PART THREE

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

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

National Center on Substance Abuse and Child Welfare

Acknowledgment

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

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

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

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

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

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

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

Part 3: Implementing and Sustaining the Essential Pillars of an Effective System of Care: Site Examples from Key Federal Initiatives

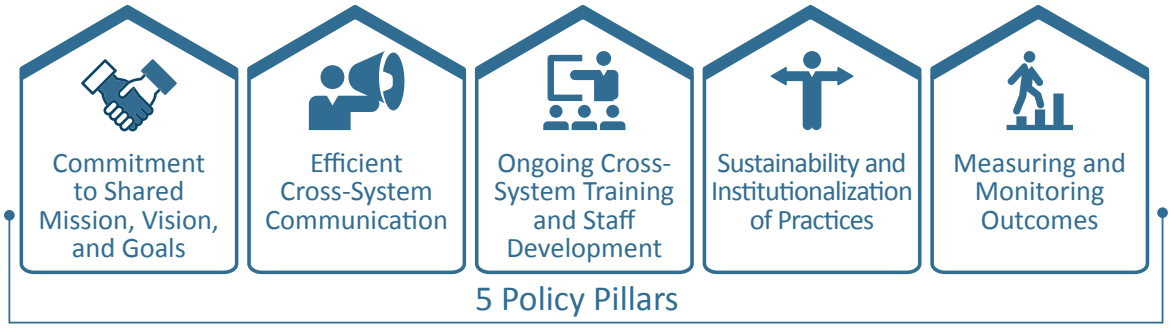
Decades of experience working with hundreds of Tribal, state, county, and local-level collaborative partnerships has revealed what works to effectively and holistically serve families affected by substance use and mental health disorders, and at risk of child abuse and neglect. *Part 3* of this blueprint offers an in-depth description of each of the 10 essential pillars of the system of care introduced in Part 1, with strategies and tactics to implement each pillar to improve access to family-centered services and to enhance family outcomes. It offers rich policy and practice examples from the RPG and IDTA programs described in Part 2. Part 3 illustrates what these pillars really look like in practice, describes implementation and sustainability challenges and strategies, and instills hope that implementing these policy and practice pillars creates an effective system of care for families.

NCSACW offers technical assistance to Tribes, states, counties, and communities on implementing these pillars as they establish an effective system of care for these families. Implementing these policy and practice pillars enables Tribes, states, counties, and communities to establish an effective system of care that promotes more access to comprehensive and family-centered care to promote positive outcomes for all families affected by substance use and mental health disorders.

POLICY AND PRACTICE PILLARS: ON THE GROUND EXAMPLES FROM RPG AND IDTA

System-Level Policy Pillars

As described in Part 1, there are five policy pillars essential to building a strong, multiagency collaborative team. These pillars can be put in place first to best implement and sustain the innovative practice strategies.



- **Pillar 1: Commitment to Shared Mission, Vision, and Goals**

  The cornerstone of a strong collaborative team is a united commitment to shared mission, vision, and goals, which can take a considerable effort to develop. Cross-system partners often initially come to the table with differing opinions and values related to the mission and priorities of the work, as well as varying viewpoints of parents with SUDs. Further, the mandates, training, and methods of the partner agencies are often quite different. These differences in values can create tension when developing a collaborative partnership if they are not acknowledged early on and throughout the process. The goal is not to change the values of partners, but to find the common purpose.

  To achieve common mission, vision, and goals, collaborative teams can first conduct open and honest discussions about their perceptions, values, hopes, and definitions of success related to serving families affected by SUDs. These discussions are an opportunity to consider what barriers exist, and how to improve access and outcomes for all children, parents, and family members. Often when differences are not identified, acknowledged, and discussed early they can emerge and frustrate efforts to make important systems changes.

  Children and Family Futures' *Collaborative Values Inventory* (CVI) is a self-administered questionnaire providing jurisdictions with an anonymous way of assessing the extent to which group members share ideas about the values that underlie their collaborative efforts. NCSACW provides technical assistance to collaborative teams as they complete and analyze CVI results. Partners can also reinforce their shared values and principles while using them as building blocks for developing a joint mission statement. A clear mission statement specifies the client- and system-related goals of the partnership; it's based on the values and principles of collaboration that all partners share.

  Partner agencies can also take time to learn about each other's roles, responsibilities, terminology, and current practices. Conversations and exercises that educate partners on each other's practices enlighten team members, help unearth current strengths and barriers, and support collaborative efforts to serve families affected by SUDs. Many collaboratives use systems walkthroughs to identify how efficiently families move through the systems and how effectively they achieve the desired results or outcomes, including how current practices create barriers. Ongoing cross-system training programs also increase understanding of partners' services and processes.

> "IDTA site representative: "We decided to bring everybody to the table; everybody got to learn what everyone else did and what their requirements were—whether it was funding requirements, laws, or policies—so that everybody started with a clear understanding. But what it all kept coming back to was that we were all still talking about the same families and the same goal, which was helping them be successful in their community."

Developing common mission, vision, and goals requires leadership to devote ample time to plan meetings and establish a formal governance structure that promotes engagement from all involved partners with all levels of staff—from the executive level to the front line. Having a set governance structure helps formalize the initiative and hold each partner accountable for achieving the initiative's goals on behalf of families. The chart below illustrates a formal governance structure:

Level	Primary Function	Membership
Oversight Committee	Ensure the initiative takes priority; provide final approval of policy and practice changes; promote long-term sustainability	Executive-level representatives from partner agencies (e.g., child welfare, SUD treatment, public health, dependency courts)
Steering Committee	Create, direct, and evaluate the activities required to achieve the goals of the initiative and remove barriers to ensure program success	Mid-level managers and supervisors from partner agencies; program evaluators
Subcommittees	Identify and resolve specific topical issues related to the initiative; provide and receive feedback about policies and practices	County-level/local frontline and supervisory staff from all partner agencies

NCSACW Resource Spotlight:

- *Building Collaborative Capacity Series, Module 1 – Setting the Collaborative Foundation: Developing the Structure of Collaborative Teams to Serve Families Affected by Substance Use Disorders*
- *Building Collaborative Capacity Series, Module 2 – Setting the Collaborative Foundation: Addressing Values and Developing Shared Principles and Trust in Collaborative Teams*

RPG Regional Partnership Grants

Site Example: Oklahoma Partnership Child Well-Being Initiative

The Oklahoma Partnership Child Well-Being Initiative Phase-3 (OPI-3), a 2017-2022 RPG recipient, uses a multifaceted approach to treat SUDs within the context of Oklahoma's child welfare system. The program is a partnership between Oklahoma Department of Mental Health and Substance Abuse Services, Department of Human Services, University of Oklahoma Health Sciences Center on Child Abuse and Neglect, University of Delaware Infant Caregiver Project, University of Kansas Center for Research, Inc., and University of Kansas School of Social Welfare. The RPG program strives to: 1) implement the Attachment and Biobehavioral Catch-Up (ABC) intervention, 2) disseminate best and evidence-based practices on the effects of substance exposure on young children, and 3) design strategies to demonstrate children's needs to the various community partners who serve them.

> "RPG project director: "Our project struggled the most when our steering committee was not as engaged as it needed to be. They need to be actively participating and feel like they're bringing value to the project, and we certainly need to keep them informed."

