



State Strategies to Meet the Needs of Young Children and Families Affected by the Opioid Crisis

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This report highlights effective strategies by Kentucky, New Hampshire, and Virginia to support families impacted by OUD:

- Improve access to care for at-risk children and parents/caregivers;
- Expand services, provider capacity, and benefit options;
- Implement family-focused and trauma-informed care; and
- Align and maximize resources across systems by sharing data and leveraging diverse program funding.

View a comprehensive chart detailing available federal funding sources for state OUD initiatives [here](#).

Introduction

The opioid epidemic continues to have devastating consequences for children and families across the country, with growing social and financial implications for states. The estimated cost of the epidemic nationwide in 2016 alone was \$95.8 billion, and its estimated cost between 2001 and 2017 exceeded \$1 trillion from lost productivity and increased spending on health care, social services, education, and criminal justice.¹ There has also been a dramatic increase in neonatal abstinence syndrome (NAS), which is costly to treat and poses long-term threats to a child's health.

As states develop and implement strategies to combat the current epidemic of opioid use disorder (OUD), many are focusing on whole-family prevention and treatment approaches. Evidence shows that providing parents with supports that help them care for their families and provide children with services and supports for their developmental, behavioral, and social-emotional needs can help mitigate the long-term impacts of OUD.² The federal government is also making significant investments in a variety of programs, including Medicaid, behavioral health, public health, child welfare, and criminal justice to help states address the opioid epidemic and meet the needs of young children.

In the spring of 2018, the National Academy for State Health Policy (NASHP), in partnership with the Alliance for Early Success, interviewed Kentucky, New Hampshire, and Virginia officials representing state Medicaid, child welfare, and behavioral health programs to discuss how their child-serving agencies are responding to the opioid epidemic. This resulting report explores:

- These states' strategies to support young children and families impacted by OUD;
- Available state and federal funding sources for these initiatives; and
- Key considerations for states working to improve services and outcomes for this vulnerable population.

The Impact of the Opioid Epidemic on Young Children and Families

The opioid epidemic, which encompasses both prescription and illegal opioid misuse, is having deadly and far-reaching consequences across the nation. In 2016, an estimated 2.1 million Americans age 12 and older had an OUD.³ Additionally, 115 Americans continue to die daily from opioid overdose, and the number of overdose deaths involving opioids increased five-fold between 1999 and 2016.⁴ The epidemic has hit children and families in specific regions and from specific racial and socioeconomic backgrounds particularly hard. States in New England and Appalachia have experienced higher overdose death rates than other regions.⁵ Those living in rural areas are more likely to die from opioid overdose, as are individuals with lower educational attainment.^{6,7} Eighty percent of overdose deaths are among non-Hispanic, white Americans, but OUD rates are now rising among all races and ethnicities, with overdose rates for African Americans rising faster than those of other races.⁹

What is opioid use disorder (OUD)?

OUD is a type of substance use disorder (SUD), which is characterized by the recurrent use of alcohol and/or drugs leading to clinical and functional impairment, such as health problems and failure to meet one's personal and social responsibilities. OUD specifically entails the misuse of opioids – a class of drugs that serve as pain relievers. Opioids include prescription drugs, such as oxycodone and hydrocodone, and illegal drugs, such as heroin.¹⁰

The effects of the opioid epidemic span generations, with young children directly impacted by OUD among their parents/caregivers. Young children can experience numerous negative consequences, including:

- Poor outcomes and costs associated with prenatal exposure to opioids;
- Accidental ingestion of opioids;
- Increased risk of removal from the home and placement in the foster care system; and
- Increased risk of trauma and adverse childhood experiences (ACEs), which are linked to negative health consequences later in life.

