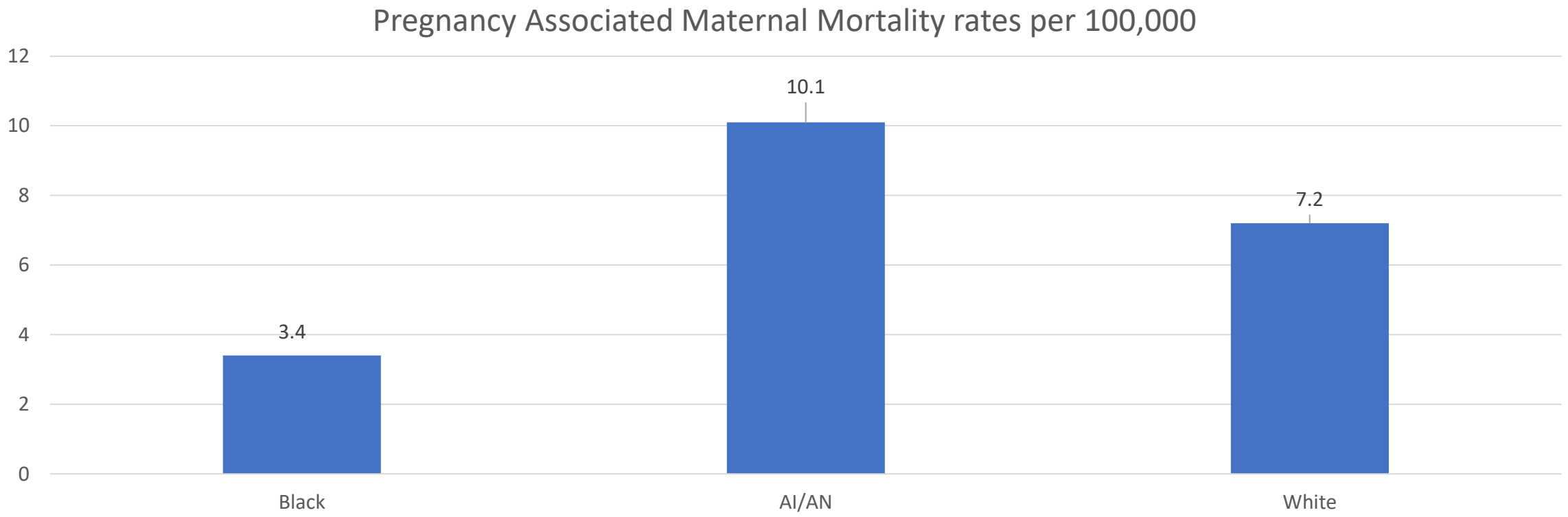
- Drugs (11.4%)
- Suicide (5.4%)
- Homicide (5.4%)

From 2010-2019:

- Drug-related deaths increased 190%
- Suicide increased 30%
- Homicide increased 63%

(Margerison, C., Roberts, M., Gemmill, A., et al. 2022 V. 139)

PREGNANCY-ASSOCIATED DEATH RATIO FOR DRUG-RELATED CAUSES BY ETHNICITY



(Margerison, C., Roberts, M., Gemmill, A., et al. 2022 V. 139)

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WAS THIS DATA SURPRISING TO YOU?

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HOW TO COMBAT THESE CHALLENGES

OPPORTUNITY

- Child Abuse Prevention and Treatment Act (CAPTA)
- Comprehensive Addiction and Recovery Act (CARA)
- Plans of Safe Care (POSC)

CARA AMENDMENTS TO CAPTA

Primary Changes in **CAPTA** Related to Infants with Prenatal Substance Exposure

1974	CAPTA
2003	The Keeping Children and Families Safe Act
2010	The CAPTA Reauthorization Act
2016	CARA
2018	SUD Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)

CARA PRIMARY CHANGES TO CAPTA IN 2016

- Further clarified population to 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,” **specifically removing “illegal”**
- Specified **data to be reported** by States to the maximum extent practicable
- Required **POSC** to address “the health and substance use disorder treatment needs of the infant and affected family or caregiver.”
- Required “the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.”

PLANS OF SAFE CARE

POSC COMPONENTS – BEST PRACTICES

Ensure consents are signed with all providers.

Infant's Medical Care

- Prenatal exposure history
- Hospital care (NICU, length of stay, diagnosis)
- Other medical or developmental concerns
- Pediatric care and follow-up
- Referral to early intervention and other services
- Other

Mother's Medical Care

- Prenatal care history
- Pregnancy history
- Other medical concerns
- Screening and education
- Follow-up care with OB-GYN
- Referral to other health care services

Mother's Substance Use and Mental Health Needs

- Substance use history and needs
- Mental health history and needs
- Treatment history and needs
- Medication Assisted Treatment (MAT) history and needs
- Referrals for services

Family/Caregiver History and Needs

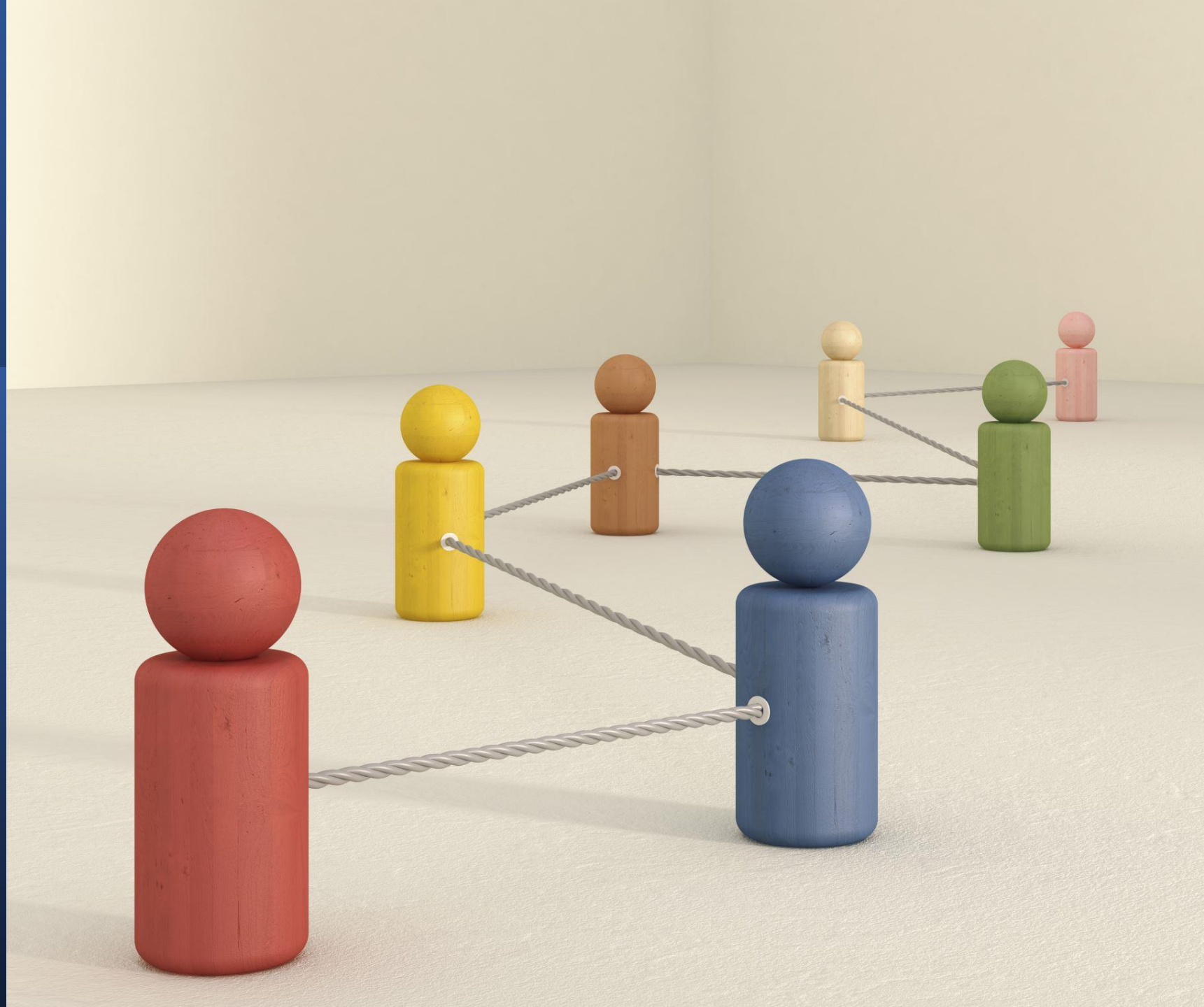
- Family history
- Living arrangements
- Parent-child relationships
- Prior involvement with child welfare
- Current services
- Other needed services
- Child safety and risk concerns

THE NECESSITY OF COLLABORATION

Substance use and child maltreatment are often **multi-generational problems** that can only be addressed through a coordinated approach across multiple systems to address needs of both parents and children.