A key lesson from this project in developing joint mission, vision, and goals is to ensure a dedicated planning period in which to establish the governance structure and build the cross-system partnerships. The fact that the RPG project required key partnerships between child welfare services and SUD treatment helped; it laid the foundation on which they could build the initiative. Still, the team faced a challenge: a significant change in leadership and turnover meant the individuals who wrote the initial RPG application were no longer in those roles at the time of implementation. The established planning period afforded them the time to engage the new staff into the initiative and help them acclimate to the mission and purpose of the project.

> "Parent participant: "Out of all the things DHS had me do to get my son back—and it has been a lot of things—[the RPG program] has been my favorite. I know all the answers in the other things, and I feel like this stuff is different. It is helpful."

Another key strategy is ensuring the ongoing, consistent engagement of collaborative partners on the steering committee and subcommittees. This was especially important amid leadership changes and staff turnover. Partners benefitted from focusing not just on the practice-level strategies and challenges related to the program, but also on the overall collaborative engagement of the team. Strategizing with partners through specific committees also helped them identify and resolve program barriers. For example, when a challenge emerged getting referrals to the program, the team developed a subcommittee focused specifically on recruitment. It involved evaluators, program staff, and developers of the intervention.

Statewide cross-system training also helps the collaborative partners commit to common language, vision, and goals. The project director noted that, during a recent national collaborative meeting, she heard child welfare staff agree to working with families affected by substance use in a way they had been opposed to a couple of years earlier. She attributed this shift in position to cross-training and the identification/acknowledgement of differing values across partners.

- **Pillar 2: Efficient Cross-System Communication**

  Collaborative teams can establish formal information sharing protocols that dictate the specific information to be exchanged, the method for exchange and responsible parties, and the frequency of the exchange. Each partner agency can agree to the parameters of this protocol and disseminate the information across their agencies. Having a formal protocol in place ensures: 1) information is shared consistently over time, 2) all confidentiality requirements are met to protect participants' rights, and 3) partners can trust that information will be shared appropriately. Federal, state, and local laws govern confidentiality and dictate limits on the nature and extent of information disclosed. Collaborative teams can also jointly develop a participant consent form compliant with 42 CFR Part 2 so the parent's SUD treatment provider can share information with the child welfare agency and the court. Further, agencies can ensure leadership and staff receive ongoing training on information sharing procedures.

  Established information sharing agreements and protocols allow service delivery partners to collaboratively monitor parents' progress toward goals developed in the case/treatment plan. Partners can jointly identify problems that families are experiencing, detect unmet service needs, and make adjustments to treatment/case plans accordingly. Some of the practice-level information shared among partner agencies may include:

  - Details about a parent's recovery from substance use, including periods of sobriety, the nature and frequency of lapses or relapses, negative drug test results, and participation in treatment activities
  - Engagement in parenting, mental health, employment, or other services identified in the child welfare case plan
  - Consistency and quality of child visitation
  - Indicators of safety and stability for the children

NCSACW Resource Spotlight:

- *Building Collaborative Capacity Series, Module 3 – Setting the Collaborative Foundation: Establishing Practice-Level Communication Pathways and Information Sharing Protocols*

Site Example: New Mexico Comprehensive Addiction and Recovery Act (CARA) Program (IDTA)[1]

New Mexico participated in IDTA in 2021 to receive strategic planning support for their CARA Program. The CARA Program is a state-level collaborative effort focused on supportive care for pregnant women affected by substance use; and coordination of services for parents, caregivers, and family members of infants affected by prenatal substance exposure. Invested partners include families, birthing hospitals, Medicaid Managed Care Organizations (MCOs), Tribal governments and services, community-based family service programs, SUD treatment and recovery programs, private insurance providers, and the New Mexico legislature.

There have been over 3,000 Plans of Care developed in New Mexico since the program's inception in 2020.

The CARA Program emerged following the 2019 passing of HB230, state legislation aligned with federal CARA amendments to the Child Abuse Prevention and Treatment Act (CAPTA). New Mexico's HB230 requires: 1) hospitals to create Plans of Care for all infants identified as substance exposed, 2) tracking and reporting of federally required data on the number of infants with prenatal substance exposure 3) care coordination provided through the family's insurance provider (primarily MCOs) to facilitate access to needed services, and 4) a non-punitive approach by not requiring an automatic referral to child welfare services solely on the basis of the finding of prenatal substance exposure. The last two components are state-specific and aim to improve outcomes for families with an infant with prenatal substance exposure. New Mexico has worked hard to shift its approach to serving pregnant women with SUDs and infants affected by prenatal substance exposure from a child welfare-led response to a supportive public health effort that emphasizes the health and well-being of mothers, infants, and families.

Prior to the program, the MCOs reported they could not reach 50% of the population. From 2020-2021, 63% of CARA families were engaged in care. Through this care coordination, 90% of parents brought their newborns to a primary care physician.

Source: NM Department of Health-Presentation of Task Force Findings 2022. Nick Sharp, MCH Epidemiology/Evaluator for the CARA Program. Presented to the Interim HHS Committee NM State Legislature, with Dr. Andy Hsi and Susan Merrill, LCSW

Presented November 29, 2022

The CARA Program has excelled in developing efficient cross-system communication and a clear and consistent flow of information regarding Plans of Safe Care (POSC). The program developed a flow chart for the two pathways by which families with an infant identified as prenatally exposed to substances move through the system. Parents/caregivers and the health care provider develop Plans of Care before the newborn leaves the hospital and share them with the CARA team. If the provider determines that caregivers do not demonstrate competence to care for the infant and lack access to resources and supports, they may make a referral to the Statewide Central Intake (child welfare). In these cases, protective services then conducts safety planning and consults with hospital staff and caregivers regarding CARA Plan of Care. One of the following implements the POSC: 1) MCO Care Coordinator, 2) Department of Health Care Coordinator, through Children's Medical Services, 3) CARA Navigator, or 4) another designated coordinator. The Care Coordinator engages with family and service providers on a regular basis regarding progress and changes in circumstances that may require updates to the Plan of Care. An assessment for continuation of the Plan of Care occurs at 12 months.

[1] Since the initial interview for this report - the NM CARA Team-Program has a new partner: the Early Childhood Education and Care Department (ECECD). This new state agency houses all of the home visiting, early intervention, childcare and other services for birth to 5 years of age. They were able to bring on board an ECECD CARA Navigator and are working closely with NM CYFD, Department of Health (DOH), and Human Services Department (HSD) (Medicaid) to cross collaborate.

A key strategy in allowing for the CARA Program's consistent flow of information between partners is the use of their Healthy Families Portal. The Children, Youth & Families Division (CYFD) funds and maintains this online portal through the CARA/CAPTA grant. The portal was designed with input from the Department of Health. They have business agreements that allow hospitals and the Medicaid MCOs to access both the portal and family Plans of Care. There is also an agreement in place for data sharing across all state agencies. Staff use the portal to make the CAPTA notification by providing CYFD with a copy of the Plan of Care. The portal then sends the notification to child welfare when there are safety and risk concerns. When no safety or risk concerns are identified, the portal sends the Plan of Care to a Care Coordinator.

Another key to the state's successful system-level communication is holding monthly workgroup meetings that involve all partner agencies, including leadership and frontline staff, as well as ongoing training. Partners include the Department of Health CARA lead, CARA Navigators, MCO Care Coordinators, and child welfare workers. These meetings provide a forum to discuss successes and challenges while increasing the understanding of partner agencies' roles and processes. The partners also discuss larger policy changes across disciplines and agencies. Department of Health and CYFD Navigators also offer large trainings to hospital staff, insurance care coordinators, community service providers, Tribal entities, judges, attorneys, child welfare field staff, and other entities in direct contact with these families to ensure they understand CARA requirements and New Mexico's public health approach. They also offer online CARA training modules for all providers.