Poor outcomes and costs associated with prenatal opioid exposure. Opioid exposure in utero can cause an infant to experience NAS due to sudden withdrawal. NAS has an array of signs and symptoms, including severe irritability, feeding difficulty, respiratory problems, and seizures, and typically leads to costly inpatient hospital stays for infants.¹¹ The incidence of NAS has increased rapidly, with a five-fold increase in the rate of infants born with NAS between 2004 and 2014.¹² Infants with NAS spend 16.5 days, on average, in the hospital, and the treatment of a single NAS case exceeds \$16,000.¹³ Medicaid is the primary payer for the majority of NAS-associated health care costs. In 2014, Medicaid covered 82 percent of all NAS-related births, and paid \$462 million in related hospital costs.¹⁴

There has been limited research into the long-term effects of prenatal exposure to opioids. However, some evidence suggests that prenatal opioid exposure can lead to behavioral, cognitive, and psychomotor problems in early childhood.¹⁵ The Tennessee Department of Health recently conducted a study that links health and education datasets to analyze special education outcomes among children born with NAS. The state found that prenatal exposure to opioids was associated with increased risk of developmental disabilities in early childhood.¹⁶

Accidental ingestion of opioids by young children. There has also been a significant and steady increase in pediatric hospitalizations due to opioid ingestion and poisoning, across children of all age groups. Between 2004

and 2015, pediatric opioid-related hospital admission rates increased by 39 percent.¹⁷ Young children are particularly vulnerable to accidental opioid ingestion. Children age five and younger accounted for one-third of the hospitalizations during this period.¹⁸

Increased foster care system involvement. The opioid epidemic is also associated with an increase in the number of children entering foster care.^{19,20} After a period of decline between 2007 and 2012, the number of children entering foster care rose, with a near 10 percent increase from 2012 to 2016.²¹ While changes in child welfare caseloads vary by state, the nationwide increase correlates with overdose deaths and drug-related hospitalizations, both of which are associated with the opioid epidemic.²² In fiscal year 2016, 34 percent of out-of-home placements were attributed to substance misuse by a parent.²³

Increased risk of adverse childhood experiences (ACEs) and trauma. Children affected by parental substance use are at higher risk of behavioral and psychosocial problems. Parental opioid use is considered an ACE, which is a potentially traumatic event that can include abuse, neglect, and household challenges (e.g., violence in the home, parental mental illness, and parental incarceration).²⁴ ACEs are strongly associated with a wide range of negative consequences for health and well-being later in life, such as chronic health conditions, risky behaviors, lower academic achievement, and early death.²⁵ ACEs have cumulative effects. As children with parental SUD experience additional ACEs, they are more likely to experience later issues.²⁶ Children of parents with SUD are also more likely to develop substance use problems themselves.²⁷

Multi-Agency Strategies to Support Infants, Children, and Families

Due to the far-reaching and long-term consequences that parental opioid use can have on infants and children, state responses to the opioid epidemic often involve multiple child-serving agencies and take multi-pronged approaches to provide prevention and intervention services for the whole family. The following highlights a range of strategies that states can use, as employed by Kentucky, New Hampshire, and Virginia. Many of these approaches build on states' historic experiences in addressing substance use epidemics and are integrated into states' broader SUD policies. These strategies include facilitating access to and expanding coverage of services and supports for parents and caregivers with OUD and their children, implementing and expanding care delivery models tailored to families' needs, and aligning and maximizing resources across agencies and systems.

Strategies to Improve Access to and Coverage of Services and Supports

Evidence shows that providing integrated services and supports that treat a parent/caregiver's OUD and address other health and social needs of the family can mitigate the negative impact of OUD and improve the health and well-being of children.²⁸ In cases of NAS, involving mothers in their infants' care has been shown to benefit their infants.²⁹ Improving access to and covering services and supports for parents and children can be a complex undertaking. There are a number of Medicaid coverage options available to support NAS treatment that include their caregivers in the treatment process.³⁰ However, covering these services requires states to consider, for example, which Medicaid authorities are in place and payment approaches to support the services. Moreover, Medicaid is just one system that can be leveraged to serve families impacted by OUD. Kentucky, New Hampshire, and Virginia have taken a variety of approaches to ensure infants and children impacted by OUD receive necessary services and supports.

Identify and facilitate rapid access to care for families with at-risk infants and children.

