



*Strengthening Partnerships, Improving Family Outcomes*

**Written Testimony of**

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**Before the United States Senate  
Committee on Homeland Security and Governmental Affairs**

# Examining the Impact of the Opioid Epidemic

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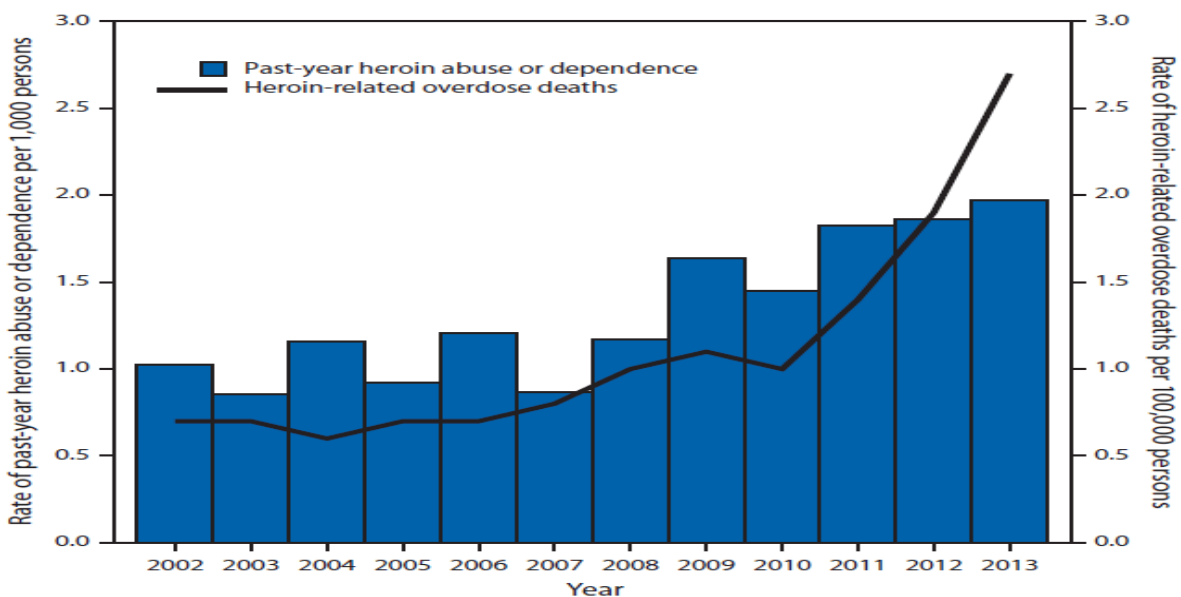
Senator Portman, Senator Brown and the other Members of the United States Senate Committee on Homeland Security and Governmental Affairs:

Thank you for conducting this hearing on our nation's opioid epidemic and the effects of opioid and other substance use disorders on our nation's child welfare and foster care system. There are four primary points I would like to emphasize in this statement for the record:

- 1) In the past three decades, our country has experienced at least three major shifts in substances of abuse that have had dramatic effects on children and families. However, the increase of opioid misuse has been described by long-time child welfare professionals as having the worst effects on child welfare systems that they have seen.
- 2) The current environment has at least two major differences from our prior experiences: (a) young people are dying at astonishing rates; and (b) many states report that infants are coming into protective custody at alarming rates.
- 3) Federal law requiring medical providers to notify child protective services of infants identified as affected by prenatal substance exposure is not consistently implemented and a review of current legislation and funding mechanisms has become essential.
- 4) Federal investments over the past decade testing strategies to improve outcomes for families in child welfare affected by substance use disorders have generated a knowledge base of effective programs, which means that we can no longer say we don't know what to do to address these problems.

### Brief Summary of the Data

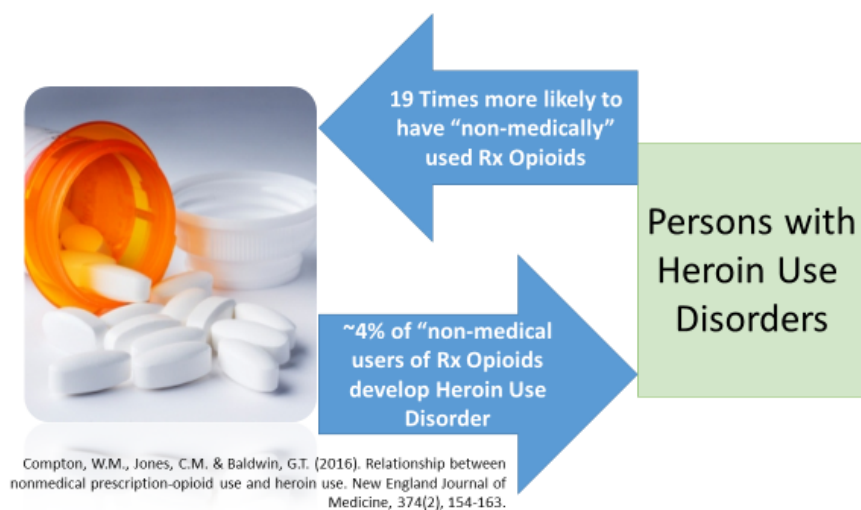
Data from SAMHSA's National Survey on Drug Use and Health show that between 2007 and 2014, the numbers of persons who misuse prescription drugs, new users of heroin and people with heroin dependence increased significantly (SAMHSA, 2014). As shown in this graph, rates of dependence on heroin has doubled and overdose deaths increased 286 percent between 2002 and 2013 (Leonard, 2015).