- **Pillar 3: Ongoing Cross-Training and Staff Development**

  Building—and sustaining—a system of care for these families requires all cross-system partners to understand the holistic needs of the population as well as knowledge about each partner agency's role in serving them. Agency staff and professionals bring their expertise and knowledge of the evidence-based practices, processes, and service needs of the priority population within their own service system. However, they often lack a deeper understanding of the *holistic needs of families in other service areas* and knowledge of the practices, processes, and roles of the partner agencies in meeting those needs. Cross-system training programs aim to increase staff knowledge about the other agencies that work with these families. For example:

  - Child welfare, court, and other social services professionals acknowledge parental SUDs, trauma, and mental health disorders (and their effect on families), as well as effective treatment approaches.[1,2]
  - SUD treatment and health care professionals understand the child welfare system processes including Tribal, state, and federal mandates; and the unique treatment needs of families involved with child welfare and the courts.[3]
  - Health care professionals are aware of and implement the protocols and processes for notifying child welfare upon the identification of infants affected by prenatal substance exposure as required by CAPTA.
  - Each of the partner agencies receives training promoting improved access to services for all families.

One program has learned the value of cross-system training in which every collaborative partner is invited to training events. For example, even though child welfare workers may not directly implement a specific evidence-based intervention (e.g., Seeking Safety), they still attend the training to learn the importance of the intervention for families.

Cross-system training should not be seen as a one-time event, but rather an ongoing and comprehensive program integrated into the system of care.

Ongoing and consistent training programs promote a more comprehensive understanding of family needs and services across systems while also encouraging sustainability of policy and practice changes. Many states, counties, and communities have noted challenges with staff turnover and leadership changes, which can affect the longevity of programs and innovative approaches over time. Requiring training for all new staff—while also offering ongoing training for existing staff—ensure that new leaders and staff understand and implement established policy and practice innovations despite a change in leadership or staff turnover.

Many states, counties, and communities also note the existence and effects of stigma related to parents with SUDs and their ability to recover and provide safe and stable homes for their children. At the individual level, stigma—particularly related to substance use during pregnancy—can affect a parent's willingness to seek medical care, SUD treatment, and support. At the system level, stigma against parents with SUDs can increase the use of more punitive responses. Stigma at every level can be ameliorated through training programs that increase understanding and knowledge of: 1) the SUD and mental health recovery process, and 2) the processes and roles of the agencies that serve families. Communities have also found success by incorporating family members and others with personal experience in the training activities to incorporate their perspective and input, and exemplify lasting recovery and family well-being.

An IDTA program developed an SUD fellows program in child welfare to facilitate an improved understanding of recovery by case workers. It includes a month long training curriculum including an experiential component and exposure to the recovery community. They have seen a shift in child welfare practice as a result; workers have noted they now understand what families are going through in a different way.

NCSACW Resource Spotlight:

- *Disrupting Stigma: How Understanding, Empathy, and Connection Can Improve Outcomes for Families Affected by Substance Use and Mental Disorders*
- *Child Welfare Training Toolkit*

RPG Regional Partnership Grants

Site Example: Families Connecting Through Peer Recovery (Family CPR) Project

The Family CPR Project, a 2017-2022 RPG recipient, is implemented by the Broward Behavioral Health Coalition, Inc. (BBHC) with cross-system partners, including ChildNet, Inc., the Florida Department of Children and Families Southeast Region, the Dependency Drug Court of Broward County, Broward Sheriff's Office (BSO), South Florida Wellness Network, Broward County Department of Human Services, Children's Services Council of Broward County, the Children & Families Leadership Association, and System of Care Partners.

Family CPR offers a family-focused and strengths-based child welfare coordination model in addition to peer support services from advocates with lived child welfare experience who are also in recovery. The program strives to increase parental retention in treatment, enhance provision of targeted services for children and parents, improve parenting practices, and decrease family trauma.

Through the RPG project, BBHC partnered with ChildNet (their child welfare community-based care lead agency), the local Recovery Community Organization, South Florida Wellness Network (SFWN), and community-based SUD/mental health treatment provider to develop and disperse mandated cross systems trainings for child welfare workers and treatment staff. Their goal is to facilitate aligned case planning, information sharing, common language, as well as shared goals and outcomes across systems serving children and families. **A key to this program's success with cross-system training is that they had the agencies' top-level leadership agree to require completion of this training for all case managers and therapists.**

Another key element to their successful training program is ensuring access to training materials for all partners. BBHC developed and hosts a Training Library—posted to their website—that houses recorded videos and training materials. BBHC disseminated these videos to their network providers serving child welfare-involved families to either train or retrain provider staff. Partner agencies created virtual training videos that provide information about the respective programs including vision, mission, description of services, and referral processes. These videos are available in the Training Library and on YouTube.

This site has excelled at actively incorporating the personal experience and expertise of the peer support workers as a component to their training program. SFWN Peers provide on-going training to Dependency Case Managers and other community providers, on topics that teach and promote Recovery Oriented System of Care principles. Topics include, Peer Experience within the Child Welfare System, What are Peer Supports, Wellness Recovery Action Planning with Families, etc.

- **Pillar 4: Sustainability and Institutionalization of Practices**

  Successful program sustainability involves shifting focus from simply how to keep an individual project funded to permanently changing the system to reflect a new way of doing business. Sustainability efforts are most successful when they begin early in the life of a collaborative initiative; teams benefit from designating one leader to ensure all of the sustainability planning steps are part of frequent and ongoing discussions at all levels of the partnership. Teams ensure that each of the partner agencies is involved and invested in sustainability planning and finding innovative ways to access the range of funding resources from multiple systems.

Program sustainability relies on demonstrating the initiative's success and positive family outcomes to garner support for continued funding.

Expectations formalized through collaborative policy settings can lead to standardized practice at the service delivery level. Collaborative teams benefit from developing a formal sustainability plan that includes information on potential funding streams to expand, replicate, or institutionalize the policy and practice changes proven effective. Importantly, this plan can also include an assessment of political and community support. States, counties, and communities have shown success implementing the following activities to support the development of their sustainability plans:

- **Community Mapping:** Promotes cross-system collaboration, aligns initiatives, and identifies and secures partnerships with existing local programs, service providers, and partners
- **Systems Walkthrough:** A structured process to identify effective practices, gaps, and barriers that contribute to (or hinder) the achievement of desired outcomes for families served
- **Cost Analysis:** A method to weigh project costs against the benefits of a service to demonstrate the cost effectiveness of a project and long-term savings
- **Dissemination Activities:** Shares project messages, products, outcomes, and findings with key leadership and other target audiences; promotes broader implementation, system change, institutionalization, and sustainability

NCSACW Resource Spotlight:

- *Sustainability Planning Toolkit - Five Steps to Build a Sustainability Plan for Systems Change*
- *Sustainability Planning for Regional Partnerships*

Site Example: New Jersey (IDTA)

As previously described, New Jersey participated in two rounds of IDTA. The state's IDTA work was built upon a foundation of prior systems improvements that increased its readiness for innovation among agencies seeking to improve outcomes for children, parents, and families affected by substance use and mental health disorders. Through IDTA and a number of other cross-system initiatives, New Jersey has excelled at sustaining practice changes and institutionalizing state policy on behalf of these children and families.