(Boles, et al., 2012; Dennis, et al., 2015; Drabble, 2010)

THE COLLABORATIVE PRACTICE MODEL



SYSTEMS-LEVEL POLICY EFFORTS THAT SUPPORT PRACTICE INNOVATIONS

- Commitment to Share Mission, Vision and Goals
- Efficient Cross-Systems Communication
- Ongoing Cross-Training and Staff Development
- Sustainability and Institutionalized Practice
- Measuring and Monitoring Outcomes

PRACTICE STRATEGIES AND INNOVATIONS

- Early Identification of Families in Need of SUD Treatment
- Timely Access to Assessment and Treatment Services
- Recovery Support Services
- Family-Centered Treatment Services
- Frequent Monitoring and Responses to Behaviors

Key Shared Outcomes with Equity for Families

All outcomes should be disaggregated by race, ethnicity, gender, and other key demographic information.

Recovery

Parents access treatment more quickly; stay in treatment longer; decrease substance use

Remain at Home

More children remain at home throughout program participation

Reunification

Children stay fewer days in foster care and reunify within 12 months at a higher rate

Repeat Maltreatment

Fewer children experience subsequent maltreatment

Re-entry

Fewer children re-enter foster care after reunification

STEP ONE: IDENTIFY DIFFERENCES IN VALUES COMMITMENT TO SHARED MISSION, VISION & GOALS

Examples of Primary Focus for Each System in the Collaborative

AGENCY	Primary Value
CHILD WELFARE	Safety, permanency and well being of the child
ALCOHOL AND DRUG TREATMENT AGENCIES	Recovery and treatment outcomes for the parent
DEPENDENCY COURTS	Safe living arrangements and permanent caregiving relationships for the child

Potential Tool: Collaborative Values Inventory

Equity Tool: Collaborative Values Inventory for Tribes

STEP 2: CREATE A MISSION STATEMENT BASED ON EXPLORATION OF VALUES AND PRINCIPLES

Partners might want to ask (and answer) these questions before proceeding:

- Who is the client?
- How significant is the problem? How will joint efforts improve results compared with baseline outcomes of the reported prevalence of both the problem and outcomes for families?
- Whose resources should we use for joint efforts? What is a fair way to allocate resources to different systems for shared responsibilities?
- What are parents' responsibilities? **What is the system's responsibility to provide parents and children with timely and effective services?**
- **Which children and parents do we prioritize for receiving help?** How long will we provide this help?

QUESTIONS TO CONSIDER

Do the mission, vision, & goals incorporate an intentional focus on reducing disproportionality and disparities, providing equitable access, and improving equitable outcomes for all families?

Have partners engaged in exercises or conversations to gain a better understanding of disproportionality and disparate outcomes in their systems?

Is there an ongoing process to identify and discuss issues related to disproportionality and disparities?

Does the collaborative team include representatives from the community being served and ensure the voice of lived experience is incorporated into the decision-making process?

THREE OPTIONS TO PROMOTE EQUITY

Early Identification

Prenatal POSC & TeamBirth

Family Centered Treatment Services

Medical Legal Partnerships, CHARM, CAPTA Notification Pathways

Recovery Supports

Peer Supports & Doulas

Early Identification of Families in Need of SUD Treatment

Prenatal POSC

PRENATAL POSC

- Can be developed by SUD programs, maternal health care providers, home visitor, or other public health supports
- Enables stronger partnerships across providers
- Can inform child welfare response to infants affected by prenatal substance exposure
- Can prepare families for impact of exposure and child welfare investigation
- Is not required by federal CAPTA changes, but a supportive, preventive practice

STATE TRENDS: PRENATAL POSC

Some states are expanding their focus to support families ***in the prenatal period*** as an opportunity to enhance family well-being and protective capacities prior to birth.

This can result in families:

- Obtaining concrete supports
- Expanding their support connections prior to a highly vulnerable time
- Developing a network of recovery supports
- Understanding infant social and emotional development
- And ultimately reduce the need for child welfare involvement or family separation

PRACTICE IMPLICATIONS

- States continue to **adapt and modify** their strategies
- Some are moving **beyond compliance** to focus on **community collaboration**
- Aligning with parallel initiatives allows states to coordinate changes across systems and expand **equitable access to care**
- Shifting to prenatal POSC allows states to **change the reactive approach** to a proactive, **prevention approach** and to avoid a crisis at delivery

IMPACT OF PRENATAL FAMILY WELLNESS PLANS IN TWO PILOT SITES OKLAHOMA

The Center for Therapeutic Interventions

Prenatal FCP initiated & Monitored by SUD/OTP Provider

*(Data from October 2019-August 2022)

S.A.F.E.R. Program
Safely Advocating for Families Engaged in Recovery

100% of infants discharged home with parents to continue treatment with SAFER FCP
(*Two babies are currently in NICU with plans to be discharged home)

73 Prenatal Family Care Plans Implemented OUTCOMES	
64	Babies born w/ CTI SAFER FCP
8	DHS Investigation at Birth
0	DHS Custody of Child (Foster Care)
5	VSA of FCS Child home w/ Family
9	Pregnant Women currently in Care
1 (currently)	Baby NICU Stay due to NAS (+1 non-NAScurrently)
62	Baby able to Room-in as requested
62	Baby/mom utilized Eat-Sleep-Console
61	Moms on MAT at time of Delivery

OU STAR Clinic Updates (Prenatal FCP initiated by OB/GYN)

*(Data from October 2019-March 2022)

91% of infants are discharged with parents

Number of pregnant individuals served: 172

Number of infants delivered: 108*

Number currently pregnant: 24

Number of individuals on MAT at time of delivery: 85%

Percentage of infants placed in Out of Home Care (DHS custody): 9%
(12 out of 108, 2 of the 9 were due to mother's current incarceration)