According to the 2014 National Survey on Drug Use and Health:

- 10.3 million persons used prescription painkillers non-medically in 2014<sup>1</sup>
- Approximately 1.9 million met criteria for prescription painkillers use disorder
- 4.8 million people have used heroin at some point in their lives
- 212,000 people aged 12 or older used heroin for the first time within the prior 12 months
- Approximately 435,000 people were regular (past-month) users of heroin

The pattern of initiating heroin use has changed over the past decade. Approximately three-quarters of persons who use heroin report prior nonmedical use of prescription opioids, as well as current abuse or dependence on additional substances such as stimulants, alcohol and marijuana. Conversely, a small percentage, approximately four percent, of persons with nonmedical use of prescription drugs become regular users of heroin. However, given the 10.3 million persons who reported nonmedical use of prescription drugs in 2014, this small percentage of conversion to heroin generates two hundred thousand new heroin users in a year and 435,000 regular heroin users (Compton, Jones & Baldwin, 2016).



Among pregnant women, the highest rates of use continue to be the legal substances which have known detrimental effects on the neurodevelopment of the fetus. Among pregnant women aged 15 to 44, 5.4 percent were current illicit drug users based on data averaged across 2012 and 2013. This was lower than the rate among women in this age group who were not pregnant (11.4 percent). In the most recent year for which the data on specific substances are available, among pregnant women in 2011-2012, 18% reported using cigarettes, 9.4% used alcohol and 5% used illicit drugs; heroin use was reported by .2% of pregnant women and .9% non-medically used prescription drugs (SAMHSA, 2012).

<sup>1</sup> Nonmedical use of prescription drugs includes using medications that are not prescribed for these drugs or using them for the effect or feeling rather than the medical purpose for which they were prescribed

There are two aspects of parental opioid use that affect the child welfare system:

- (1) prenatal opioid and other substance use exposure when it is determined that there are immediate safety factors resulting in the newborn being placed in protective custody; and,
- (2) post-natal use that affects parents' ability to safely care for their children.

Congress has been specific that hospital notification of cases of prenatal substance exposure is not substantiated child abuse or neglect.<sup>2</sup> Rather, when these children come to the attention of the child welfare system, assessment of risk and safety are to be conducted and plans of safe care instituted to ensure the newborn's well-being. Unfortunately, as the recent Reuters series made clear, often this is not happening (Wilson & Shiffman, 2015).

Each year, the number of infants who have been prenatally exposed to illicit drugs (240,000), binge drinking (108,000), and heavy alcohol (12,000) are an estimated 360,000 – the population of New Orleans.

If you add that across the years of 0 to 5, kindergartners with prenatal substance exposure total the population of the State of Nebraska.

In April 2016, the Administration on Children, Youth and Families (ACYF), issued Program Instructions to States for their June 2016, reporting on child welfare programs. This instruction includes details on how States are to report their programs and policies specific to this population of infants who were identified with prenatal exposure in accordance with the current Child Abuse Prevention and Treatment Act (CAPTA). Future analyses of these reports will assist in determining what actions may be needed to ensure the well-being of these infants and their families. At present, data are not available to report how often infants are referred to child protective services resulting from prenatal substance exposure. Clearly however, the CAPTA State grants at approximately \$25 million dollars for the entire country are inadequate to provide services and supports for this population. The policy focus should be on the need for legislative changes and sufficient funding, including links to other child welfare and treatment funding, in order to implement the congressional intent of the CAPTA legislation.

In addition, there has been a lack of clarity on the requirements and components that should be included in a plan of safe care for these infants. Our agency has issued a discussion draft to clarify how States and local communities should be addressing the implementation of plans of safe care. It includes a two-pronged approach: (1) a Governor-appointed task force that works across the multiple administrative agencies and the family courts to set State policies and (2) a local implementation committee that clarifies practice components such as screening tools, assessment, referrals and communication protocols. This draft is being circulated to gather input from multiple stakeholders to assist States and communities. A plan of safe care must address a two-generation approach to the needs of the parents and the child.

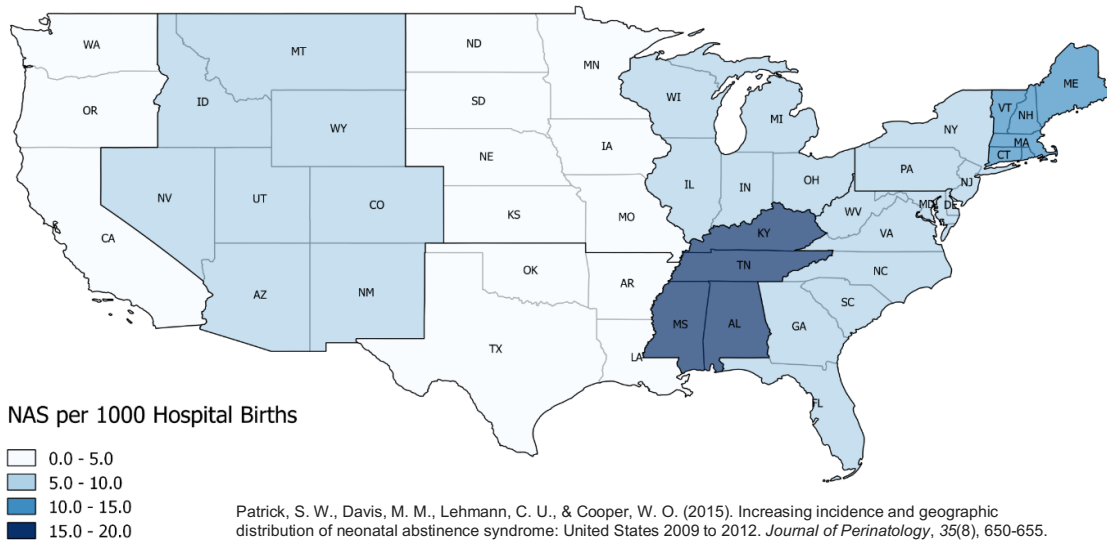
Neonatal abstinence syndrome (NAS) occurs in about half of babies with exposure to opioids during pregnancy. At this time, there are not clear data as to why babies do or do not experience the withdrawal syndrome. In a national study on the use of methadone and buprenorphine during pregnancy, researchers found that NAS did not appear to be related to