For example, in 2017 a Request for Proposals (RFP) was issued by the New Jersey Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) to develop intensive case management and recovery support services for pregnant women with opioid use disorder. The Department of Children and Families (DCF) partnered with DMHAS and provided funding to support this new service. The RFP for the Maternal Wrap Around Program (M-WRAP) was issued for three regions of the state. M-WRAP offers intensive case management, wraparound services, and recovery supports for pregnant and postpartum women with opioid use disorder (and their families) up to one year following birth. The governor, in 2018, announced statewide expansion of M-WRAP through funding from the state's opioid initiative. Key state-level DMHAS and DCF leaders sat on a state-level opioid committee that allowed them to elevate the work of M-WRAP and the IDTA program while informing the governor's office on the success of the program. July 2022, M-WRAP statewide initiative eligibility criteria was expanded to include pregnant women with substance use disorders, not exclusive to opioid dependency.

A key strategy to sustaining policy and practice innovation is to engage leaders who act as change agents and champions to drive ongoing collaboration. While change agents and champions are essential, institutionalized systems changes do not happen through just one or two devoted individuals. They require investment in an entire team of committed partners who are involved in and take ownership of various aspects of the work. It is key that **current champions invest in, mentor, and support development of other emerging leaders at different points in their careers.** This supports the longevity of the systems change and ensures that—even as devoted leaders retire or change roles—the heart of the work continues.

Sustaining policy and practice changes also requires leaders to memorialize the work (i.e., document the history of the initiative and the important activities and steps taken, as well as those considered but not acted upon). This step allows future leaders and partners to understand the context and background of the work even amid leadership changes. It takes significant time and effort to make these lasting policy and practice changes since this work spans decades and shifts in leadership; thus, it is important that the lessons, strategies, and challenges are clearly documented to inform continued efforts.

- **Pillar 5: Measuring and Monitoring Outcomes**

  Developing standardized protocols to jointly measure and monitor family outcomes allows collaborative teams to establish shared accountability across systems when pursuing goals of the initiative. Measuring and monitoring family outcomes also allows teams to make data-driven decisions regarding program improvement strategies and activities. It is crucial for collaborative teams to regularly collect and review data when attempting to understand if there are barriers to families' access to services or unexpected outcomes. This process can illustrate how groups (e.g., fathers, families living in remote geographic areas) are represented across the systems and identify any barriers in access to and engagement in services.

Using data to inform program improvement decisions is a key lesson from the RPG and IDTA programs.

States, counties, and communities have had success implementing the following steps to jointly monitor outcomes:

- **Create a Data and Evaluation Subcommittee:** A designated data and evaluation subcommittee leads efforts to evaluate the initiative's success and ensure consistent sharing of data among partner agencies. Having a designated team leading this effort ensures data sharing and evaluation remain a priority and are not superseded by other practice and policy issues. It is important to include program staff in the subcommittee so the team can draw meaningful conclusions from the compiled data to improve program outcomes.
- **Develop Shared Outcomes and Performance Measures:** Early in the initiative, partners can agree upon a set of performance measures to monitor comprehensive family outcomes, such as safety, permanency, and well-being for children, along with SUD treatment completion and recovery for parents. The team can use these outcome measures in conjunction with data from state systems to yield qualitative and quantitative information and explain the successes and shortcomings of their collaborative work.
- **Develop and Maintain Effective Information Systems:** Independent agencies have their own administrative databases to track outcomes across clients; these data systems are governed by distinct information sharing policies and procedures. These separate data systems are not traditionally connected or linked. Teams can develop and maintain effective information systems to accurately—and jointly—measure the agreed-upon goals. This may involve linking administrative data sets to match parents in treatment with children involved with child welfare services, allowing them to jointly monitor cases and track family outcomes based on the identified performance measures.
- **Regularly Review Data:** Teams benefit from developing a data dashboard to regularly review critical data points and monitor progress, as well as identify potential problems and make program modifications. Teams can also use a data dashboard to capture their progress in achieving the mission and goals while sharing these outcomes with invested partners and funders.

NCSACW Resource Spotlight:

- *Building Collaborative Capacity Series, Module 4 – Setting the Collaborative Foundation: Establishing Administrative-Level Data Sharing to Monitor and Evaluate Program Success*

Site Example: Preserving Families Through Partnerships

The Preserving Families Through Partnerships—Southwest Missouri (PFTP-SWMO) program, a 2017-2022 RPG Round 4 recipient, builds on Preferred Family Healthcare's Round 2 RPG project. The program used a trauma-informed, responsive, evidence-based, family- and community-centered process to both preserve families and enhance family and child well-being. PFTP-SWMO enhanced the community's collaborative capacity to improve recovery from SUDs and improve family safety and stability—thus promoting long-term family and child well-being.

The project used a randomized controlled trial (RCT) to examine the effect of its services. All participants received the same set of core services: enhanced case management from project staff, peer recovery mentor services, in-home treatment of SUDs as needed (offered only in rural areas), the Nurturing Program for Parents in Substance Use Treatment and Recovery, and primary/basic SUD and mental health treatment. Using a value-added randomized controlled trial model, RPG4 provided enhanced core services to both the control group and the experimental groups, which included one of two evidence-based programs addressing factors that were suspected of affecting client lives and causing them to not complete project services (trauma and the impact of SUD on daily living). In RPG4, in addition to core wraparound services, Experimental Group 1 received Helping Women/Men Recover which addressed the impact of trauma on participants' lives, while Experimental Group 2 received Living in Balance which addressed how to handle life events impacted by SUD.

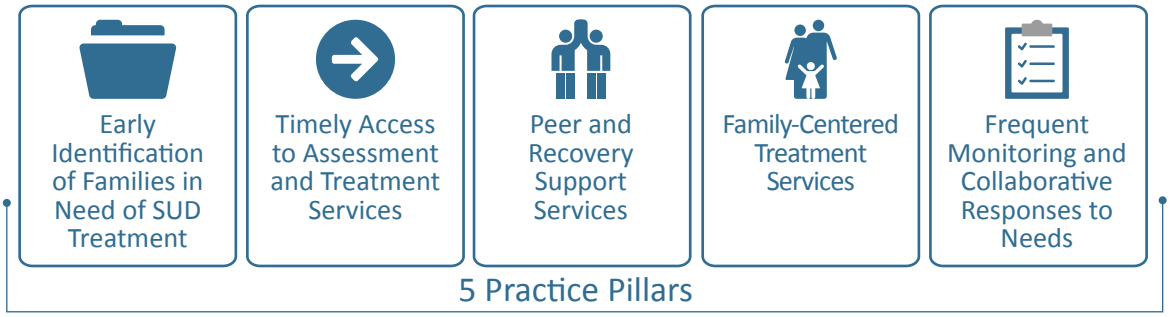
A key strategy boosting this program's success is ensuring consistent communication and collaboration between program services and evaluation. This had a huge effect on using data to inform adaptations and improvements to services. For example, a midpoint local evaluation of client outcomes revealed the team was not fully seeing the change they wanted to see from families as measured on the Adults/Adolescent Parenting Index. The team assessed the problem and identified a response; they made modifications to their parenting skills curriculum. The process of assessing and discussing these data allowed the team to work together to make the required changes to better meet family members' needs.

The team also ensured their collected data provided them with information they needed to properly access client progress and outcomes. The team worked for 18 months to develop an Outcomes Scoring Summary that provides a quantitative means of capturing client progress toward program objectives. They initially determined the target outcomes by reviewing the research literature and data from the local SUD treatment provider and prior RPG work. They created a process of measuring each client against each objective using a weighted scoring system that considers how essential the objective is. Table 1 below highlights the program's goals and objectives.