Facilitating early and rapid access to care for families with infants and children exposed to opioid use is key to mitigating the potential long-term impacts on children's health and well-being. The Kentucky Sobriety

Treatment and Recovery Teams (START) program is an evidence-based child welfare intervention that serves child protective services (CPS)-involved families with substance-exposed infants or children up to age five. START's core elements include early identification of families who have been referred to CPS and are in need of services (within 10 days of CPS referral), and rapid access to SUD treatment (within 48 hours of receiving a behavioral health assessment).³¹ Rapid access to SUD treatment relies on collaborative efforts between child welfare staff and community providers, and is facilitated by early assessments, linkages, and warm hand-offs to services by CPS-based peer supports.³² START also provides direct services to children, such as screenings and home visits. START integrates child welfare and SUD services for families with the goal of keeping children at home whenever it is safe and possible.

Kentucky's START program integrates child welfare and substance use disorder services for families, with the goal of keeping children at home whenever it is safe and possible.

Early and rapid access requires identifying infants and children who are at-risk due to parental opioid use. Implementing reporting and tracking systems can facilitate early identification of infants and children exposed to parental opioid use, yet their use can also pose potential challenges to supporting young children and families. Twenty-four states and Washington, DC require health care providers to report suspected substance use during pregnancy to CPS.³³ But officials acknowledge the fear of CPS involvement – both real and perceived – can prevent pregnant women with OUD from receiving prenatal care and can stop parents/caregivers from seeking OUD treatment services and supports, which can also negatively impact their children. As a result, developing effective state reporting policies requires careful consideration.

For example, **New Hampshire's** recent legislation requires health care providers to develop plans of safe care in coordination with the Division of Public Health Services (DPHS) for any infant born with substance exposure or withdrawal symptoms. A plan of safe care is a treatment plan that addresses the health and safety needs of infants born with withdrawal symptoms or affected by substance misuse. It also addresses the health and SUD treatment needs of a parent/caregiver with SUD.³⁴ The legislation clarifies that prenatal substance exposure is not in itself a mandatory reporting requirement, although health care providers must continue to report cases of child abuse and neglect.³⁵ The legislation is designed to clarify what is expected of health care providers when it comes to reporting substance exposure among infants in order to improve identification of parental OUD and connect infants to services.

Expand coverage of services supporting children and families. States are expanding coverage of services and providers that can help families affected by OUD by employing a variety of mechanisms and funding streams. One such benefit is the use of peer support specialists. Peer support specialists are individuals who are in long-term recovery from SUD themselves and are trained to:

- Provide emotional support while helping parents/caregivers with OUD or SUD navigate treatment;
- Connect them with other community services and supports; and
- Provide parenting education and training.

Evidence indicates that peer support specialists, used in conjunction with clinical treatment, are effective in helping individuals maintain long-term recovery.³⁶ **Virginia's** Medicaid agency incorporated peer support services as a new service in its Addiction and Recovery Treatment Services (ARTS) program, which is the state's enhanced SUD treatment benefit that expands access to a comprehensive continuum of addiction treatment services for Medicaid enrollees.³⁷ Similarly, **Kentucky's** Medicaid agency added coverage of peer support specialists to its Medicaid State Plan in 2014.³⁸

State Medicaid agencies can also facilitate access to treatment services that will benefit parents/caregivers and children by adjusting reimbursement rates, if funding is available. Increasing reimbursement rates for specific services or targeted populations can incentivize providers to provide the service or serve the population. For example, **New Hampshire's** Medicaid agency offers higher reimbursement rates to SUD residential treatment programs that provide specialized care for pregnant and postpartum women and their children -- compared to programs serving general adult populations -- as a strategy to promote access to OUD treatment for this population.³⁹

