Supporting Substance-Using Caregivers: Pregnancy, Birth, and Early Childhood

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Introduction

The American substance use crisis is significantly harming children and families.[1]

From 2010 to 2017, the number of women with opioid-related diagnoses at delivery increased by 131%, and the number of babies born with Neonatal Abstinence Syndrome (NAS) increased by 82%.[2] In 2022, more than a third of children entering foster care had at least one parent using substances.[3] Today, one in eight children lives with a caregiver who has a substance use disorder.[4]

Families with the youngest children are the most likely to experience adverse outcomes as a result of substance use disorders, such as child and maternal fatalities and near fatalities,[5] and children's removal from home.[6] In addition to immediate harms to their health and well-being, substance-exposed infants and children face the potential for life-long mental and behavioral disorders and academic difficulties.[7]

Social service leaders say they believe that **supporting caregivers on their journey to recovery is essential for both parent and child health and well-being**. Early intervention can strengthen family stability and improve the likelihood that children can remain in their parents' care.[8] Yet many jurisdictions punish or ignore parental substance use disorder,[9] rather than see it as a disease requiring treatment.

The Government Performance Lab (GPL) has worked with jurisdictions across the United States that are reconsidering how they interact with substance-using caregivers, including Colorado, Connecticut, Florida, Michigan, New Hampshire, New Mexico, Rhode Island, and Washington.

This publication draws on those direct experiences, as well as observations in the field, and desk research to present **three common challenges** that jurisdictions must address and **three promising practices** that social service leaders can implement to better support substance-using caregivers and their families along the journey to recovery:

Challenge	Promising Practice
Engaging with supports can trigger stigma and fear of punitive responses	Structure supports to build trust
Intervention often comes only after a crisis	Offer support earlier
Recovery services are not usually designed for parents	Design recovery services to honor caregiving

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The legacy of substance use disorder criminalization

Even though substance use disorder harms children and families across communities, we begin this publication by highlighting that Black, Native American, and low-income families are particularly likely to experience punitive approaches to substance use disorders. For example:

- During the crack cocaine epidemic of the 1980s and 1990s, Black women were much more likely than white women to be criminally prosecuted for substance use during pregnancy, and SUD was highly stigmatized.[10] Today, opioid use disorder is increasingly impacting white communities and public health officials consider it a public health crisis. Even though a greater proportion of white children are being removed from their homes as a result of caregiver substance use, they are significantly more likely to be later reunified with their parents, compared to young Black children who are removed for similar reasons.[11]
- Studies show that women of color, women who are young, and women who are publicly insured are disproportionately more likely to be tested for drugs, as well as reported to health and child welfare authorities following the birth of a child, when compared to white, older, and privately insured women.[12]
- The rate of children entering foster care with parental substance use as a contributing factor increased 71% from 2008 to 2017 for children of all racial and ethnic groups; however, Native American children experienced the fastest growth in entry rates (139%) and were the most disproportionately represented within the foster care system, at more than three times their population representation.[13]

These historical and current realities can contribute to significant stigma and fear among these communities in asking for help and engaging with prevention services.

We have included questions throughout the publication that jurisdictions can consider as they seek to redesign recovery service systems in just and equitable ways.

Terminology Notes

- This publication uses the terms "substance use disorder" or SUD, and "using substances" to describe a life-impacting situation involving a substance such as alcohol or drugs, legal or illegal, whether an individual is clinically diagnosed or not.
- This publication uses the term "pregnant woman," which reflects language used by most studies in this field, while acknowledging that individuals who do not identify as a woman may also become pregnant and give birth.
- This publication uses the terms "caregiver" and "parent" to reference anyone who cares for an infant or child, even if that individual is not the child's biological parent, e.g., grandparent, sibling, foster parent, or anyone with custody of a child.

Challenge: Engaging with supports can trigger stigma and fear of punitive responses

For caregivers with a substance use disorder, accessing treatment and other supportive services can be logistically daunting. Additionally, many caregivers may feel ashamed or worry about the stigma associated with SUD and parenting.[14] Parents may also fear a punitive response such as criminal charges or losing custody of their child.[15] These fears may be an especially significant deterrent for Black, Native American, and low-income families whose communities have disproportionately experienced punitive responses to substance use.