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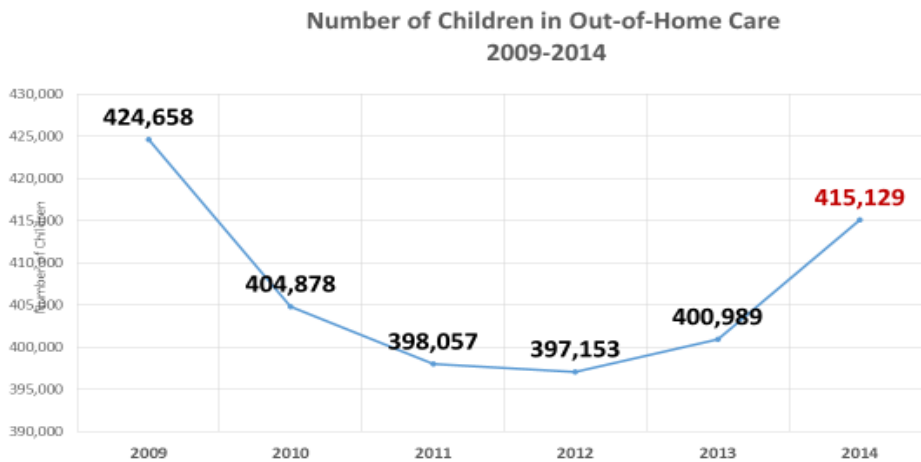
<sup>2</sup> The exact language is that "...such notification shall not be construed to— (I) establish a definition under Federal law of what constitutes child abuse or neglect; or (II) require prosecution for any illegal action."

the dose of these medications that are used to treat opioid dependence. But there were data suggesting that experiencing NAS was related to mothers who also smoked during pregnancy (Jones, 2015).

Dr. Stephen Patrick and colleagues (2015) have analyzed hospital data to monitor the trend of infants who are diagnosed with Neonatal Abstinence Syndrome. There is variation across regions in rates of NAS, with the north-east and mid-south central regions experiencing the highest rates of diagnosed cases in hospital births.

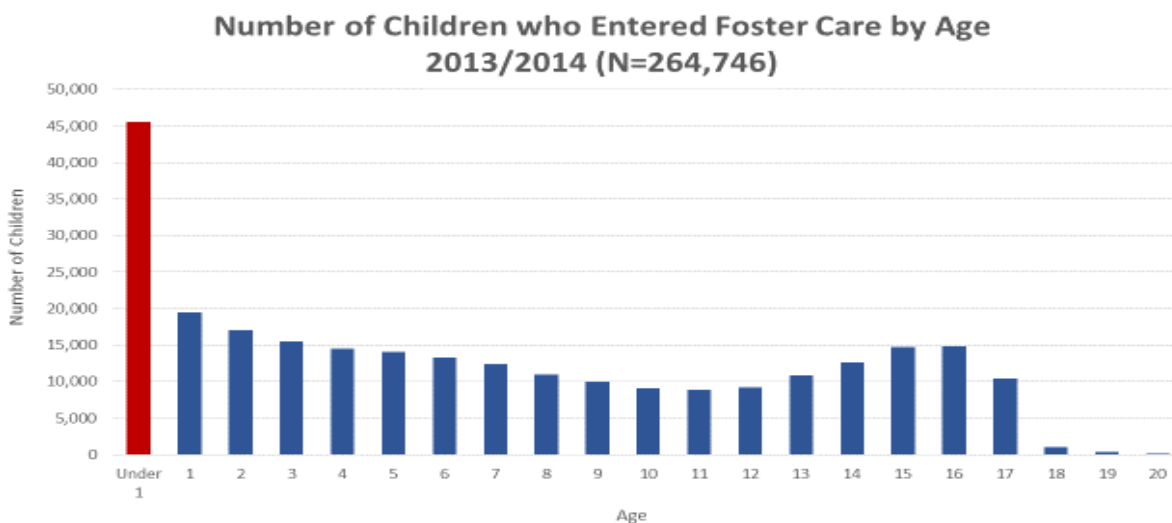


While there is not a clear relationship of rates of NAS and the dramatic increase of infants being placed in protective custody, the trend of younger children in care and particularly the number of infants is alarming. After a decade of decreasing numbers of children in out-of-home care, that trend began to reverse in 2012-2013. The total number of children in care are both new intakes as well as children who are remaining longer in care.



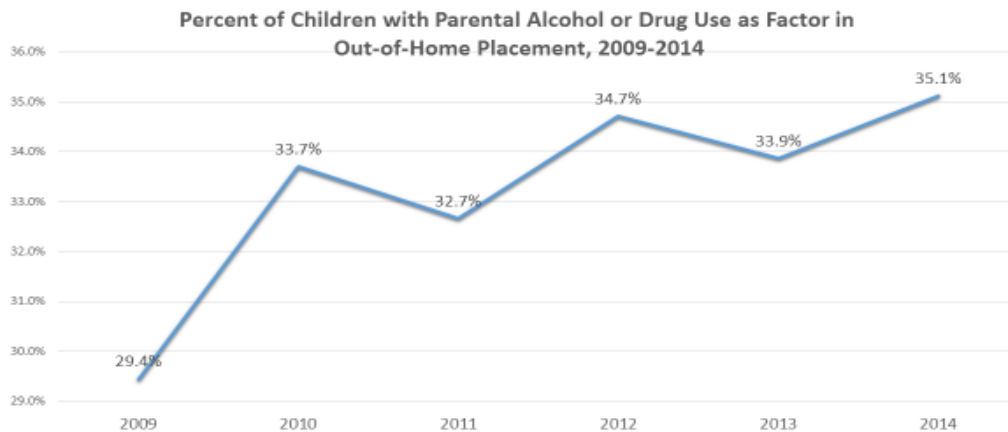
From the all-time high point in 1999 of 567,000 children, there was a steady decline until 2012 when the trend reversed

Of the nearly 265,000 children who entered care in 2014, the largest group were infants. The data are not available on the percentage of those infants who also experienced prenatal substance exposure, since they are not collected at the federal level nor by the majority of states. One might suggest however, that there are few underlying factors other than a parent's substance use disorder that would disrupt the ability of a parent to care for their infant—particularly in areas of the country that are experiencing a profound opioid epidemic.