HEALTHCARE CHANGES SUPPORTING COLLABORATIVE PRACTICE:
DELIVERY DECISIONS INITIATIVE:
TEAMBIRTH

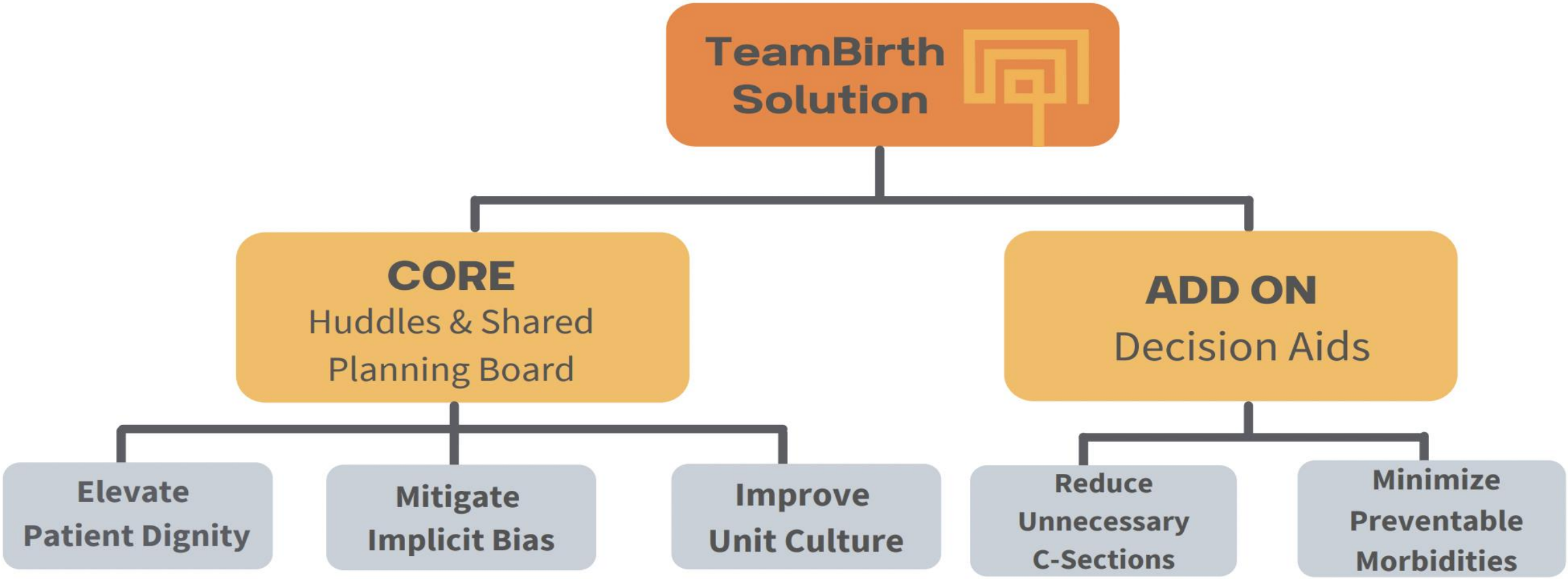
Our vision

is a world in which every person can choose to grow their family with dignity.

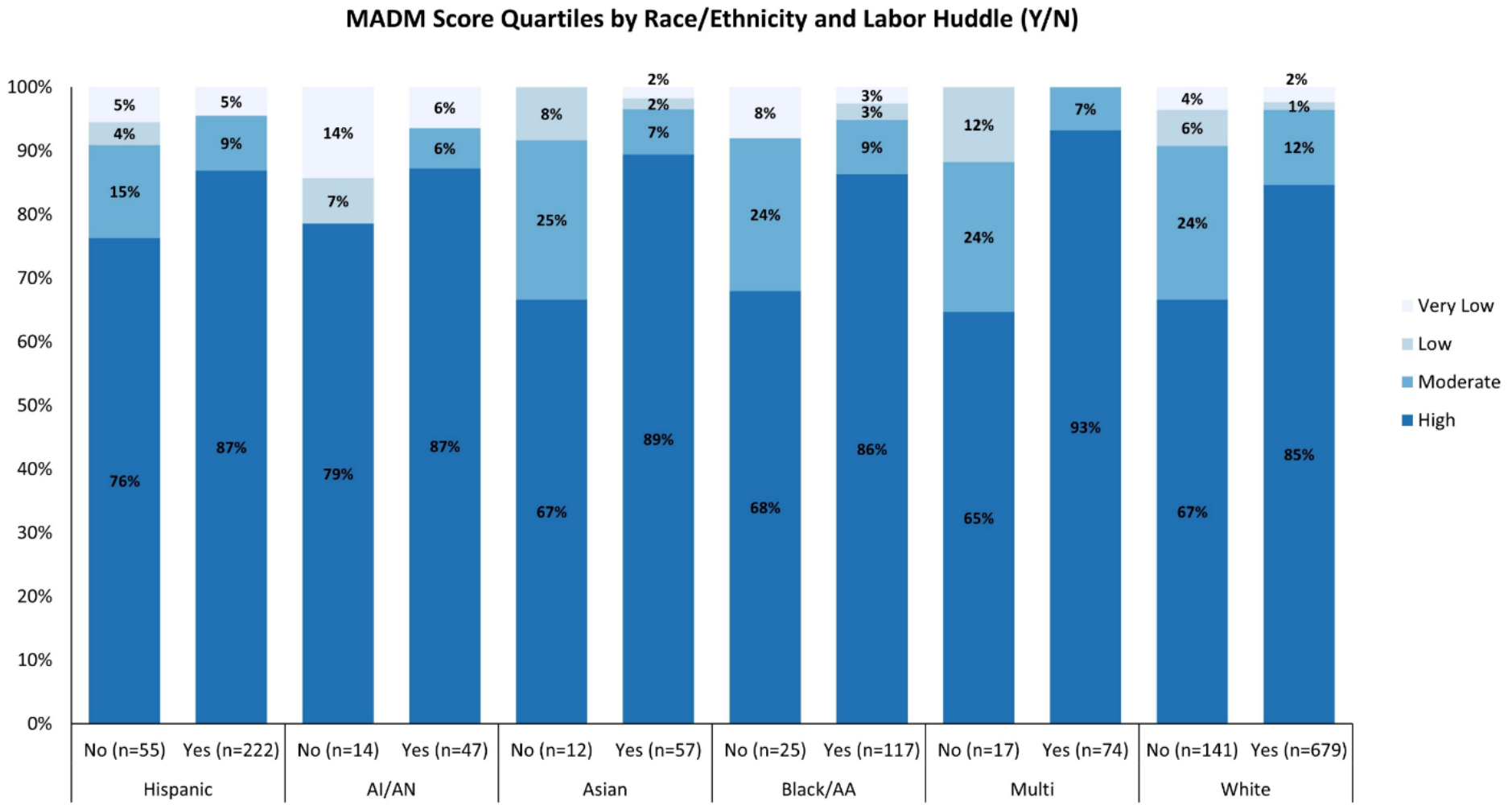
"Over the past generation, giving birth in America has become less trustworthy."

- U.S. women have the **highest rate of maternal mortality** among high-income countries, and this rate is rising. These women are also more likely to experience severe maternal morbidity.
- **Black women** experience **3-4x higher mortality.**
- **Two-thirds** of pregnancy-related deaths may be **preventable.**
- In a national survey, almost **1/3 of women who gave birth in a hospital reported experiencing one or more types of mistreatment,** such as loss of autonomy or receiving no response to requests for help.
- Mistreatment is experienced more frequently by **women of color** and among those with **social, economic, or health challenges.**

(Vedam, S., Stoll, K., Taiwo, T.K. et al., 2019)


TeamBirth Solution
CORE
Huddles & Shared Planning Board
ADD ON
Decision Aids
Elevate Patient Dignity
Mitigate Implicit Bias
Improve Unit Culture
Reduce Unnecessary C-Sections
Minimize Preventable Morbidities

MOTHERS AUTONOMY IN DECISION MAKING* BY "HUDDLE" AND RACE/ETHNICITY



*Data includes Oklahoma Cohort 1 sites May-August 15, 2022

(Vedam S, Stoll K, Martin K, et al., 2017)

TEAMBIRTH ADAPTATIONS IN OKLAHOMA

Developing	Developing guidance for working with families experiencing a SUD
Consulting	Consulting with tribal representatives to adapt the approach to meet needs of Native American families
Expanding	Expanding to prenatal care and the NICU

QUESTIONS TO CONSIDER

Is the screening and assessment process reviewed regularly to ensure equitable access?

Do screening and assessment practices help reduce disproportionate representation in child welfare and promote more equitable access to treatment services?

What data are being used to monitor and track?

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Knowing what you know now, what's a strategy you'd like to take back and implement in your community to promote equity?