Promising Practice: Structure supports to build trust

Agency leaders in several states are working to adjust services to hopefully make the experience less fear inducing for parents with SUD. The examples below highlight how jurisdictions have tried to normalize support and offer it in humanizing and non-punitive ways by working to:

- Position support services outside child protective services
- Hire staff who understand parents' journeys
- Offer tailored supports within universal services

Position support services outside child protective services

For many families, interaction with the child welfare system can be a traumatic event. Families may have been questioned, surveilled, had their homes searched, or been threatened with the removal of their children. These past experiences, for a specific family or within the broader community, can create a fear of future child protective services (CPS) involvement. Yet in many jurisdictions, supportive services are closely linked to CPS, often requiring active CPS involvement for a family to be eligible for support. The examples below illustrate how some jurisdictions are working to decouple supportive services from CPS involvement to hopefully decrease parental fear and increase caregiver engagement.

In 2016, the federal Comprehensive Addiction and Recovery Act (CARA) amended existing child welfare legislation regarding infants with prenatal substance exposure. This law required that states create their own "Plans of Safe Care" to coordinate services for both the substance-exposed infants and their caregivers.[16]

- One part of **North Carolina's** Plans of Safe Care policy requires that hospitals and CPS refer all substance-exposed infants to the voluntary Care Management for At-Risk Children (CMARC) program. A significant share of families referred through the Plans of Safe Care pathway accept CMARC services. In CMARC, which sits outside of CPS and is used by families regardless of their involvement with CPS, staff link families with health care providers, community programs, and family support programs. The Division of Public Health and the Division of Mental Health, Developmental Disabilities, and Substance Use Services also provide a toll-free number that pregnant or new parenting families can call to access screening, information and referrals — all outside the CPS system.
- In **New Mexico,** lawmakers passed a state CARA law in 2019 requiring health care professionals to refer families with newborns who have been exposed to substances during pregnancy to Medicaid managed care organizations or children's medical services separate from CPS for voluntary care coordination aimed at reducing potential future CPS involvement.[17]

Through **Michigan's** Healthy Moms Healthy Babies initiative, the state expanded public health funding for slots in home-visiting programs outside of CPS. Some spots are reserved for families impacted by substance use. The state has also funded Peer Navigators, who are individuals with lived experience and in long-term recovery. These navigators are placed in behavioral or medical health systems to support families on their recovery journey and help them access services, including home visiting.

> ? Have we developed safeguards against the real or perceived risk that engaging in services may expose caregivers to punitive interventions? (E.g., trained community providers in surveillance bias.)
>
> Building a Just and Equitable Recovery Service System

Hire staff who understand parents' journeys

Even when families are ready to seek supportive services like substance use treatment, navigating systems can be stressful. Asking for help may be a source of embarrassment or shame. More programs are hiring staff with cultural backgrounds and lived experiences that mirror those of their clients.[18] These peer specialists, peer navigators, or peer recovery coaches can offer emotional support and help connect caregivers to financial and community resources as they seek recovery.[19] The examples below highlight promising practices from jurisdictions the GPL has supported that could be replicated elsewhere.

New Hampshire's Division for Children, Youth, and Families introduced a Strength to Succeed program. This voluntary program connects parents with peer-recovery workers who have experienced and overcome similar challenges. These workers help families affected by addiction as they navigate treatment and recovery support, access resources to address concrete needs, and seek to comply with child welfare service plans.

The **Washington State** Department of Children, Youth, and Families (DCYF) partnered with a local Native-led behavioral health provider to support Native American women with SUD who are reported to the CPS hotline (and are "screened out") during pregnancy. DCYF's tribal liaisons worked with two local tribes to identify a partner organization, the American Indian Community Center. The AICC, which is led by and for Native people, receives the referrals from DCYF and connects clients to voluntary community services including substance use treatment, food assistance, and housing supports.