Enhance the capacity of child-serving professionals. As states focus on young children and families impacted by OUD and connecting them to services and supports, a key concern is whether there is sufficient capacity and expertise to address the myriad of OUD-related needs among a state's child-serving professionals. Within the context of the opioid epidemic, workforce development, training, and education is multi-faceted due to the breadth of systems that serve these children and families. In many health care systems, early childhood mental health professionals and family-centered treatment providers who can meet the needs of children and families impacted by OUD tend to be in short supply, especially in rural communities.⁴⁰ Criminal justice staff may not understand appropriate treatment options for OUD. This lack of knowledge can lead to mandated treatment services that are neither appropriate nor effective, leaving families vulnerable to negative outcomes or the erroneous removal of children from their homes. Child welfare professionals may also need training to understand how to identify OUD, treatment approaches, and legal requirements.⁴¹

New Hampshire is taking several approaches to enhance the capacity of professionals in its child-serving systems to respond to families' needs. The state's Division of Children, Youth, and Families (DCYF) is in the midst of a transformation initiative that focuses on preventing child abuse and neglect.⁴² While this transformation is not specifically in direct response to the opioid epidemic, it is designed to strengthen the capacity of DCYF staff to improve the well-being of the children they serve, including those impacted by opioid use and the associated trauma. New Hampshire DCYF's Project First Step also provides support to CPS and juvenile justice staff to better meet the needs of children and families affected by OUD. Project First Step embeds licensed alcohol and drug counselors (LADCs) in select child welfare program district offices across the state. The LADCs train DCYF and juvenile justice staff on substance misuse issues and screening techniques, and provide consultation to help staff better facilitate family access to SUD treatment and community-based services and supports.⁴³

Project First Step embeds licensed alcohol and drug counselors in select child welfare program district offices across the state to train DCYF and juvenile justice staff to effectively facilitate family access to SUD treatment and community-based services.

Implementing and Expanding Care Delivery Models Tailored to Children and Families' Needs

In addition to facilitating access to services and supports, states are considering care delivery models that can meet the needs of young children and families as part of their strategies to address the opioid epidemic. Many states are leveraging, expanding, or enhancing existing models of care that have demonstrated effectiveness in serving young children living in households with a history of substance misuse. Additionally, many of these promising models provide a family-based approach to care, ensuring that services are tailored to children's needs and are provided in tandem with those delivered to the whole family.

Care coordination for infants and children exposed to OUD. States have a rich history of using care coordination to support individuals with chronic and/or complex needs and improve quality of care. Care coordinators serve as bridges between systems, helping individuals access all needed services and supports, overseeing referrals and follow-up care, and facilitating communication between providers.⁴⁴ Care coordination plays an important role in care for infants and young children whose parents are in OUD treatment. Given the number of systems that may be involved in serving this population, including primary care, specialty care, child welfare, and early learning and education, care coordination helps ensure children receive appropriate services that are specific to their needs and prevent duplication of services.⁴⁵ As states design their opioid response strategies, they are leveraging care coordinators to not only support parents/caregivers in their OUD treatment, but also their children.

Virginia requires all Medicaid managed care organizations (MCOs) to use ARTS care coordination for individuals with SUD. When supporting individuals with children, care coordinators can link families to community-based services and supports to help meet the needs of the member. Through its Medicaid managed care program (Medallion 4.0), Virginia's Medicaid agency also requires its MCOs to provide care coordinators to specifically manage the care needs of substance-exposed infants and infants with NAS. These care coordinators must also ensure alignment between the mother's and infant's care plans.⁴⁶

Integrating trauma-informed care. Many states are integrating a trauma-informed approach to care in their efforts to support young children. Due to the strong link between trauma and SUD, including OUD, trauma-informed approaches to care for both children and parents can help mitigate the cycle of SUD. There is no one specific model for trauma-informed care. Rather, a trauma-informed approach, "realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."⁴⁷ As a result, a trauma-informed approach can be integrated into the full spectrum of systems serving children.