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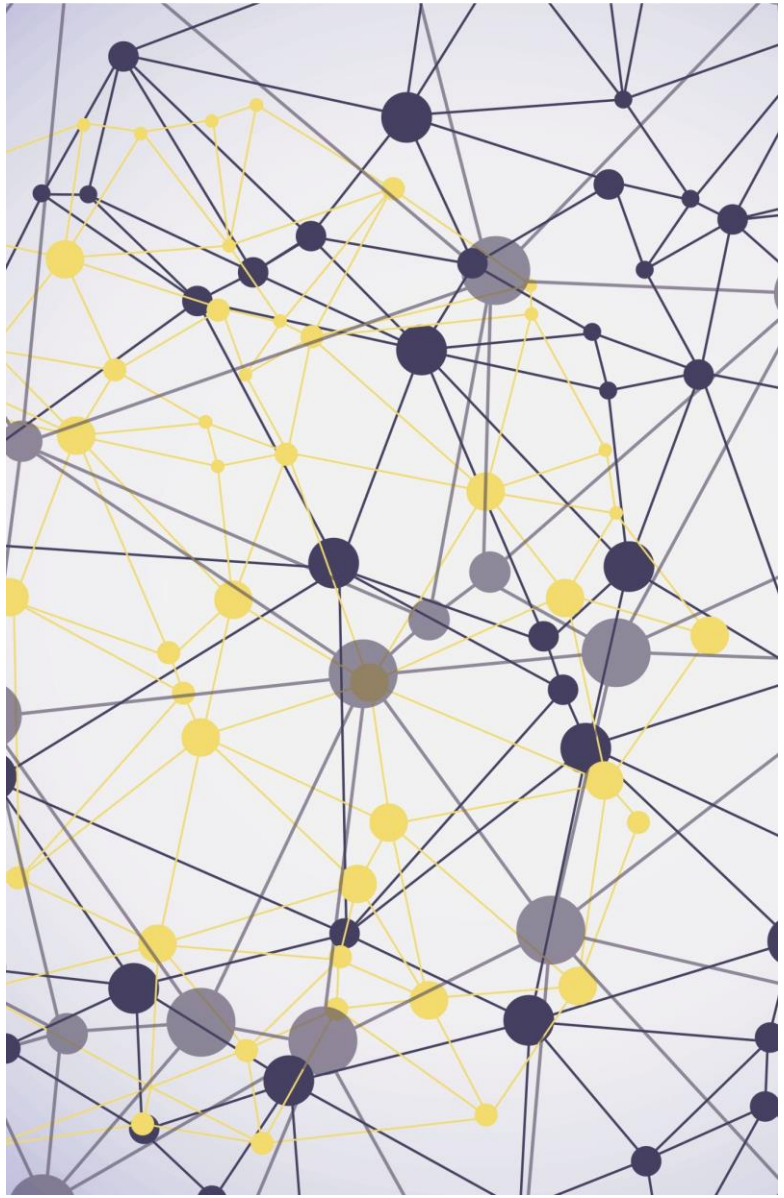

FAMILY CENTERED TREATMENT SERVICES

MEDICAL LEGAL PARTNERSHIPS,

CHARM AND CAPTA NOTIFICATIONS

FAMILY-CENTERED APPROACH

Recognizes that addiction is a **brain disease** that affects the entire **family,** and that recovery and well-being occurs **in the context of the family**

Provides a comprehensive array of clinical treatment and related support services that meet the needs of **each member in the family**, not only the individual requesting care

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Extends well beyond the substance use disorder (SUD) treatment system, the child welfare system, the courts, and mental health services, and includes **all other agencies and individuals** that interact with and serve families

(Adams, 2016; Bruns et al., 2012; Children and Family Futures et al., 2020)

LEGAL-MEDICAL PARTNERSHIPS

(The First Clinic)

- Family Intervention Response To Stop Trauma (F.I.R.S.T clinic) (Everett, WA).
- Interdisciplinary and cross-discipline upstream approach to child welfare **combines legal advocacy with connecting a family with services to prevent removal and future involvement with CPS.**
- Having a confidential and trusted resource to help a parent navigate through the hurdles of CPS involvement **PRIOR** to court action has made all the difference in the lives of clinic clients.
- Between July 2019 and November 2021, out of 72 cases with a recorded outcome, **89% of babies remained with their parents or other relatives.**

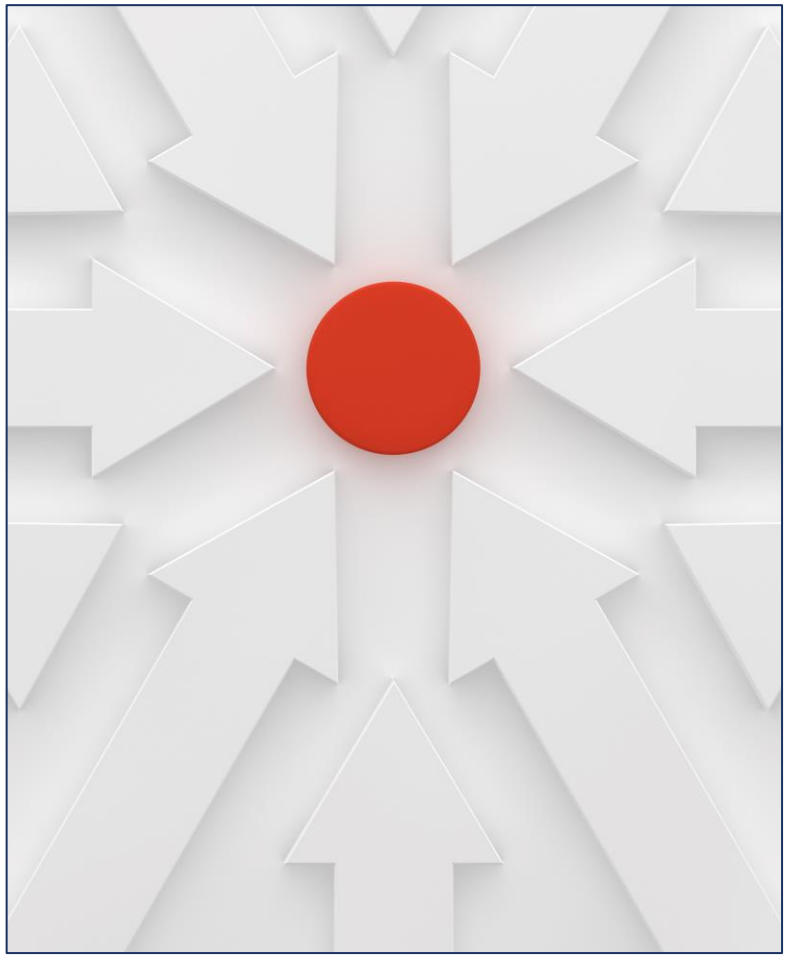
CHARM COLLABORATIVE

- A collaborative approach to supporting pregnant and parenting individuals with SUDs and infants affected by prenatal substance exposure

THE GOAL OF CHARM

CHARM is an **inter-disciplinary** and **cross-agency team** which coordinates care for pregnant and postpartum individuals affected by a SUD, and their babies.

- Improve the health and safety outcomes of babies born to individuals with a history of SUD by coordinating
- Ensure appropriate medical care
- Increase access to substance abuse treatment
- Collaborate with child welfare
- Increase social service supports.



HOW DOES **CHARM** WORK? **INFORMATION SHARING!**

Prenatal Care:

- **Initial:** Confirm pregnancy, assess for substance dependence
- **Ongoing:** compliance with prenatal visits and monitoring; referrals for specialty or community services
- **Medication Assisted Treatment**: consistency; urine drug tests; dose adjustment; substance use counseling follow-up: post-partum MAT provider plan
- **Residential** program option for moms and babies

Case Management, Referrals and Support:

- WIC, breastfeeding, Home Visiting, social support services.
- Gift cards, transportation passes, baby items

WHY CONSIDER CREATING A CAPTA NOTIFICATION PATHWAY?

- In many jurisdictions, all infants with prenatal substance exposure are mandated reports of child abuse or neglect to child welfare.
- However, many are screened out at intake or closed after initial investigation.

What if:

- A CAPTA notification option for families with a lower risk profile were created, and
- Family engagement, POSC development and ongoing tracking were provided by a community partner (such as a treatment provider or home visitor)

Then:

- All infants with prenatal substance exposure and their families could receive supports and services.

CAPTA SUBSTANCE AFFECTED INFANT (SAI) DEFINITION

- Healthcare providers involved in the delivery of care of an infant born “affected by substance abuse” must notify child protective services.
- A POSC is to be developed for these infants and their families.
- The requirements are intended to provide the needed services and supports for infants with prenatal exposure, their mothers with SUDs and their families to ensure a comprehensive response to the effects of prenatal exposure.
- Congress stated that these reports to CPS, on their own, are not grounds to substantiate child abuse or neglect.

CAPTA NOTIFICATIONS: 3 KEY POINTS

1. Healthcare providers involved in the delivery of care of an infant born "affected by substance abuse" **must notify** CPS. These reports on their own, are not grounds to substantiate child abuse or neglect.