Table 1: PFTP Goals and Objectives
Goal 1: Increase SUD/Co-Occurring Disorder Recovery by Integrating and Coordinating Treatment as a Core Component of Child Welfare Services
Objective 1.1: 60% of the clients will complete a SUD treatment program.
1.2: Of clients who participate in services for a minimum of 6 months, 65% will have at least one period of abstinence from drugs/alcohol of 6 consecutive months or more.
1.3: 70% of clients are involved in at least one form of community support by 6 months.
1.4: 40% of PFTP clients were actively participating in reducing the effect of trauma on daily functioning.
Goal 2: Enhance Family and Child Safety with Coordination of Care Across Multiple Settings
2.1: 90% of active PFTP families have no new verified CA/N reports during PFTP services.
2.2: 90% of active PFTP clients and partners are free from new arrests during PFTP services.
Goal 3: Improve Family and Child Permanency with Coordination of Care Across Multiple Settings
3.1: PFTP families do not have a child placed out of the home and in child welfare custody: 90% during PFTP services and 80% six months following case closure.
3.2: Of children in child welfare custody who return home, 90% remain there during services.
Goal 4: Enhance Family and Child Well-Being with Coordination of Care Across Multiple Settings
4.1: Enhance Physical Health of PFTP Family Members
4.1.1: 90% of PFTP women and their babies will be substance free at the time of the child's birth.
4.1.2: 90% of PFTP children receive well-childcare and are fully immunized at the end of 1 year.
4.1.3: 95% of PFTP children are screened and connected, as appropriate, to services for SUD-related childhood (NAS, FASD) or other disorders.
4.1.4: 50% of postpartum women will use family planning methods as recommended by their physician.
4.2: PFTP Adults have Increased Economic Stability with Coordination of Care Across Multiple Settings
4.2.1: 50% of active PFTP clients will be employed (part time or full time) by the conclusion of services.
4.2.2: 60% of clients and their children will be living in safe, stable housing by the conclusion of services.
4.3: Enhance Family and Individual Functioning
4.3.1: 60% of active PPWS parents demonstrate positive parenting behaviors at the conclusion of services.
4.3.2: 50% of PFTP clients and placement providers request support to enhance their parenting and behavior management skills.
4.3.3: 90% of active PPWS children demonstrate age-appropriate education readiness & ability to perform developmental tasks at the conclusion of services.
4.3.4: 90% of active PPWS adult family members increase their access to community resources and social supports by the conclusion of services.
4.3.5: 70% of active PPWS children demonstrate healthy coping skills and an ability to process unpleasant experiences at the conclusion of services.
4.3.6: 70% of active PPWS adult family members enhance their ability to react to difficult life events at the conclusion of services.

Practice Pillars

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



- **Pillar 6: Early Identification of Families in Need of SUD Treatment**

  One of the most integral steps in keeping families safely together and preventing out-of-home placement is the early identification of parents in need of SUD treatment through universal screening practices. Substance use and its effects on child and family safety are not always evident from an initial report of maltreatment or an initial visit with a health care or community services provider. Thus, families benefit when child welfare and health care agencies universally screen all parents for SUDs and mental health disorders at the onset of care.

Universal screening practices can help reduce gaps in services for all families.

Child welfare workers can universally screen all parents with cases of suspected maltreatment for SUD and mental health disorders using a validated screening tool in addition to environmental observations of signs/symptoms of use, drug testing, and review of corroborating reports. There are several validated screening tools available to identify a potential SUD; communities can research and select the tool that best fits their own needs. Screening tools are ideally selected based on the individuals and community served.

One example is the UNCOPE, a free, validated screening tool that identifies risk for alcohol and other substance misuse or dependence.[4] Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated approach to the delivery of early intervention and treatment services for individuals with SUDs.[5] The SBIRT approach offers a pathway from screening through linkage with treatment services. SBIRT requires follow-up with motivational enhancement techniques to help link identified patients with appropriate care.

The World Health Organization recommends health care professionals ask all pregnant women about their use of alcohol and other substances as early as possible in the pregnancy and at every follow-up visit.[6] Universal screening is an important first step in helping pregnant women access a clinical SUD assessment and treatment services.[7] It also ensures that women are linked to any indicated specialized health care and prenatal care.

Implementing universal screening requires collaborative teams to select an appropriate screening tool, provide ongoing training on screening processes, and ensure both consistent sharing of results among partners and effective referral for assessment and treatment services for family members.

NCSACW Resource Spotlight:

- *Building Collaborative Capacity Series, Module 5 – Frontline Collaborative Efforts: Developing Screening Protocols to Identify Parental Substance Use Disorders and Related Child and Family Needs*

Site Example: New Jersey (IDTA)

New Jersey, guided by a strong partnership between the Division of Mental Health and Addiction Services (in the Department of Human Services) and the Division of Child Protection and Permanency (in the Department of Children and Families), has participated in two rounds of IDTA with NCSACW since 2009. The first round aimed to implement a statewide coordinated plan to serve families affected by SUDs and involved with child welfare. Major accomplishments included enhanced capacities for cross-system data collection, analysis, and management and preliminary planning for a recovery support model. The state embarked on a second round of IDTA in 2014 focused on improving policy and practice for infants with prenatal substance exposure and their parents and families. The IDTA program goals included: 1) increased perinatal screening at multiple intervention points (e.g., health care, SUD, and mental health services); 2) increased rates at which women who screen positive for prenatal substance use (per the 4Ps Plus©[1] validated screening instrument) are connected to assessments; and 3) increased rates at which infants with prenatal substance exposure and their parents/families receive early support services through leveraging existing programs and policy mechanisms.

Data from the hospital survey as well as 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.

A major accomplishment of the second round of IDTA included the administration of a survey of the state's 50 birthing hospitals regarding their current substance use screening practices for pregnant women and care of infants with prenatal substance exposure. They also surveyed 200 outpatient pediatric care providers working in birthing hospitals regarding assessment and care of infants with neonatal abstinence syndrome (NAS). The survey indicated that over 80% of private physicians and hospital staff use the 4Ps Plus© tool to screen pregnant women on Medicaid. However, the survey identified inconsistencies across hospitals in screening as well as areas of low utilization of the screening tool. **In response, New Jersey's MCOs now require prenatal screening for substance use to collect reimbursement for prenatal care.**

The state team used these results to: 1) discuss statewide best practices for screening, and 2) develop cross-system models to ensure these families receive the services they need. They developed the M-WRAP, which offers intensive case management, wraparound services, and recovery supports for pregnant and post-partum women with opioid and other SUDs and their families for up to one year following birth. In New Jersey's request for proposals for contractors to implement M-WRAP, they require referring entities to use appropriate screening tools, such as the 4Ps Plus©, prior to referring to M-WRAP. The agencies implementing M-WRAP are also required to screen referred women using an evidence-based screening tool designed for SUDs.

New Jersey also developed the Project ECHO Program, which provides education and training on best practices for the assessment, case management, intervention, treatment, and recovery support services for pregnant and parenting women with opioid and other substance use disorders. The training is provided to primary care practitioners, SUD treatment providers, SUD and mental health providers and practitioners, and other invested partners; it's led by a multidisciplinary team of specialists and primary care practitioners.