These trends are resulting in an increasing shift toward younger children making up a larger percentage of children in out-of-home care with children under six representing nearly 40% of children in care. These data indicate a short window of time for intervention with these children and families. This alarming rate of young children coming into care is especially troubling, as children ages 0-3 are especially vulnerable. Infancy and toddlerhood is a time of rapid development across all domains of functioning. The brain of a newborn is about one-quarter the size of an adult's and by the age of three, the brain has developed to about 80 percent of its adult size (Nowakowski, 2006). It is imperative that the development of that child take place in a stable environment with a caregiver who fosters mutual attachment with the child.

Unfortunately, I cannot report reliable data that would indicate to what extent parental opioid or other substance use disorders are associated with the number of children in out-of-home care. The nation's data system to monitor these factors does not require collection of parental substance use as factors in child removal, since those are voluntary collection items in the data system. However, our agency has been monitoring the available data for 15 years, and there has been a steady increase in reports of removals due to substance use by parents. The graph on the following page shows that since 2009, states report a 19.4% rate of increase in parental alcohol or drug use as factors in the child's removal.



There has been an increasing trend in the percentage of child placement cases with parental alcohol or drug use as factors in the protective custody placement over the past 15 years. Due to identification and data entry complexities, there is great variability across states with States reporting less than 10% to some reporting more than 60%.

Source: AFCARS Data

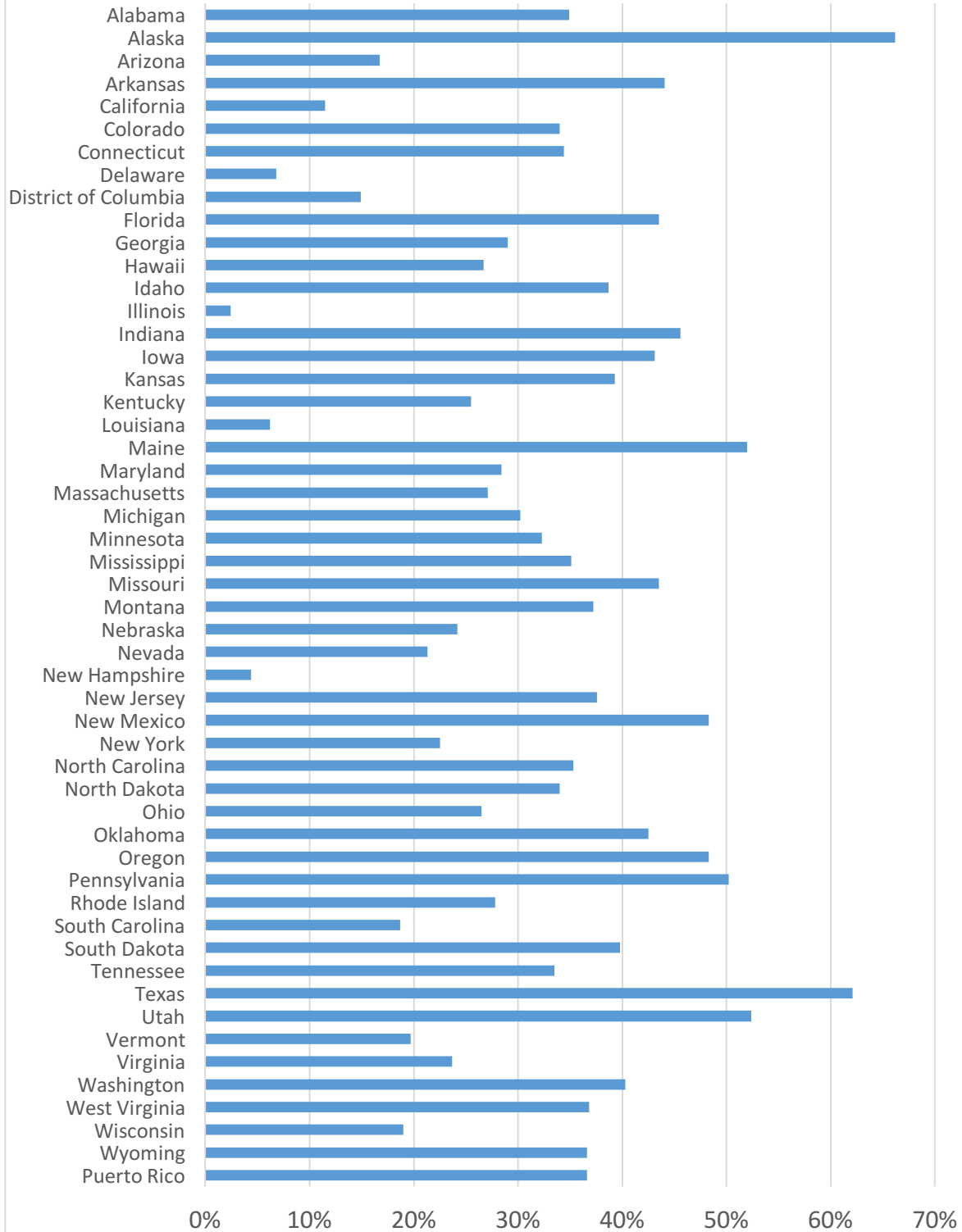
However, we have been to all the States in the country and asked child welfare professionals if they believe these data represent the prevalence of parental substance use in their cases. Not a single state believes these data accurately reflect their experience and nearly all tell us that these numbers greatly understate the vast majority of cases in which a child is placed in protective custody for causes related to parental substance use disorders.