2. A POSC is required for "infants affected by substance abuse" whether or not the circumstances constitute child maltreatment under state law.

3. CAPTA does not specify which agency or entity (such as hospitals or community-based organizations) must develop the POSC.

Site Example: Delaware

AIDEN'S LAW (SIGNED 6/7/18)

Healthcare providers must notify DFS of infants born with and affected by substance abuse, withdrawal symptoms or FASD.

POSC are prepared to address health and SUD treatment needs of both the infant and affected family or caregiver.

Monitoring of the POSC to ensure referrals for and delivery of services to both the infant and the affected family or caregiver.

DELAWARE
INFANTS WITH PRENATAL SUBSTANCE EXPOSURE

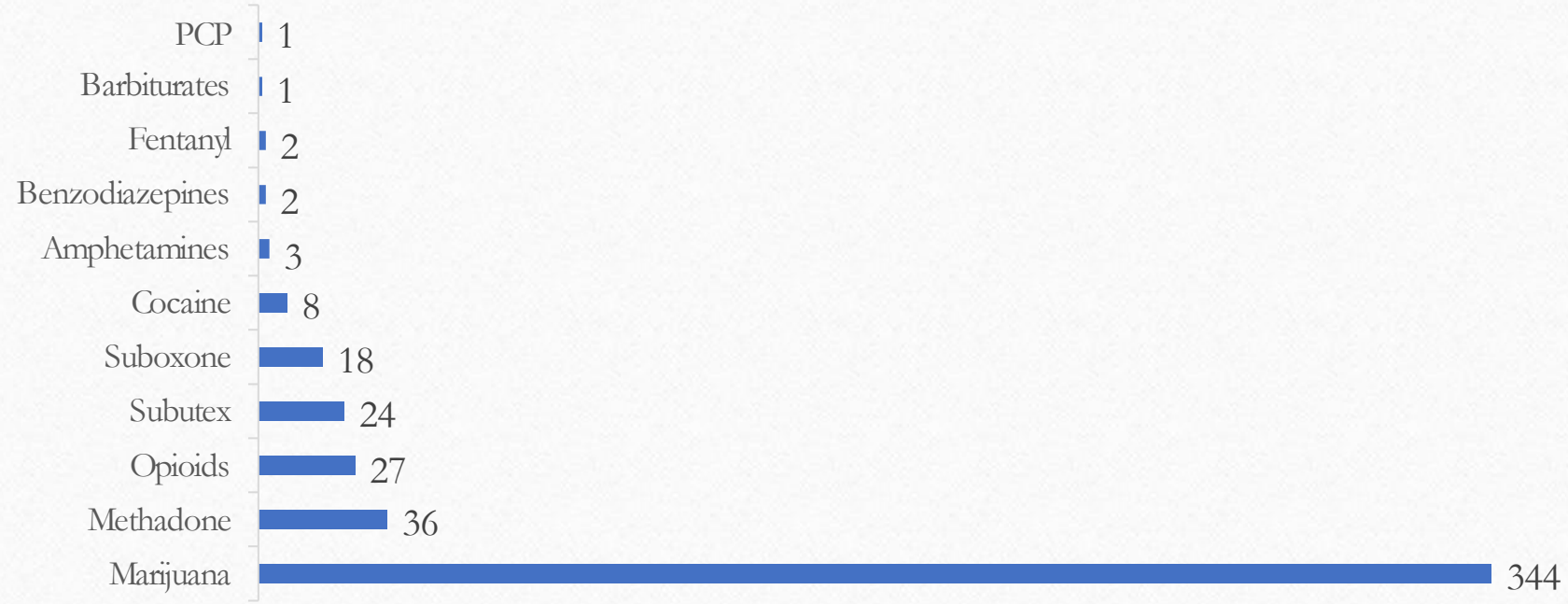
2020
YEAR IN REVIEW

Trenee Parker, MA, DFS Director
Jennifer Donahue, Esq., IC/OCA

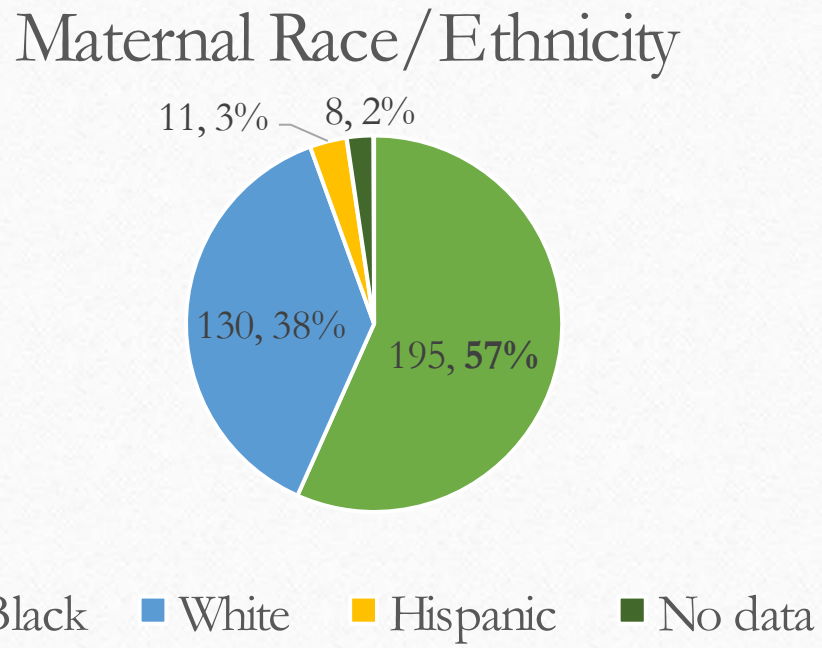
POSC PATHWAYS

Type of Substance Exposure/ Risk Factors	Notification to DFS at birth event? (yes/no)	POSC Coordinator
Alcohol or Illicit Drugs (other than marijuana)	Yes	Division of Family Services
Misuse of legal/prescription drug	Yes	Division of Family Services
Any substance with high risk factors	Yes	Division of Family Services
Marijuana and no other risk factors	**Yes**	**Contract Agency (ie. Holcomb)**
Medication Assisted Treatment (ie. methadone, Subutex, suboxone) and no other risk factors	**No (quarterly data exchange with DFS)**	**MAT provider**
Legal prescription that can cause withdrawal symptoms in infant, no other risk factors and no diagnosis of substance use disorder	**No (quarterly data exchange with DFS)**	**Hospital ("Medical POSC")**

Most Prevalent Substances in Single Substance Exposure (n: 466)

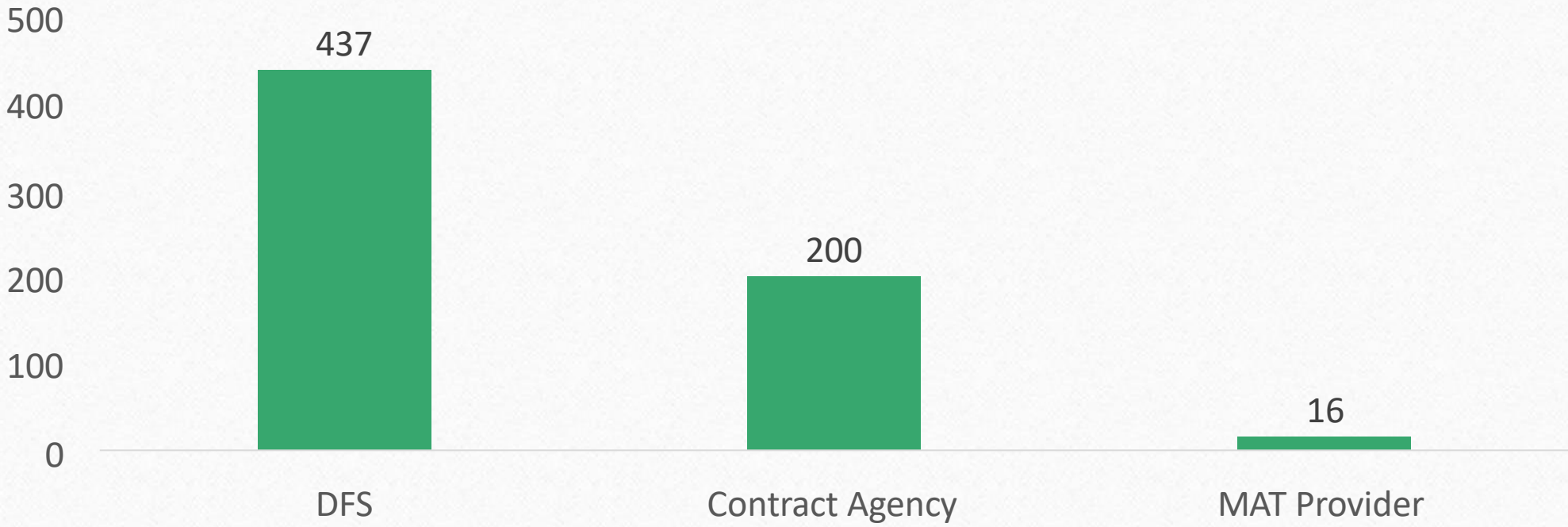


Marijuana Only Cases(n:344)