The F.I.R.S.T. (Family Intervention to Stop Trauma) Clinic in **Washington state** is a legal-medical clinic that seeks to prevent the trauma of family separation. The clinic provides wraparound support to families, pregnant people, and new parents with SUDs, no matter where they are in their recovery journey.[20] The team includes parent allies who are in recovery and have experienced child welfare involvement themselves. These parent allies build relationships with the parents and help connect them to substance use treatment, parent support groups, and housing assistance. Contracted attorneys also provide legal assistance.

Do our community providers engage in training related to diversity, equity, and inclusion as well as trauma-informed and recovery-friendly principles?

Building a Just and Equitable Recovery Service System

Offer tailored supports within universal services

Offering a service to all parents, not only those at risk of CPS involvement, may reduce feelings of stigma that caregivers may feel when they need support.[21] Such universal services can be especially effective when offered during pregnancy or in the weeks following the birth of a child, when families might be more willing to accept broad, and then tailored, support. These three models have shown encouraging results in their jurisdictions.

Both **Allegheny County, Pennsylvania,** and **Rhode Island** have community-based home visiting programs — Hello Baby and First Connections — for which all families with new babies are eligible. These programs also screen participating families to identify more complex needs. Families who could benefit from recovery supports are then referred to more specialized, high-intensity community services. During focus groups in Allegheny County, families said that those facing adversity would be more likely to engage with a universal intervention, and that having a universal entry point, like the birthing hospital, could raise awareness, decrease stigma, and increase caregiver engagement with the program.

Many other communities are experimenting with universal home visiting programs, such as the Family Connects model that was developed in **Durham, North Carolina**. This program offers no-cost home visits to all families in the county with a newborn, regardless of income or socioeconomic status. Registered nurses visit three weeks after the baby's birth to conduct a health check, assess families' needs, and make subsequent referrals as appropriate.

Challenge: Intervention often comes only after a crisis

When jurisdictions wait too long to intervene, they may miss opportunities to offer upstream resources to caregivers, such as legal or financial support, mental health resources, or substance use recovery supports. Responding only when there is a crisis can lead to traumatizing experiences for children and parents, higher rates of CPS involvement, and emergency foster care placements.[22]

Alternatively, some jurisdictions may act quickly but punitively, pursuing more upstream deterrents or surveillance-oriented actions. These include increased reporting, testing, or criminalization of parental substance use.[23] These punitive approaches often do not address families' underlying needs, nor are they likely to decrease the fear and stigma that may prevent families from proactively seeking help.

Promising Practice: Offer support earlier

Many jurisdictions are seeking to scale practices that allow them to engage families in voluntary, upstream interventions. The goal is that punitive responses, including CPS involvement, would then be less likely. The following examples outline jurisdictional attempts to:

- Proactively identify families who could benefit from recovery services
- Connect families screened out at child protection hotlines to supports
- Integrate medical and behavioral services

Proactively identify families who could benefit from recovery services

Jurisdictions and community organizations can adapt screening tools in existing services to proactively identify those who could benefit from recovery services *before* they reach the child welfare system. Agencies and providers adopting this approach can work to ensure screening tools are offered in a destigmatizing, supportive manner with full disclosure and consent, so as to not potentially deter patients from returning to subsequent appointments.[24] These examples highlight approaches in two jurisdictions.

The **Maryland** Department of Health directs physicians and other medical providers to identify patients who may benefit from care coordination by screening all pregnant Medicaid users. During the patient's first prenatal appointment, providers complete the Maryland Prenatal Risk Assessment, which screens for factors related to social support, behavioral health, financial and food insecurity, and substance use disorder. Patients are then referred to the health department's Administrative Care Coordination Unit, where nurses and community health workers can connect patients to community supports.

In line with **California** Department of Health Care Services guidance, Kaiser Permanente conducts a universal SUD screening for all pregnant patients during their prenatal care appointments. This Early Start program embeds a substance-use specialist in OB/GYN offices who administers a urine toxicology test and substance-use questionnaire as part of a standard visit. Patients with a positive assessment receive an individualized care plan, which includes ongoing counseling and case management.[25]

Connect families screened out at child protection hotlines to supports

Many substance-using caregivers are reported to CPS hotlines. However, many of these families' situations do not meet the statutory threshold for a CPS investigation, and they are often screened out without being offered community support. This is often true for pregnant people, who may initially screen out because of an unborn child — but then screen in after the child is born. Across the country, the largest group of children entering foster care are infants less than one year old.[26] Jurisdiction leaders are recognizing that waiting for a child to be born, or for a family to screen in and meet CPS requirements, is a missed opportunity to offer upstream support that might help prevent a future removal.