As shown in the graph on the following page, these data vary substantially across states. We do not believe that these data reflect true variation in incidence; rather they reflect states' systems of identification and specifics of how these data are recorded in each state's automated data system. Only a handful of states have a standardized screening tool that is used to detect parental substance use disorders during investigations of child abuse and neglect. Very few states have consistent policy and protocols on how the results of investigations regarding parents' substance use are to be recorded in the automated information system.



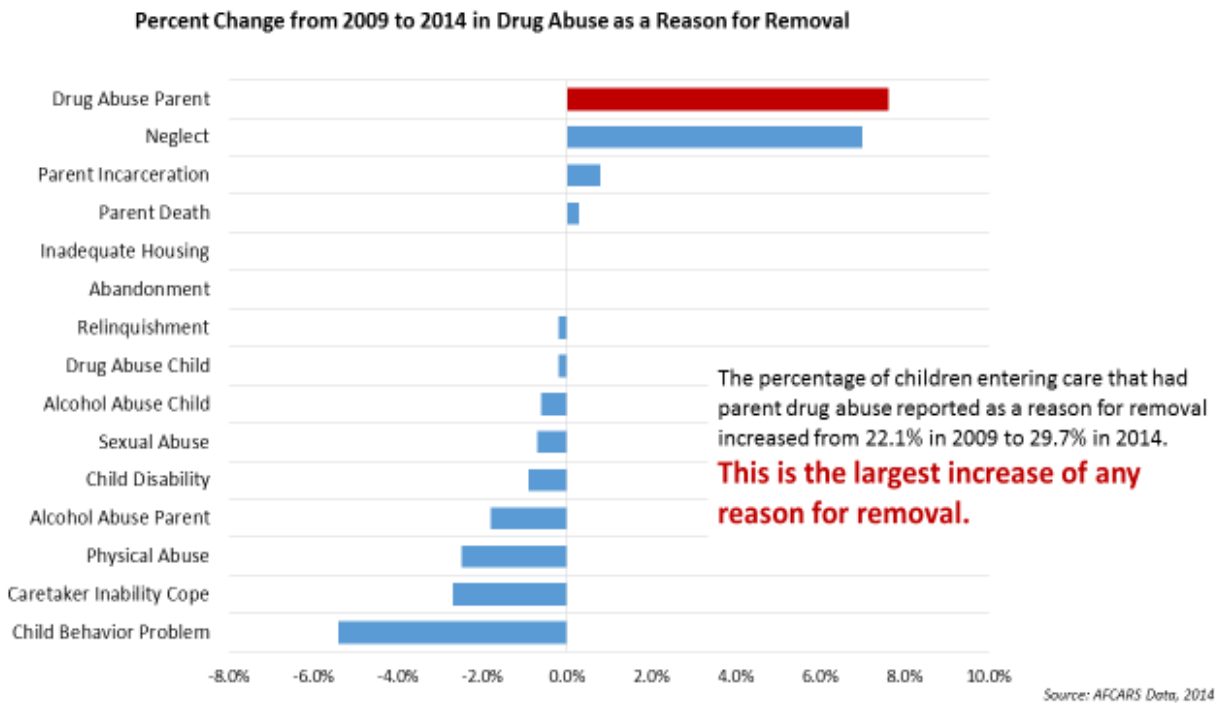
### Parental Alcohol or Drug Use as a Reason for Child Removal, 2014

We do not believe that these data reflect true variation in states' incidence; rather they reflect states' systems of identification and specifics of how these data are record



U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children,

Among all reasons for child removal, drug abuse by parents showed the largest rate of increase over the past five years. In addition, child welfare professionals often tell us that neglect is the category that is checked in the data system but that neglect is almost always associated with parents' substance use disorder.



These data are reflected in statements by child welfare agency professionals from around the country. I have had the privilege to work with the State of Ohio over the past year and a half. Recently, I was told by a child welfare administrator from a county that borders Kentucky that 2015 was the first time ever that there were more children whose parents' rights were terminated than were reunified. That small county had 70 terminations attributed to parents' opioid use disorders. Child welfare officials reported that this trend is evident across the state. They report that over the past five years, parents with opioid use disorders have increased the number of children placed in care at the same time that overall resources to serve families have decreased.

To summarize:

- Infants are the largest age group of children entering foster care; however, it is not currently known how many of these infants were referred due to prenatal substance exposure
- Overall removals of children due to parental substance abuse have increased significantly as reported by the states
- Child welfare professionals across the country, particularly in the north-east and Appalachian states, report that parental opioid use disorders are having a major impact on increasing child removals, preventing reunification and increasing termination of parental rights

## What Works for Families Affected by Opioid and other Substance Use Disorders

Families and child welfare agencies have been affected by multiple drug epidemics over the past several decades—cocaine in the late 1980s, methamphetamine in the early 2000s and now opioids. This month an article in *Governing* reports that the next trend in drug epidemics is on the horizon with bath salts and “synthetic marijuana,” “K2” or “Spice.” Synthetic marijuana is dried plant leaves that are sprayed with a synthetic cannabinoid similar to THC. Alabama in particular has reported increases in overdoses and deaths associated with these synthetics (Buntin, 2016).

During the cocaine epidemic, Congress enacted legislation to expand specialty treatment programs for women and their children and required that the Substance Abuse Prevention and Treatment Block Grant prioritize treatment admissions for pregnant and parenting women.

During the methamphetamine epidemic, Congress made the largest ever investment in demonstration grants linking child welfare, treatment agencies, and the courts to find out what works to improve outcomes for these families and ensure child safety, permanency in caregiving relationships, and child and family well-being. A key shift in policy was that many of the communities that received these grants worked to prevent removal of children by providing services to children and their families while the children remained safely at home. States use different labels to refer to these “in-home” cases—protective supervision, for example. But they represent the majority of the caseload of families in child welfare services, often about 70% of the state’s caseload.