[1] The 4Ps Plus© tool is proprietary. Another commonly used tool is the 5Ps which is in the public domain

- **Pillar 7: Timely Access to Assessment and Treatment Services**

  Once families are identified through universal screening processes, the next step is for cross-system collaboratives to ensure timely access to SUD assessment and treatment services. This is a critical component to the effective system of care since a parent's successful treatment, engagement, retention, completion, transition to recovery, and recovery maintenance are all essential to positive child welfare and court outcomes. Research shows prompt entry into SUD treatment significantly increases the length of time parents spend in treatment and increases the likelihood of treatment completion and reunification.[8,9,10,11]

Timely access to and engagement in SUD treatment for parents are important ways to prevent or reduce risk of child placement in out-of-home care.

Assessment is conducted by a clinical professional using a standardized and appropriate assessment tool to ensure that parents and children are correctly diagnosed and matched to the right level of care and services.

The following policy and practice strategies enhance timely access to assessment and treatment services:

- **Care Navigators:** Providing families with care coordination services, often through care navigators or peer support workers, helps parents and other family members navigate multiple systems and access assessment and treatment services.
- **Established Partnerships and Information Sharing Between Child Welfare and SUD Treatment:** Facilitating timely access to treatment services requires an established partnership between child welfare and local SUD treatment providers to solidify smooth processes for referrals to assessment and treatment services, such as warm handoffs and information sharing agreements to communicate assessment results and treatment progress.
- **Motivational Enhancement:** Many communities increase family member engagement in assessment and treatment services through Motivational Interviewing (MI). MI is a therapeutic counseling technique based on the stages of change; it aims to help clients resolve ambivalence about risky behaviors, including substance misuse, while enhancing motivation to change.[12] (MI is a well-supported evidence-based practice listed on the California Evidence-Based Clearinghouse for Child Welfare.)
- **Plans of Safe Care:** Engaging pregnant women with SUDs in treatment and other services as a component of prenatal care has strong benefits, including the reduction or prevention of negative birth outcomes.[13] One mechanism to improve timely access to treatment in the prenatal period is through development of a prenatal POSC. A public health approach to POSC prioritizes the health and well-being of mothers, infants, and families over punitive measures that penalize the family. This approach emphasizes the role of health care and treatment providers in promoting access to comprehensive prenatal care, family-centered SUD treatment services, and other community-based supportive services for pregnant women and their infants and families. The following site example highlights one state's "public health approach" to developing prenatal POSC and engaging pregnant women in treatment and supportive services prior to birth.

NCSACW Resource Spotlight:

- *Building Collaborative Capacity Series, Module 6 – Frontline Collaborative Efforts: Establishing Comprehensive Assessment Procedures and Promoting*

Site Example: Delaware (IDTA)

Delaware participated in IDTA from 2016-2018 with a focus on serving infants with prenatal exposure and their families while also implementing legislation, policies, and protocols to align state practice with federal changes in CAPTA. The program's four goals were to: 1) discuss universal screening during pregnancy, 2) build a system of care to support providers working with pregnant women with SUDs, 3) implement a statewide POSC protocol, and 4) maintain an awareness of the effects of stigma related to child welfare involvement.

Delaware developed an innovative public health approach to developing POSC outside the child welfare system for pregnant and parenting women adhering to a SUD treatment plan or following a medically prescribed course of treatment with no other risk factors. **This approach has improved timely access to treatment services specifically for pregnant mothers by encouraging development of prenatal POSC.** Their innovative approach to serving these families involves a number of potential pathways and responses, including:

- In some cases, medication-assisted treatment (MAT) providers take the lead on developing and managing prenatal POSC for mothers actively engaged in their SUD treatment plan. For these cases, MAT providers share an aggregated total number of POSC developed with child welfare on a quarterly basis even though child welfare remains uninvolved with development or implementation of the plans. Removing child welfare from the equation improved access to prenatal care and treatment services rates while reducing reluctance to enter treatment due to fear of automatic child welfare referral.
- In other cases, birthing hospitals develop and coordinate POSC for pregnant and postpartum mothers following a physician's prescribed course of treatment.
- In cases involving infants with prenatal substance exposure that **do** require a referral to child welfare, child welfare assigns designated caseworkers to work with families with prenatal exposure to increase engagement in treatment. These dedicated staff members have the training, experience, and established relationships with local treatment providers and birthing hospitals to ensure a high level of support and a seamless coordination of services. They also place child welfare liaisons in SUD treatment centers in each county to smooth transitions and access to services.
- For cases in which parents use marijuana but have no other risk factors, child welfare implements a differential response process that involves assessment and connection to resources and services but does not require child welfare intervention. They developed a contract with a local SUD and mental health treatment provider to implement the differential response program. They assign specialized workers assigned to these cases to build relationships with partners and family members.

A recent study assessed the effect of these coordinated POSC and found that nearly 94% of infants with prenatal substance exposure received one. **Nearly 90% of these infants avoided out-of-home placement.**

Source: Deutsch, S., Donahue, J., Parker, T, Hossain, J., Loiselle., C, & DeJohg, A. (2022). Impact of Plans of Safe Care on Prenatally Substance Exposed Infants. Journal of Pediatrics, 241.

Another key strategy they implemented to increase engagement into services was to combat the stigma associated with child welfare's role in serving families. Child welfare workers visit SUD treatment agencies to talk with pregnant mothers about the service's role and what to expect once a baby is born. They emphasize to parents that child welfare has the same goal they do, which is to ensure their child is healthy and safe. They explain that, while some families may have child welfare involvement, other families with a prenatal POSC who adhere to their treatment plan with no other risk factors do not. This transparency and education help to destigmatize child welfare involvement and encourage mothers to seek prenatal care and treatment as needed.

- **Pillar 8: Peer and Recovery Support Services**

  Parents with SUDs and child welfare involvement often face many obstacles accessing and remaining in treatment. Recovery support services—either through peers with personal experience of SUDs and child welfare involvement or professionally trained recovery specialists—help parents through this process and ensure they receive the necessary assessments, treatment, and support services to succeed with their treatment and child welfare case plans. For example, they may serve as the support person who prepares the parent for SUD treatment assessment and may even help with transportation or attend the assessment with them. Peers and recovery supports, within the context of child welfare, help coordinate services to achieve cross-agency goals of fostering adult recovery and parental capacity, strengthening adult and child bonding, and promoting child safety and permanency in the caregiving relationships.[14]

A majority of RPG and IDTA sites interviewed noted that peer support is one of the most valuable components to their program as far as supporting parents long-term recovery.

Peer supports, sometimes called recovery coaches or parent mentors, are typically individuals in recovery from a SUD, and may have also experienced involvement with child welfare. They serve as trusted allies for parents as well as positive role models for recovery that extends beyond the reach of clinical SUD treatment. They have a number of roles, including: 1) advocating for people in recovery, 2) sharing resources and building skills, 3) building community and relationships, 4) leading recovery groups, and 5) mentoring and setting goals.[15] Their experience offers them a unique and invaluable ability to connect with and support other parents, as well as strengthen their own recovery through service.

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

Recovery specialists, also sometimes called substance abuse specialists, are professionals with training or certifications related to SUD treatment and recovery. They may be placed in child welfare offices or at the court through agency partnerships. They may offer on-site SUD consultation, SUD assessments, and case management services for parents to access treatment. Both peers and recovery specialists offer parents support to build recovery capital (the internal and external resources necessary to begin and maintain recovery) while also serving as a liaison between agencies and advocating on the parent's behalf.

Ideally, family members are matched with peer and recovery specialists with similar characteristics. This requires collaborative partnerships to recruit and engage peer and recovery specialists that are representative of the community being served. Teams can also ensure that peer and recovery specialists receive adequate, ongoing training to meet the unique needs of those being served.