In **Washington**, among all infant removals, more than 60% are situations involving parental substance use. Leaders in the Washington State Department of Children, Youth, and Families worked with the GPL to adjust CPS hotline protocols to be more proactive in offering support. Now, when a call comes into the hotline about a pregnant person using substances, hotline workers share the family's contact information with local, non-CPS service navigators at community-based organizations. These community navigators try to reach the family to offer voluntary supports. It is entirely up to the family if they would like to accept any type of support service, and this information cannot be accessed or used by DCYF case workers if a family becomes involved with CPS in the future. As of early 2023, the agency was referring

nearly 100% of the calls about pregnant caregivers to community service navigators, and over two-thirds of caregivers reached by navigators chose to be connected to voluntary prevention services.

Integrate medical and behavioral support services

Jurisdictions are increasingly investing in integrated behavioral health strategies. This often looks like co-locating support services in settings where families already receive prenatal or pediatric care and support, such as primary care offices, hospitals, or social benefits offices. This approach can increase providers' awareness of available services and may make immediate referrals and warm hand-offs easier for providers and more comfortable for families.

In **Washington**, the state's Health Care Authority oversees the Substance Using Pregnant People (SUPP) Program in partnership with local hospitals. The SUPP Program offers Medicaid-eligible pregnant people a combination of medical stabilization, withdrawal management, one-on-one group treatment, and referrals to inpatient treatment — all in a hospital setting.

The Centers for Medicare & Medicaid Services created the Maternal Opioid Misuse (MOM) Model that provides federal funding to support programs that serve pregnant and postpartum Medicaid recipients with opioid use disorders.[27] One such program in **Tennessee**, Firefly, brings perinatal medical care and addiction recovery services together in one care clinic, based in the Center for Women's Health at Vanderbilt University Medical Center. Each patient is assigned a peer recovery specialist, lactation consultant, and counselor. The clinic also includes social workers who can address families' other needs — such as food, diapers, or transportation.

Other communities are embedding patient navigators or community health workers in hospitals and other perinatal care locations, as they often have more time and knowledge to make community referrals than do medical professionals.

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When we identify families who could benefit from services, are we doing so in ways that are supportive, voluntary, and equitable? (E.g., are we asking for consent before drug testing, and not targeting certain racial or ethnic groups, etc.)

Are we reviewing data about our services in the aggregate or breaking data down by race, ethnicity, age, gender in order to improve equitable service provision?

Building a Just and Equitable Recovery Service System

Challenge: Recovery services are not usually designed for parents

Substance-using caregivers seeking recovery are caring for children while also trying to overcome a SUD. These dual responsibilities are interwoven and concurrent, yet many services may only focus on one responsibility at a time.[28]

If programs do not consider parents in their service design, they may limit treatment hours, offer no child care facilities, or disenroll clients if they miss appointments — all of which can introduce potential barriers to successful recovery. Some inpatient programs may require that parents attend without their children, a separation that can be traumatic for both parent and child. Other programs may enforce "zero tolerance" policies around relapses, which may negatively impact reunification chances for parents whose children have been placed in foster care.

Promising Practice: Design services to honor caregiving

The examples below offer insight into how many jurisdictions are working to better design services to meet parents' multifaceted needs by trying to:

- Adapt existing recovery services to be more parent friendly
- Create new services that combine parenting supports with recovery supports

Adapt existing recovery services to be more parent friendly

Some treatment program leaders are finding ways to support the family relationship in the recovery journey, recognizing that despite its challenges, caregiving can provide parents with a unique source of motivation.[29] The following examples highlight how several jurisdictions are working to support both parents and their children.