Across child welfare programs, approximately 85% of children stay home, or go home, or in the case of children who are not reunified, they find homes when they age out of foster care or become adults and access their adoption records. These realities make evident the imperative that child welfare service agencies, substance abuse treatment providers, courts, and community partners work together to address the needs of parents to prevent placement, reunify with their children or potentially play another supportive role in their child’s life.

The demonstration grants included the Regional Partnership Grant Program (RPG) and SAMHSA’s Children Affected by Methamphetamine Program (CAM). The RPG and CAM programs documented a set of common ingredients and strategies leading to positive outcomes for families affected by substance use disorders. These strategies include:

These evolving patterns in drugs of abuse warrant our current policy attention to:

- Ensure that the lessons from prior Federal investments are used to respond to the effects of the opioid epidemic on the child welfare system; and,
- Build the capacity of States to protect children and heal families from future changes in drugs of abuse.

1. **Identification:** A system of identifying families in need of substance use disorder treatment
2. **Timely Access:** Timely access to substance use disorder assessment and treatment services
3. **Recovery Support Services:** Increased management of recovery services and monitoring compliance with treatment
4. **Comprehensive Family Services:** Two-generation family-centered services that improve parent-child relationships
5. **Increased Judicial Oversight:** More frequent contact with parents with a family focus to interventions
6. **Cross-Systems Response:** Systematic response for participants based on contingency contracting methods
7. **Collaborative Structures:** Collaborative non-adversarial approach grounded in efficient communication across service systems and the courts

Implementation of these common strategies for collaborative policy and practice has shown five core outcomes, the 5Rs:

1. **Recovery:** Parental recovery from substance use disorders
2. **Remain at Home:** More children remain in the care of parents
3. **Reunification:** Increased number and timeliness of parent-child reunifications
4. **Re-occurrence:** Decreased incidence of repeat maltreatment
5. **Re-entry:** Decreased number of children re-entering out-of-home care

### **Regional Partnership Grants**

The Child and Family Services Improvement Act of 2006 reauthorized the Promoting Safe and Stable Families program and provided a competitive grant program with funding over a five-year period to implement regional partnerships in states, tribes and communities to improve outcomes for children and families who were affected by parental substance use disorders.

In October 2007, the Administration on Children Youth and Families (ACYF), Children's Bureau (CB) awarded grants to 53 partnerships across the country, including 7 tribes. Family Drug Courts were part of the initiative in 21 of the grantees. The outcomes of the grants were measured in a performance measurement system focused on documenting child safety, permanency, and well-being; systems improvement; and treatment-related outcomes such as timeliness of treatment access, length of stay in treatment, and parents' recovery.

In September 2012, ACYF/CB awarded 17 new RPGs and 2-year extension grants to 8 of the 53 original grantees. This was made possible by Child and Family Services Improvement and Innovation Act (Pub. L. 112-34) signed into law in September 2011. In September 2014, four additional 5-year grants were awarded.

RPG grantee **OnTrack** is located in Medford, Oregon. They developed an alternative to children being placed in foster care by creating emergency shelters and residential treatment in which parents and children could stay together. Of families who participated in the program, 98% of children were reunified with families within 10 months.

After one year of program completion, only 6% of families had a subsequent removal, compared 28% of families receiving standard services—comparison group children were four times more likely to experience subsequent removal.

The original 53 grantees served a total of 17,820 adults, 25,541 children and 15,031 families. Key positive outcomes across sites include:

- Parents achieved timely access to substance abuse treatment (36.4% entered treatment within 3 days), stayed in treatment (65.2% stayed in treatment more than 90 days), and reported reduced substance use.
- The majority of children at risk of removal remained in their parent's custody – 92.0% of children who were in custody of their parent or caregiver at the time of RPG program enrollment remained at home through RPG program case closure. The percentage of children who remained at home significantly increased through program implementation from 85.1% in Year 1 to 96.4% in Year 5.
- Most children in out-of-home placement achieved timely reunifications with their parent(s)
  - 83.0% of children discharged from foster care were reunified
  - 63.6% reunified within 12 months
  - 17.9% were reunified in less than 3 months
  - 72.7% of infants reunified within 12 months.
- After returning home, very few children re-entered foster care
  - only 4.2% of children had a substantiated maltreatment within six months versus 5.8% subsequent maltreatment rate based on state data.

The RPG in the State of Kansas implemented the evidence-based Strengthening Families Program (SFP) with 367 Children and 473 adults. On average, the SFP child participant spent 190 fewer days in out-of-home care than their non-SFP counterparts. For example, at the 360-day point from start of SFP, almost half (45.0 percent) of the SFP children were reunified, compared to 27.0 percent of the comparison children. The evaluation conducted by University of Kansas researchers found that SFP saved approximately \$16,340 per child in State and Federal out-of-home care costs (McDonald & Brook, 2013).

## **Children Affected by Methamphetamine Grants**

Funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), the Children Affected by Methamphetamine (CAM) Grant Program focused on expanding and enhancing services to children and their families who are affected by methamphetamine and other substance use disorders. The Public Health Service Act of 2000 Section 509 provided funding from 2010-2014 to 12 Family Drug Courts to improve the well-being, permanency, and safety outcomes of children, who were in, or at-risk of out-of-home placement as a result of parental methamphetamine or other substance abuse. The primary focus of the grant program was to provide services directly to the children and to provide supportive services for parents, caregivers, and families.

The **Sacramento County CAM Project** (known as Children in Focus) served children and families in the Dependency Drug Court (DDC) and the Early Intervention Family Drug Court (EIFDC). The DDC serves families in which children have been removed from parental care and the EIFDC serves children, primarily infants, who are in the care of their birth parents. The CAM grant supported family-centered services including an evidenced-based specialized parenting program for parents in recovery called Celebrating Families (CF) and the use of Recovery Specialists who conduct active engagement based on motivational interviewing and monitoring activities with parents. The project also linked participants to family resource centers and other community resources to provide recovery support during CF participation and beyond program completion.