Tribes, states, counties, and communities have found the importance of engaging peers and individuals with personal experience as integral partners in their collaborative team since they have expertise that guides program development. One IDTA site representative noted, "You have to include people with personal experience who can speak to the experiences that they had—or are having currently—and what their needs are because we can't build something for them without them."

Implementing recovery support services requires collaborative teams to clarify roles and responsibilities, secure funding for paid positions, and provide an ongoing training program for peer and recovery support workers that includes education on working with families who have child welfare involvement as well as those receiving MAT.

NCSACW Resource Spotlight:

- *The Use of Peers and Recovery Specialists in Child Welfare Settings*
- *Engaging Parents and Youths with Lived Experience: Strengthening Collaborative Policy and Practice Initiatives for Families with Mental Health and Substance Use Disorders*

RPG Regional Partnership Grants

Site Example: Colorado Circle of Parents Expansion Program

The Circle of Parents Expansion (COPE) project, a 2019-2024 RPG, has implemented Circle of Parents in Recovery peer support groups who operate in partnership courts who manage child welfare cases using the Dependency and Neglect System Reform (DANSR) approach in eight Colorado counties. DANSR is an approach to managing cases in the Dependency and Neglect Courts; it uses family treatment court (FTC) principles to improve positive outcomes for families with SUDs and co-occurring mental health issues as well as child welfare involvement. COPE offers free weekly support groups led by parent peers and a trained facilitator. The peer support groups inspire a family experience by providing dinner and childcare; they are trauma-informed, strengths-based, welcoming, and nonjudgmental. In many groups, children participate in *Children's Circle*, offering a developmentally appropriate and trauma-informed program focused on structured skill building and play to build social-emotional competence. The program aims to increase all five protective factors associated with improved child welfare outcomes; the ultimate goal is to coordinate practices across systems and organizations to enhance child and family safety, permanency, and well-being. The protective factors include: 1) parental resilience, 2) social connections, 3) concrete supports in times of need, 4) knowledge of parenting and child development, and 5) social and emotional competence of children.

> "A Circle of Parents group facilitator said: "This is the largest and most meaningful group I facilitate. The group is nonjudgmental and provides support and validation for struggles, including those around parenting. It is not focused on fixing or changing things, but helping members understand they are not alone."

COPE is comprised of a multidisciplinary team with representatives from the Colorado Judicial Branch, Illuminate Colorado, RTI International, the Kempe Center at the University of Colorado School of Medicine, the Administration of Behavioral Health, the Division of Child Welfare within the Colorado Department of Human Services (CDHS), the Office of Respondent Parents' Counsel, and Grays Peak Strategies.

> "Judge Ann Meinster (Jefferson County, CO): "Of all the things we do and offer, there is nothing that has been more successful and helpful to engage parents and help them achieve long-term sobriety than Circle of Parents. You cannot replace or overestimate the importance and effectiveness of peer support with a facilitated leader."

This program emerged from the need to provide additional extra-therapeutic and social support to parents with SUDs (on top of clinical SUD treatment) to inspire change, build community, and support long-term sobriety. The approach has required a philosophical and values change for many collaborative partners in non-traditional paths to treating SUDs. They look beyond traditional SUD treatment and 12-step programs and emphasize recovery through multiple pathways. Circle of Parents helps parents build positive, supportive peer connections and relationships they can sustain after their child welfare cases close and they maintain their recovery.

Importantly, this program offers parents sustained peer-based support even after their child welfare case ends—often a time when they need the most help to maintain recovery as traditional services wane. The continued peer support through Circle of Parents allows them to maintain a constructive support system, positive role models, and healthy relationships.

A key strategy to this program's success has been building partnerships across diverse systems, including problem solving courts, public health nursing, Court Appointed Special Advocates, churches, and faith-based communities; each has a role in implementing the program. The program also benefits from having key champions in the field, including a judge who consistently communicates the program's success. **Another lesson has been the need for ongoing messaging about the program's success from the state level to local providers for program referrals.**

- **Pillar 9: Family-Centered Treatment Services**

SUDs and mental health disorders affect the entire family; they can interfere with a parent's ability to take care of and bond with a child while also disrupting family health and well-being. A comprehensive system of care for these families relies on delivery of family-centered and trauma-informed services that provide a comprehensive array of clinical treatment and related support services to meet the needs of the children and each member in the family—not just the identified client. Family-centered interventions seek to build parental capacity, enhance family relationships, and improve family functioning.[16] Ideally, families receive multigenerational programs and parenting curricula tailored to parents in recovery. Family-centered treatment programs ensure parents receive full support in their parenting roles while children get the necessary services and supports to remain with their parent(s) during the treatment and recovery process. That way, the family can remain safely together and jointly heal.

Parental recovery occurs within the context of family relationships.

This approach leads to positive outcomes for families. Mothers who participated in residential treatment programs with their children achieved positive parent and child outcomes, such as enhanced parent-child bonding, improved interactive and reciprocal communication, and maternal sensitivity to the child's needs.[17,18,19,20,21,22,23,24] Parenting women with SUDs who participated in residential treatment with their infants stayed in treatment longer and had higher completion rates than women who did not have their children with them.[25]

NCSACW defines the essential ingredients of a family-centered approach:

1. **Collaborative Partnerships:** SUD treatment providers establish collaborative partnerships with community service providers, county and state administrators, and funders to support the development of a comprehensive community-based, family-centered approach.
2. **Adequate and Flexible Funding:** SUD treatment providers and their collaborative partners work with state and county leaders to identify new funding sources to support family-centered services, such as the Family First Prevention Services Act that can fund approved EBPs through the state prevention plan; or the range of grants available through CAPTA.
3. **Performance Monitoring:** SUD treatment providers and their collaborative partners identify shared performance measures and build data dashboards to monitor families' success and drive program improvements.
4. **Intensive and Coordinated Case Management:** A family-centered approach requires coordinated case management among SUD treatment providers and their collaborative partners to remove barriers for parents, children, and family members to engage in comprehensive services that meet their needs.
5. **High-Quality Substance Use Disorder Treatment:** A family-centered approach requires high-quality SUD treatment programs that are evidence-based and trauma informed.
6. **Comprehensive Service Array:** A family-centered approach involves identifying and meeting the needs of parents, children, and identified family members.[26]

NCSACW Resource Spotlight:

- *Implementing a Family-Centered Approach For Families Affected by Substance Use Disorders and Involved With Child Welfare Services (Three Modules)*

Site Example: Oklahoma Safely Advocating for Families Engaged in Recovery (SAFER) Initiative (IDTA)

Oklahoma participated in IDTA from 2020-2022 with key leadership from health care, child welfare, SUD treatment services, and a wide array of partners. Goals included creating: 1) a statewide protocol for identification, assessment, and reporting of infants with prenatal substance exposure; 2) a pathway for community held POSC for families with no abuse/neglect concerns; and 3) a continuum of supports for families experiencing a SUD.

Oklahoma has excelled in promoting a family-centered approach to supporting pregnant, postpartum, and parenting women with SUDs (and their infant(s), child(ren), and families) through expanding the use of Family Care Plans. The state has developed a pathway for prenatal, postnatal, and parenting Family Care Plans for families with or without abuse or neglect concerns. In these cases, family-centered treatment providers, obstetricians, and other health care providers can develop and implement Family Care Plans at any of the five points of intervention: whether thinking about becoming pregnant, prenatally, at birth, postnatally or early childhood. **Family Care Plans ensure families receive comprehensive family-centered treatment and auxiliary services not only for pregnant, postpartum, and parenting women, but also the infant, child(ren), and other family members. The individuals drive their own Family Care Plans—empowering them to determine and pursue the supportive services they need.**

Evaluation data indicate that infants with prenatal exposure who received Family Care Plans and/or specialized prenatal care were discharged home with parents more than 85% of the time, and most children remained at home a year later. The site noted that, prior to implementation of Family Care Plans, nearly all infants were experiencing extended NICU stays, and entered foster care for at least a year.