Virginia is currently advancing trauma-informed approaches across systems, including its departments of Medical Assistance Services (DMAS), Behavioral Health and Developmental Services, Social Services, and Education. For example, DMAS is integrating trauma-informed care into the newest iteration of the state's managed care program, Medallion 4.0, which launched in August 2018. As part of the provider network adequacy requirements, MCOs are expected to include providers with expertise, capability, and experience in trauma-informed care in their networks. The MCOs also must have demonstrated experience in serving or identifying innovations to improve care for specific populations, including children and youth with special health care needs (CYSHCN). The age range for CYSHCN programming includes young children (birth to age 3) and children/adolescents (ages 3-26). As part of their efforts to serve these populations, MCOs must have the capacity to provide care coordination and services or interventions to support substance-exposed infants and infants with NAS. They must provide trauma-informed case management services to the foster care, former foster care, and adoption assistance populations. MCOs must also ensure that they have trauma-informed behavioral health providers in their networks to serve this population.⁴⁸

Providing services where children live and grow. Families face numerous hurdles to accessing appropriate OUD treatment, ranging from the stigma associated with parental substance misuse to the logistical challenges associated with receiving care, including balancing work and school attendance, limited transportation options, and the lack of childcare.⁴⁹ One approach to providing services to children and families impacted by the opioid epidemic is bringing services to a location where they are convenient and easily accessible for the family. This can include residential treatment programs that accept both mothers and children. For example, Medicaid programs in **Kentucky, New Hampshire, and Virginia** all cover residential treatment programs for pregnant and parenting women, including those that accept children. A

second approach is co-locating services and supports for children and parents/caregivers in community settings. For example, through **New Hampshire's** Project First Step, LADCs, who are embedded in DCYF district offices, also provide direct services to DCYF-involved families, in addition to providing training and consultation to child welfare professionals. These services can include screening and assessment for the family, immediate counseling, and connecting families to additional community supports.⁵⁰ The services provided by LADCs are covered by federal Title IV grant program and Child Abuse Prevention and Treatment Act (CAPTA) funds -- no public or private insurance is billed. The LADCs are consultants, not DCYF employees, which allows for confidentiality between LADCs and families.

Additionally, evidence-based home visiting programs provide a comprehensive set of in-home social, health, and educational services to families and young children on a voluntary basis. They are designed to help support healthy child development, reduce health and social problems such as child abuse and neglect, and identify opportunities to intervene early in a child's life to avoid costlier interventions in the future. These home visiting programs can support families affected by the opioid epidemic by screening parents and caregivers for SUD, connecting them to treatment services, and screening children for potential developmental, behavioral, or social-emotional issues.⁵¹ All 50 states, Washington, DC, and several territories administer home visiting programs with funding from the Health Resources and Services Administration's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.⁵² States are increasingly exploring home visiting as a mechanism to identify and support families impacted by the opioid epidemic.

New Hampshire expanded its home visiting program through DCYF with funding from the 21st Century Cures Act. The New Hampshire DPHS has supported home visiting programs since 1997, starting with three pilot programs, and subsequently expanded them across the state.⁵³ While DPHS continues to administer Home Visiting New Hampshire (the state's home visiting program serving pregnant women and families with children up to age 5), DCYF has integrated evidence-based home visiting into its Strength to Succeed program. The Strength to Succeed program is a collaborative effort among DCYF, the Bureau of Drug and Alcohol Services, DPHS, and the Bureau for Children's Behavioral Health. It is designed to support DCYF-involved children (up to age 10) and their parents/caregivers with SUD, including OUD, in order to reduce and mitigate childhood trauma and increase family protective factors and reduce risk factors. Evidence-based home visiting is a core component of this initiative. Other components include rapid access to treatment, parent-partner peer support, and cross-training of SUD treatment providers and DCYF professionals. All children and families referred to this program can receive voluntary home visiting services, if indicated in their treatment plan. The home visiting services include developmental screenings, parent education, collaboration with DCYF to create a shared goal plan for the family, and connecting the family with additional community supports.⁵⁴

Integrating family-centered treatment approaches. Family-based services for parental substance use fall along a continuum. They include services that focus on an individual in treatment, but emphasize the importance of familial relationships to that individual's care. The most comprehensive level – family-centered treatment – provides services tailored to each family member, including parents and children, along with an integrated care plan for the family unit. Family-centered treatment models provide comprehensive services and supports to address a family's behavioral health, physical health, and social needs, and coordinates care across systems.⁵⁵ There is not one specific model of family-centered care treatment -- this care approach can be integrated into a variety of settings, including residential treatment and community-based OUD programs.⁵⁶