Outcome data shows that 97.8% of children who were at home at the time of enrollment remained at home, saving an estimated \$34,494 per child in placement costs. Within 6 months of program entry, only 1.5% of children experienced maltreatment reoccurrence. Higher reunification rates and shorter times in out-of-home care compared to standard services saved an estimated \$12,254 per child.

Outcome data from across all 12 sites indicated that children enrolled in the CAM program services were kept safe with lower rates of repeat maltreatment than in the general child welfare population. Outcomes included:

- More than 90% of children remained in their home with their parent/caregiver throughout program participation and the majority of children exiting out-of-home care were discharged to reunification
- Over two-thirds (68.2%) of CAM children were reunified in less than 12 months
- Less than 6% of reunified children re-entered foster care within 12 months after being returned home. This is about a third of the national average with standard services.

The CAM grantees' experience increased our knowledge about the timing and type of parenting classes that should be delivered to parents in early recovery. These grantees experimented with when to start and what type of parenting classes these families need. They found that they could increase retention in treatment when they engaged parents early in their recovery in parenting programs specifically developed for parents with substance use disorders, focusing on teaching effective parenting skills, and providing opportunities for children and parents to repair their relationship.

The other good news about these projects is that they saved money. Not only did they reduce foster care costs, but they also kept parents in treatment long enough for treatment to have a lasting effect. And in the long term, these programs are keeping children out of higher-end, higher-cost mental health, special education, and juvenile justice programs when they get older. These programs proved that they could save millions of dollars, justifying the increase in enhanced services for children and their parents.

Although these grant programs operated in different drug epidemics than the current opioid wave, there is much that can be applied to today's crisis. We do know that access to medication-assisted treatment is imperative for success in today's population. But, as important as access to effective treatment has proven to be in prior eras, access to medication-assisted treatment for this population is not being provided on a timely basis. For example, months of wait lists for treatment are the norm across the country.

In Ohio last month, I was told that in a FDC model that includes facilitating treatment access, it still takes approximately one month to get access to medication assisted treatment. Without participation in the specialized drug court docket, it takes at least three months to access medications. When children's safety and well-being are at stake, parents need to access treatment much faster than that.

While some states have access to Medicaid funding for some families involved with child welfare, it's important to recognize that the health-related criteria for accessing treatment and the outcomes measured in the health care system may not always relate to the needs of families in child welfare. Medical criteria to access a certain level of care with Medicaid or private insurance does not include the safety or impact on the child as criteria for residential or intensive out-patient levels of care. Similarly, outcomes for substance abuse treatment for adults in the Medicaid or private insurance system do not typically count family safety and child well-being in their performance measures. Rather, these outcomes are the responsibility of the child welfare system in collaboration with substance abuse treatment agencies and courts.

Another factor affecting the expansion of treatment resources in a family-centered approach is the restriction on residential programming under Medicaid due to the Institutions for Mental Disease (IMD) exclusion on treatment access for individuals with a substance use disorder. We note that the Comprehensive Addiction and Recovery Act (CARA) legislation would require a GAO report on the implications of this restriction and would urge that specific attention to its impact on families involved in child welfare be included in that report.

We would suggest that referral to a wait list does not meet child welfare's legal standard of reasonable efforts, and in the case of Native American children the higher standard of active efforts, to prevent placement and to reunify children. Merely referring does not connect parents and children with services; ensuring access to treatment and treatment availability is what is needed.

In summary, we can no longer say we don't know what to do. We can build on the track record of dozens of fine, smaller-scale programs in your states and communities. That's a big difference in this epidemic, compared with prior eras. We can take what works into system change approaches, instead of helping only a few families at a time.

## Opportunities to Take What Works into System-Wide Reform

The impact of opioids on children and families in the child welfare system must be placed in context of the history of parental substance use disorders, the need to comprehensively address the current epidemic, and the potential to mediate the effects of future shifts in drug use patterns from severely impacting children and their families. These efforts should focus on:

- Building on lessons from prior federal investments;
- Resolving the current gap in timely treatment access;
- Improving data collection and monitoring; and,
- Prevent future crises and costs as substance use patterns change over time.

In Fiscal Year 2015, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) funded five states to take the lessons from effective family drug courts and implement those on a larger scale. The states are Alabama, Colorado, Iowa, New York and Ohio. Another solicitation to add a small number of additional States is currently underway. The first round of States were awarded two years of planning grants and in 2017, it is anticipated that the States will compete for implementation awards. In addition to a grant award, each State receives significant resources in technical assistance and training through OJJDP's FDC Technical Assistance contract with Children and Family Futures.