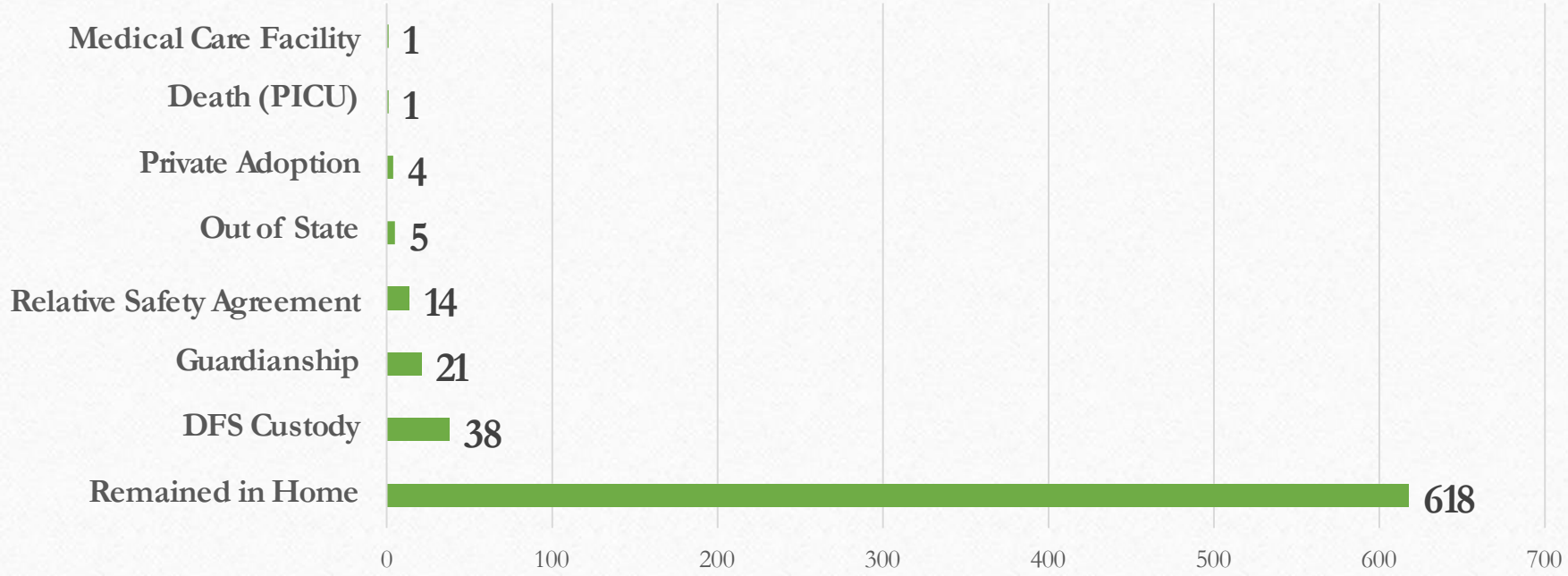


POSC PREPARED: 653

(FOR CASES THAT REQUIRED A NOTIFICATION TO DFS AT BIRTH EVENT)



PLACEMENT
REMAIN IN HOME VS. OUT OF HOME (702 CASES)



QUESTIONS TO CONSIDER

How are voices of families from differing demographic groups represented on the collaborative team?

Is family-centered treatment available for diverse family structures including nuclear family members, extended family members, and/or non-blood relatives? Are clients able to identify their family members?

Do parents and children have access to trauma-responsive services including providers who understand the effects of historical trauma?

RECOVERY SUPPORTS

PEER SUPPORT SPECIALISTS/FAMILY MENTORS/DOULAS

FUNCTIONS OF RECOVERY SUPPORT SPECIALISTS

Liaison

- Links participants to ancillary supports; identifies service gaps

Treatment Broker

- Facilitates access to treatment by addressing barriers and identifies local resources
- Monitors participant progress and compliance
- Enters case data

Advisor

- Educates community; garners local support
- Communicates with FDC team, staff and service providers

PEER RECOVERY SUPPORTS- ROLES AND ACTIVITIES

- Provide mentoring and coaching
- Serve as recovery role models
- Help families navigate public systems
- Parent engagement in child welfare setting
- Connect families to services, community resources, and recovery supports
- Help remove barriers to services and progress
- Transportation, childcare referrals, court, family meetings
- Help raise awareness, reduce stigma, and
- promote advocacy and recovery
- Help establish new recovery supports in community
- Change organizational cultures where they work
- Share experience, strength, and hope

PUBLISHED OUTCOMES

- Women in START have **nearly double sobriety** rate of non-START counterparts (66% vs 37%)
- Children in START are about **half as likely to enter foster care** (21%vs 42%)
- At case closure, over **75% of START kids remained with or were reunified** with their parent(s)
- For every dollar spent on KY START, **$2.22 is saved in off set of foster care costs**.
- Listed as having **promising evidence of effectiveness** on the California Evidence-Based Clearinghouse for Child Welfare

(Huebner, R.A., Willauer, T., and Posze, L. 2012)

START Sobriety Treatment and Recovery Teams©

Recovery Support Matters

A Randomized Control Trial – Cook County, IL (n=3440)