In **Spokane County, Washington,** the Department of Children, Youth, and Families helps to fund Rising Strong, a family-centric, 12- to 18-month temporary housing program that offers on-site, outpatient SUD treatment, a child-centered Wraparound with Intensive Services (WISe) program, and other supports that allow caregivers to remain with their children while going through their recovery process.

In **Arizona**, Native American Connections' Patina Wellness Center allows parents to stay in the center with their children throughout the six-week, inpatient residential program. The Center combines evidence-informed practices with traditional Native healing practices, and helps parents coordinate with child welfare workers and find housing and employment following the program. The agency has found that parents who stay with their children are more likely to complete treatment than those enrolled without their children.[30]

In **Florida**, leaders from the Department of Children and Families knew that very few substance-using caregivers being referred to behavioral health providers were actually receiving outpatient services. One provider told DCF they noticed many parents were spending much of their scheduled treatment session waiting in line to check in at the front desk. Because these parents were often waiting with their children, delays were frustrating and discouraged parents from returning to subsequent appointments. Other providers noticed parental challenges such as lack of transportation, child care, and scheduling barriers, as well as hesitancy to engage in treatment. As a result, only 7% of caregivers referred for services received treatment within 30 days of their referral. In response, treatment providers expanded telehealth options, streamlined the registration process, provided child care, and sent text message reminders. After these and other changes in practice, the number of clients who accessed treatment within 30 days doubled.

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Do we have culturally responsive programs and services?
Do our providers reflect and represent the communities they serve?

To learn more about developing equitable client referral pathways through contracting with diverse providers, please see the GPL publication: "What is Procurement Excellence?"

Building a Just and Equitable Recovery Service System

Create new services that combine parenting supports and SUD supports

More recovery programs are trying to expand their services, meeting families in their own homes and offering more "wraparound supports."[31] When agency leaders work to address foundational challenges like food insecurity, unstable housing, transportation gaps, and lack of child care, caregivers may be more able to participate in and benefit from services.

Connecticut recognized that caregivers often go to multiple places to seek help for parenting and recovery supports. This is logistically challenging and can result in conflicting program requirements. In response, the state's Department of Children and Families invested in the Family-Based Recovery program, a coordinated in-home service that combines intensive psychotherapy, substance use treatment, and attachment-based parent-child therapy.[32]

In **Kansas**, the state uses federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program funding to support The Team for Infants Exposed to Substance Abuse (TIES) program. This home visiting program offers voluntary, personalized, culturally appropriate services for families including counseling, crisis intervention, support for substance use treatment, child health and development, parenting education, and connection to community services.[33]

Developed in **Washington**, the Parent-Child Assistance Program (PCAP) provides three years of home visiting and case management support to pregnant and parenting women with substance use disorders. Case managers connect moms to substance use treatment services, as well as community-based supports — including parenting skills, mental health services, safe housing, health care, and domestic violence services. **Oklahoma** has also adopted this program to address high rates of SUD, child maltreatment, and female incarceration in their state.

Pueblo County, Colorado, is testing an innovative approach using Temporary Assistance for Needy Families (TANF) funds to support a county TANF case manager and a community-based navigator with lived experience. Both positions focus on connecting pregnant people and new parents using substances to substance use treatment and other supports. The county is also using TANF funds to address families' basic needs.

Looking forward

The examples shared in this publication illustrate a few of the intentional and creative ways that agency leaders across the United States are trying to improve how they support substance-using caregivers on their journey to recovery. These leaders know that children and families stand to benefit when services are designed in ways that can build trust and reduce fear, focus on upstream interventions, and acknowledge the unique responsibilities inherent in caregiving. The GPL is committed to working with jurisdictions to test and scale such promising practices, and then share those findings with other agencies looking to do the same.

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The Government Performance Lab, housed at the Taubman Center for State and Local Government at the Harvard Kennedy School, conducts research on how governments can improve the results they achieve for their citizens. An important part of this research model involves providing hands-on technical assistance to state and local governments. Through this involvement, we gain insights into the barriers that governments face and the solutions that can overcome these barriers. By engaging current students and recent graduates in this effort, we are also able to provide experiential learning.

Designed by Sara Israelsen-Hartley