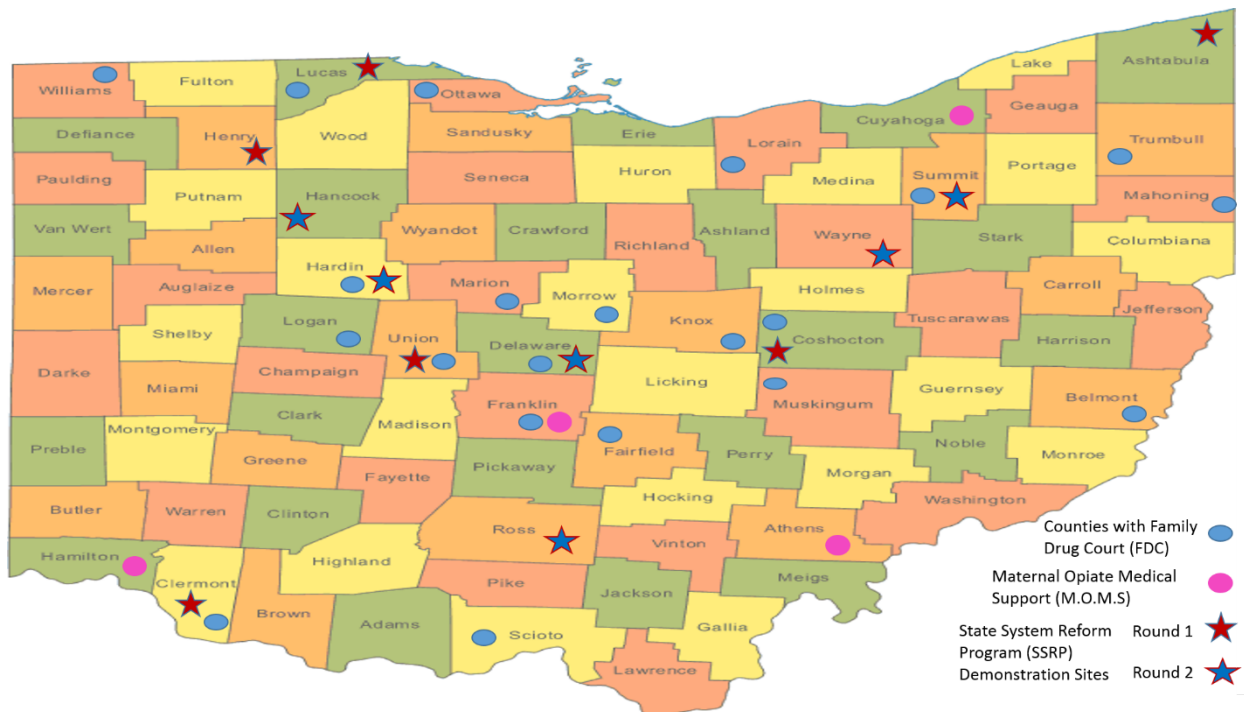
In Ohio, an Executive Oversight Committee has been created with membership from the Supreme Court of Ohio, the Ohio Department of Job and Family Services and the Ohio Department of Mental Health and Addiction Services. The Executive Committee and its representatives are working on several key strategies:

- A Memorandum of Understanding across these agencies and the court to specify agreements related to their working together including data sharing agreements.
- Various working groups and committees are developing implementation plans on:
  - Cross-system training;
  - Data collection;
  - Resource development;
  - Expanding the number and penetration rate of family drug courts to reach more families; and,
  - Determining how to best take the components of effective practice into the larger child welfare court docket.
- Eleven performance measures have been agreed upon by the State team and a code book has been developed to assist counties in clarifying how to track parents and children in the separate data systems.
- A contract is in development that will create a data warehouse at Ohio State University so that performance measures can be monitored across the state agencies and the court; this action is necessary, since the existing data systems do not have variables to track families' progress across treatment and child welfare services.
- Counties applied and two waves of six demonstration counties have been selected. The pilot sites are being provided technical assistance via the OJJDP grant and small incentive awards are being developed to assist with some of their direct costs in participation. The demonstration sites are currently working on the following priorities:
  - Developing local governance structures with representatives from the local dependency court, child welfare and treatment agencies;



- Testing strategies to implementing universal substance abuse screening protocols for all families within the child welfare system;
- Developing standardized information sharing protocols across the three systems that include formal information-sharing agreements that address the issues of confidentiality; and
- Identifying local performance measures needed to measure outcomes for families affected by substance use disorders within the children welfare system and developing strategies to engage in data sharing across the three systems.

The map below indicates the 20 counties currently operating Supreme Court-certified family drug courts, with Cuyahoga in is the process of certification. There are 12 counties that have been selected to pilot and implement the SSRP initiative, as well as four counties that are currently pilot testing the M.O.M.S. program.



In addition to the key programmatic strategies being implemented to prevent child placement, there are system changes that are also needed to effectively monitor effects over time, ensure staff are prepared to work effectively with these families, develop state-specific financing strategies to maximize recent changes in substance use disorder treatment, fill gaps in treatment access for these families, and build collaborative efforts that cross agency boundaries and support communities. Specific system reforms that are needed include:

- **Improve data collection and reporting to monitor the effects of parental substance use disorders on the child welfare system and the outcomes achieved by addressing treatment needs.** States' information technology challenges include recording alcohol and drug use factors in case files, requiring standardized reporting of alcohol and drug use factors in federal child welfare reporting systems and requiring existing outcome monitoring to report on the differential child welfare outcomes for children and families due to parental

substance use disorders. No state at present is able to report the child welfare outcomes of all families referred to and enrolled in its treatment systems.

- **Improve access to quality substance use disorder treatment.** The need for access to substance abuse treatment cannot be over-emphasized. When we refer parents to treatment as a condition of keeping or reunifying with their children, we must make sure that the treatment is state-of-the-art, comprehensive, meets the needs of the entire family, and that treatment, including medications for opioid use disorders, is available and timely. Funding of the Comprehensive Addiction and Recovery Act (CARA) is critical, including the provisions that will expand services to pregnant and parenting women. However, it is also imperative to ensure that child welfare funding is shifted to allow children, particularly infants and young children, to remain at home with parents while their parents receive substance abuse and mental health treatment to prevent the trauma of child removal and the higher costs associated with foster care.
- **Improve collaborative practice.** This can be achieved through implementation of practical strategies, such as staff development and training programs and cross-systems communication protocols. Ensuring that these strategies include a focus on infants with prenatal substance exposure will develop a workforce that is prepared to work in today's environment. Staff training and communication protocols must provide concrete and pragmatic information, such as guidance in developing comprehensive plans of safe care that keep infants with birth families whenever possible and provide interventions to address the needs of both the infant and mother.

***When we ensure timely access to effective treatment, families recover, kids stay safe at home, and we save money. Now we can and must move beyond pilots and demonstration grants and take these lessons to into systemic changes across agencies to help children and families.***

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