Comprehensive Screening & Assessment

+

Early Access to Treatment

+

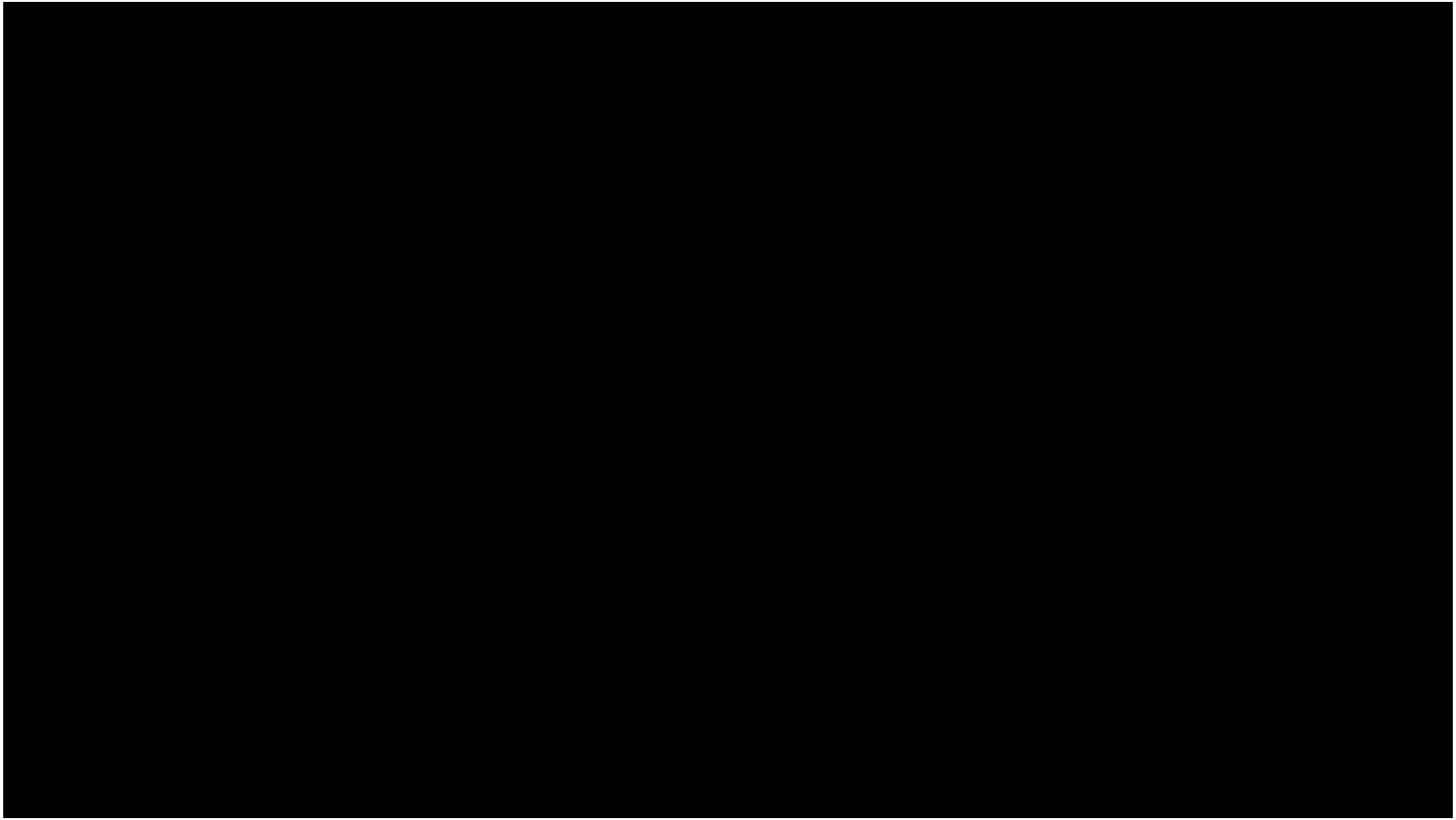
=

Positive Outcomes

(Ryan, Perron, Moore, Victor & Park, 2017)

TULSA BIRTH EQUITY INITIATIVE- DOULAS

The effectiveness of the program emerges out of the trusting relationship between the community-based doula and the participant, established through the months of pregnancy, birth and early infant care.



QUESTIONS TO CONSIDER

Are recovery or peer support services matched with parents in a gender, age, and a culturally appropriate way?

Are recovery support services supportive of MAT for opioid use disorders?

If not, what is needed to assure they are supportive?

RESOURCES

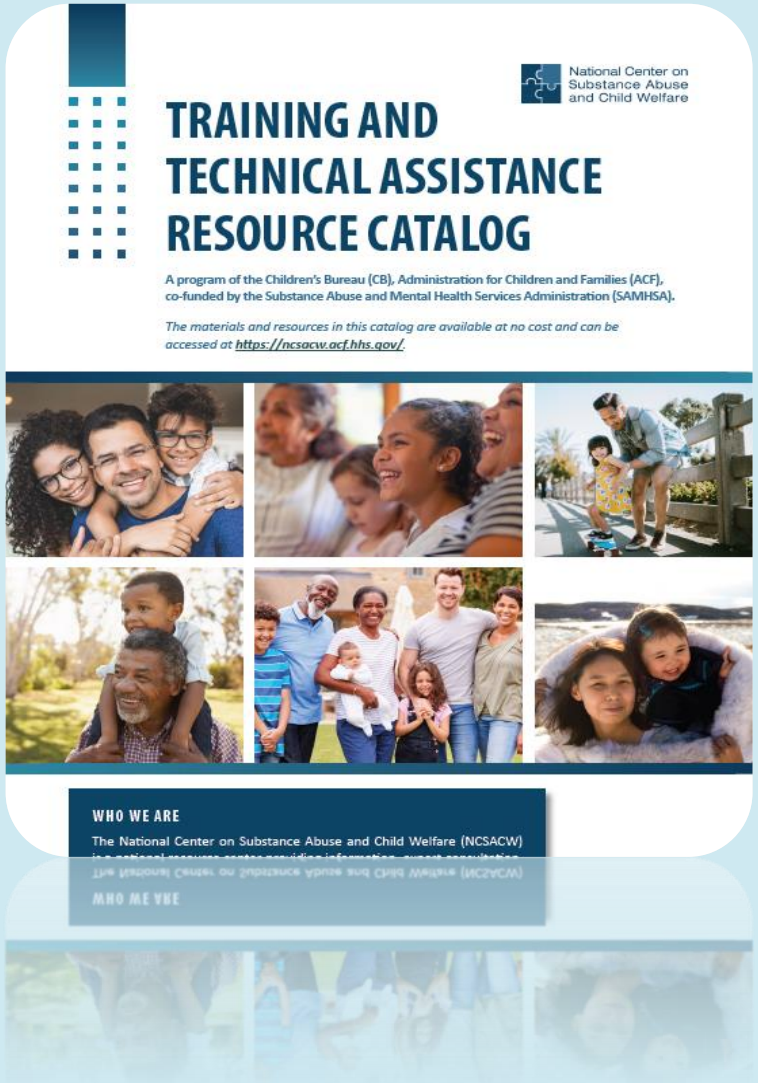
JOIN US!

Subscribe to our newsletter to get the first look at tools, resources, and webinars!

Scan the QR code to subscribe to our newsletter!

LEARN MORE ABOUT RESOURCES FROM NCSACW!

Use this QR code to access ***The Training and Technical Resource Catalog*** which includes all the most recent materials from NCSACW to help professionals best serve families.



WHO WE ARE

NCSACW provides training and technical assistance (TTA) to help agencies and professionals develop or enhance policies, practices, and procedures that improve child and family outcomes and promote their social and emotional well-being.

Contact us to learn more and for a copy of *Who We Are* at NCSACW@cffutures.org

National Center on Substance Abuse and Child Welfare

WHO WE ARE

The National Center on Substance Abuse and Child Welfare (NCSACW) has operated since 2002 and is jointly funded by the Children's Bureau (CB), Administration for Children and Families (ACF), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

NCSACW develops virtual and onsite educational materials and training curricula; maintains an extensive web presence; and provides a range of technical assistance (TA) activities for agencies, including substance use disorder (SUD) and mental health treatment, child welfare services, family courts, public health, healthcare, maternal and child health, and child and adolescent service providers.

NCSACW's primary tenets are to support systems change, improve practice and policy, and reduce stigma related to families affected by SUDs and mental health challenges. This is accomplished through enhanced agency collaboration based on a shared understanding of the needs and challenges of families and the systems that serve them.

NCSACW's goals are to:

- Facilitate healing and recovery among children, youth, parents, and families affected by SUDs and mental health challenges who are either involved—or at risk of involvement—with the child welfare and family judicial systems
- Promote the social and emotional well-being of children and youth who have experienced maltreatment, exposure to violence, or trauma associated with parental substance misuse and mental health challenges
- Advance racial equity and support for underserved communities and improving access for special populations including Tribes

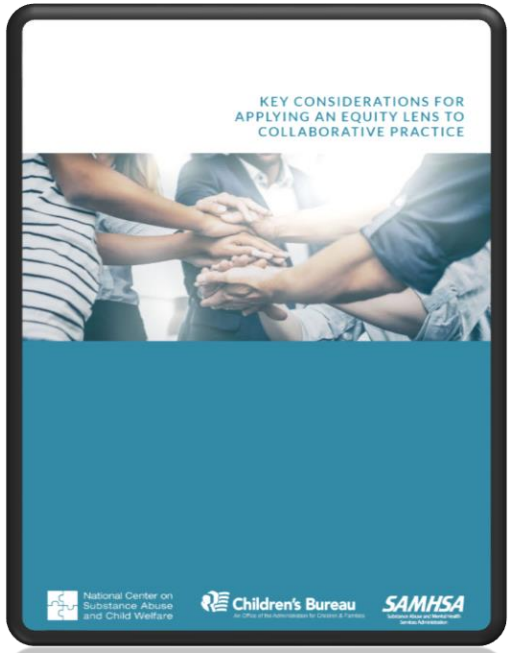
Our team of staff and consultants have experience in SUD and mental health treatment, court improvement processes, child welfare policy and direct service, health care, early childhood development, and many other fields. Staff have served as policymakers in state and local governments, held clinical and administrative leadership positions in SUD and mental health treatment agencies, worked in frontline child welfare practice, and acted as court administrators.