SAFER has piloted Family Care Plans across child welfare, SUD treatment, and health care systems in two counties and plan to launch Family Care Plans statewide in July 2023. They have also engaged Tribal nations to adapt Family Care Plans and system collaborations to meet the needs of Tribal/Indigenous families affected by substance use.

One policy-level effort supporting this work is that, as of 2023, **all state-contracted SUD treatment providers are required to offer the development of Family Care Plans for any women pregnant or planning to have a child within the next year.** The Department of Mental Health and Substance Abuse Services began discussing this requirement with contracted treatment providers a year in advance to promote the benefits of the approach and ensure a smooth transition. They developed the Family Care Plan eLearning module offering free continuing education units to provide training for providers on this approach.

- **Pillar 10: Frequent Monitoring and Collaborative Responses to Needs**

  Parents with SUDs and mental health disorders—either at risk of or involved with child welfare—require consistent and coordinated support and oversight that monitors their progress, responds to their needs, and supports continued services engagement. In a conventional approach to services, these families often have several distinct case/treatment plans from several different agencies—each with their own (and sometimes conflicting) goals and requirements. Rarely are these plans coordinated or streamlined. Further, agencies may traditionally take a punitive approach to responding to behavior that focuses more on compliance and less on meeting the parents where they are and enhancing their engagement into services.

  Alternatively, a family-centered, holistic system of care for these families involves a multidisciplinary care team that frequently communicates and meets to discuss family needs and progress, makes adjustments to joint or coordinated treatment/case plans as needed, and implements services and supports to meet needs. Consistent, supportive oversight ensures that if the parent needs an adjustment to their treatment plan, the entire team will be aware and make timely, appropriate changes to promote parental recovery and permanency for the children. It also ensures that family members can actively contribute to their treatment and case plans.

  Oversight also includes setting clear expectations and providing therapeutic, motivational responses to parents' needs. Using MI during administrative case reviews, team meetings, and court hearings can enhance parents' motivation to change and encourage engagement and retention in treatment.[27]

  States, counties, and communities have had success with several approaches to increasing supportive oversight, enhancing engagement in services, and collectively responding to family needs.

  - **Multidisciplinary Care Team Meetings:** One key strategy is developing a multidisciplinary care team that communicates and meets regularly while sending consistent, clear messaging to parents and family members. Using family group conferencing (e.g., Team Decision Making) also helps ensure all key family members understand the treatment and child welfare goals for the parent and act to support them.
  - **Collaborative Case Plans:** Another strategy to develop collaborative responses to needs is to create unified, comprehensive case plans for parents that include the services, overall goals, and mandates across systems for family members. Collaborative case planning requires all partners, including parents and family members, to consistently share information across systems regarding family members' treatment and case plan activities and progress; this protocol requires an information sharing agreement and established pathways of communication.
  - **Contingency Management:** Contingency management is a behavioral therapy that uses positive reinforcements to promote desired behaviors.[28] Examples include offering parents vouchers to exchange for services or goods (e.g., groceries, transportation) or allowing them to draw a token from a fishbowl to win a prize. Contingency management has been shown to increase participant engagement in case plans, SUD and mental health treatment, and positive parenting programs.[29]
  - **Family Treatment Courts (FTCs):** Some communities have implemented FTCs to: 1) increase parent and family member engagement in treatment and other services, and 2) improve child and parent outcomes through judicial oversight and cross-system team approach. FTCs are juvenile or family court dockets for cases of child abuse or neglect in which parental substance use, and often co-occurring mental health disorders, are contributing factors. FTCs aim to ensure: 1) children have safe, nurturing, and permanent homes within mandatory permanency time frames; 2) parents achieve stable recovery; and 3) each family member receives needed services and supports.[30] For more information on FTCs, see the *Family Treatment Court Planning Guide* and *Family Treatment Court Best Practice Standards*.

  As the approach to serving pregnant and postpartum women with SUDs shifts from a child welfare- and court-led process to a community-based public health approach in many locations, collaborative teams have expanded opportunities to: 1) encourage parent investment, and 2) monitor and respond to parent behavior without the mandates and required compliance from the court and child welfare. The following site example describes one community's approach in this area.

Site Example: Comprehensive Addiction in Pregnancy Program, University of Alabama at Birmingham

The University of Alabama at Birmingham's Department of Psychiatry and Maternal and Fetal Medicine, via RPG funding support from 2017-2022, developed the Comprehensive Addiction in Pregnancy Program (CAPP). The program aims to increase the well-being of children, parents, and families through timely identification, comprehensive service delivery, and rigorous evaluation including continuous quality improvement. Through CAPP, pregnant women with SUDs—and mothers up to 6 months postpartum—receive: 1) universal screening for SUDs (self-report), 2) SUD assessment and diagnosis, 3) specialized group prenatal care, 4) separate substance use treatment (including MAT) for men and women that is both trauma informed and family centered, 5) coordinated case management, and 6) peer recovery support services. The program implements a number of evidence-based practices, including Pregnancy and Parenting Partners (P3) and Helping Women Recover.

> "Program participants:
>
> "They had faith in me when no one else did."
>
> "They were right with me every step of the way."
>
> "CAPP is my safe place."

The pregnant and parenting mothers in this program are not typically child welfare or court involved; thus, the collaborative team focused on encouraging program participation, behavioral change, and responses to behavior in a voluntary setting without the use of judicial/court oversight. The focus is less on compliance from a punitive perspective and more on a tailored and individual service delivery approach that meets the unique needs of each family.

A key strategy is ensuring consistent messaging from the clinical team to the families. The unified clinical team includes a physician/provider, nurse, nurse practitioner, peer, and social worker; they conduct staffing once every two weeks with treatment providers to communicate information about treatment progress and needs. The clinical team meets during weekly clinics to discuss patient progress and take notes they will discuss with treatment providers. Much like an FTC, the frequent monitoring of each case looks different than what families may receive in a traditional court setting; it is less punitive and more focused on tailored, consistent support. The pregnant/postpartum mother and her family receive concise and consistent messaging from each member of her clinical team. When issues arise for a mother (e.g., challenges with recovery, medical questions, housing) there is a member of the multidisciplinary team that can respond immediately, and the entire team is on the same page in terms of the response. Support by peers plays a crucial role in this program thanks to their ability to meet parents where they are and keep them engaged.

> Rather than focusing on punitive responses to behaviors, their approach to holding parents accountable emphasizes support by "walking alongside the parent" and offering unified, clear, and consistent information and responses to needs.

SUMMARY

Part 3 of this blueprint described the 10 policy and practice pillars that form an effective system of care for families affected by substance use and mental health disorders. It offered implementation considerations that Tribes, states, counties, and communities can use to effectively change policy and practice on behalf of families. It offered on-the-ground site examples from RPG and IDTA programs to highlight how some communities have implemented these strategies with success. Implementing these policy and practice strategies through a collaborative team effort enhances the way that communities serve these families—it emphasizes timely access to family centered, trauma informed services and promotes positive recovery, safety, permanency, and well-being outcomes for all families. Through continued operation and expansion of this system of care, parents do recover, and families and communities do heal.

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