WHAT WE DO

NCSACW provides training and technical assistance (TTA) to help agencies and professionals develop or enhance policies, practices, and procedures that improve child and family outcomes and promote their social and emotional well-being. NCSACW also researches, compiles, and shares examples of successful programs with other jurisdictions to expand best practices in communities across the country. Tailored consultation and TA support occur via virtual sessions, in-person site visits, and individualized coaching to build meaningful relationships and share relevant information, resources, publications, guidance, and effective strategies.

1

Key Considerations for Applying an Equity Lens to Collaborative Practice



This brief helps collaborative teams formally **assess existing policies** to determine if and how they **contribute to disproportionate and disparate outcomes for families** being served. By working through the "*Questions to Consider*", teams begin applying an **equity lens** to collaborative policies and practices.

Available @ https://ncsacw.acf.hhs.gov/files/equity-lens-brief.pdf

NCSACW Child Welfare Practice Tip Series

- *Understanding Substance Use Disorders: What Child Welfare Staff Need to Know*
- *Understanding Engagement of Families Affected by Substance Use Disorders-Child Welfare Practice Tips*
- *Understanding Screening and Assessment of Substance Use Disorders-Child Welfare Practice Tips*
- *Identifying Safety and Protective Capacity for Families with Parental Substance Use Disorders and Child Welfare Involvement*
- *Child Welfare & Planning for Safety: A Collaborative Approach for Families with Parental Substance Use Disorders and Child Welfare Involvement*

Download @ https://ncsacw.acf.hhs.gov/topics/parental-substance-use-disorder.aspx

Safety & Risk Video Series

National Center on Substance Abuse and Child Welfare

This video series provides child welfare professionals with details on child safety and risk factors related to parental substance use disorders (SUDs). The series highlights strategies to promote parent engagement and support a coordinated approach—across systems—that helps families mitigate child safety and improve family well-being. It includes considerations when planning for safety with families.

- ***Engagement and Safety Decision-Making in Substance Use Disorder Cases***
- ***Planning for Safety in Cases When Parental Substance Use Disorder is Present***

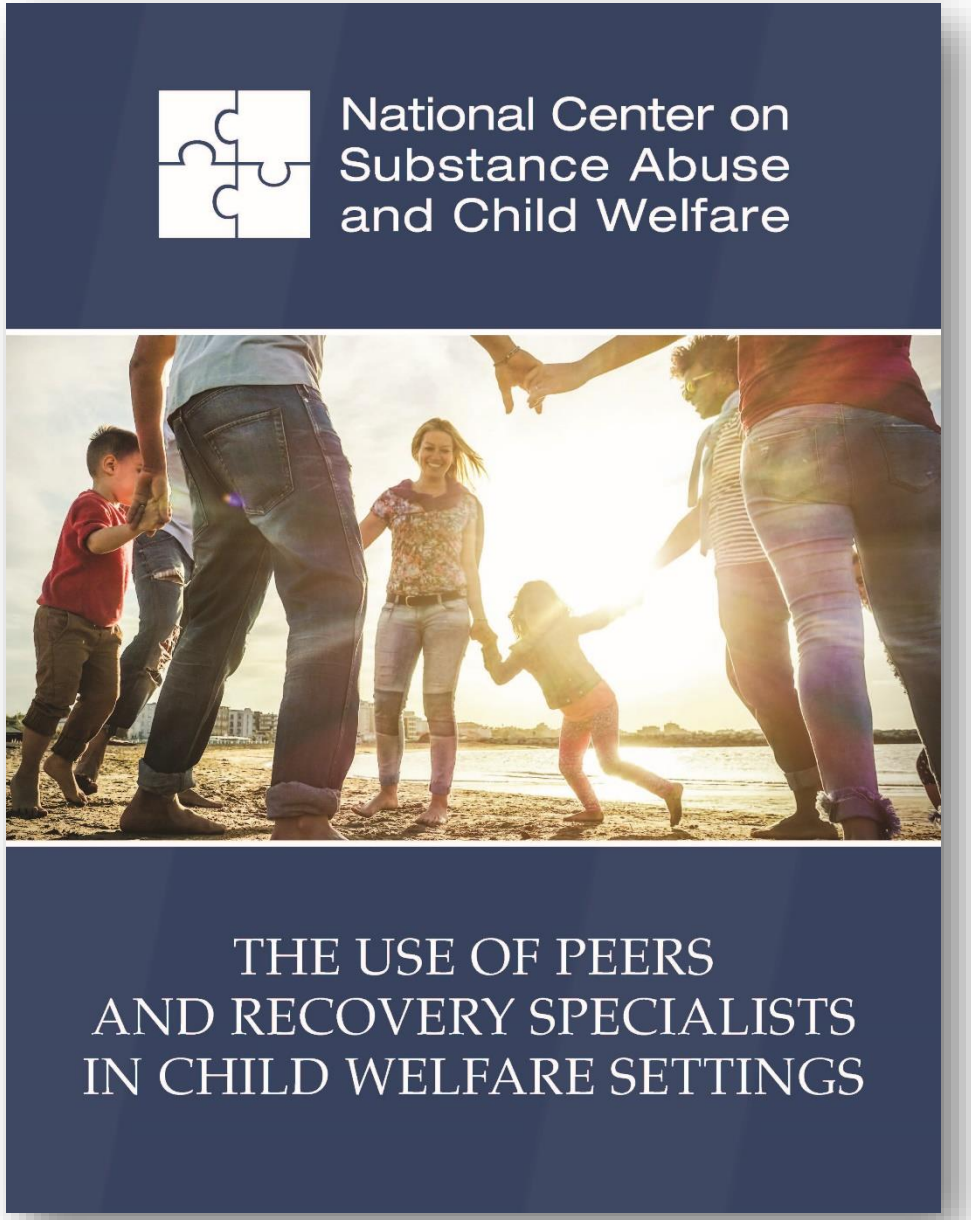
@ **https://ncsacw.acf.hhs.gov/training/videos-and-webinars/webinars.aspx**

Disproportionalities and Disparities in Child Welfare

A resource for child welfare workers to help

Understand the link between disproportionalities, disparities, and the child welfare system.
Recognize disproportionalities and disparities when working with families affected by SUD.
Implement strategies to increase engagement with families and reduce inequities.

Available @ https://ncsacw.acf.hhs.gov/files/cw-tutorial-supplement-equity.pdf



Purpose: The brief offers implementation considerations that professionals can draw from when implementing peer or recovery specialist models in their communities.

Audience: Administrative and executive-level professionals from:

- Child Welfare
- Substance Use Disorder Treatment
- Courts

Key Informant Interviews: Representatives from four programs–2 peer support programs and 2 recovery specialist programs–that have demonstrated positive child welfare and recovery outcomes for families

Available for download here: https://ncsacw.acf.hhs.gov/files/peer19_brief.pdf

National Center on Substance Abuse and Child Welfare

Understanding Fetal Alcohol Spectrum Disorders

For child welfare and substance use treatment professionals

Overview of fetal alcohol spectrum disorders (FASD)
Effect of FASD on child development
Treatment for FASD
Practice strategies to support infants, children, and families with a family-centered approach
Indicators of FASD among adults in SUD treatment

Now Available!

Download @ **https://ncsacw.acf.hhs.gov/topics/parental-substance-use-disorder.aspx**

Free Online Tutorials for Cross-Systems Learning

Understanding Substance Use Disorders and Facilitating Recovery: A Guide for Child Welfare Workers

Understanding Child Welfare and the Dependency Court: A Guide for Substance Use Treatment Professionals

Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Legal Professionals

Visit us @ https://ncsacw.acf.hhs.gov/training/default.aspx

National Center on Substance Abuse and Child Welfare

CONTACT US

NCSACW

(714) 505-3525

ncsacw@cffutures.org

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