Kentucky's START program provides a family-centered service delivery model within the state's child welfare system. START pairs a CPS worker with a family mentor, who is an individual in long-term recovery, to coordinate and provide comprehensive wraparound services to parents/caregivers with SUD (including OUD) and their children and other family members. The CPS worker and family mentor connect parents with SUD treatment services that are gender-specific and trauma-informed. They screen children for developmental delays and behavioral health issues and connect them to needed services. The team also coordinates with the various

providers involved in the families' care.⁵⁷ While START includes fathers in its family-centered approach, Kentucky has found that fathers need different strategies than mothers to engage them in treatment. Thus, the state is exploring ways to integrate father-specific interventions into START.⁵⁸

Aligning and Maximizing Resources across Systems

Sharing data across systems. Collecting, reporting, and sharing data across systems is critical to understanding and addressing the impact that the opioid epidemic has on young children. Data can reveal the scope of the problem and help states to develop, target, and monitor the impact of interventions to address children's needs. Data sharing between systems can also improve coordination of services for children and parents/caregivers. Multiple systems in states gather data related to children impacted by the opioid epidemic, including Medicaid, public health, behavioral health, criminal justice, and child welfare. There are systemic barriers to sharing data between these systems, such as state regulations, privacy concerns, and lack of comparability of data.⁵⁹ However, data sharing offers the potential to connect at-risk families to services, identify gaps in treatment, and improve cross-system care coordination for children and their parents.

Kentucky has been a pioneer in using cross-system data to combat the opioid epidemic on both a programmatic and a systems level. For example, at a programmatic level, its departments for Community Based Services, Behavioral Health, and Developmental and Intellectual Disabilities have established a data-sharing agreement for the START program that allows for fidelity monitoring and analysis of behavioral health and child welfare services and outcomes for START clients. This analysis of services and outcomes is part of a cross-site evaluation for a Regional Partnership Grant from the Administration for Children and Families. At a systems level, the state-integrated vital statistics and prescription drug monitoring program (Kentucky All Schedule Prescription Electronic Reporting or KASPER) data to better understand the causes of opioid use and overdose deaths to inform prevention strategies.⁶⁰ State regulations also require providers to report NAS cases to the Department for Public Health.⁶¹ Using this data, Kentucky has maintained an NAS Reporting Registry to monitor state-level trends and develop and assess the impact of prevention and treatment strategies.^{62,63}

Kentucky is exploring new opportunities for leveraging cross-system data to support its OUD strategies. For example, its Department for Public Health is considering how it can cross-reference the NAS Reporting Registry with the state's Childhood Fatality Review as a way to identify and target interventions to high-risk communities to prevent fatalities or near-fatalities among infants.⁶⁴ The state also is working to develop mechanisms for sharing and integrating data from criminal justice, workforce, Medicaid, and vital statistics to advance targeted programs, garner resources, guide policymaking, and begin to change practice. By using shared data to inform prevention and intervention efforts, state officials believe they can mitigate the impact of the opioid epidemic on young children.

Leveraging diverse funding streams to provide a full continuum of care. Children and parents/caregivers impacted by OUD benefit from a comprehensive array of services to promote recovery and the well-being of all family members. Critical services and supports can include transitioning from inpatient to community settings, supportive housing, childcare, and parenting education and training, in addition to medical and behavioral health services. However, providing a continuum of care to children and families is costly. For example, implementing Kentucky's START program costs an estimated \$5,900 per child.⁶⁵ Both states and the federal government are currently investing in initiatives and programs designed to support these types of services. (See the textbox for funding streams used by each state and the **appendix** for a more in-depth examination of federal funds available to address the opioid epidemic.) With these investments in various state systems,

there is an opportunity for a range of state agencies to coordinate funding sources and activities.

Kentucky's START program draws from multiple funding sources to support the services provided to enrolled children and families. Once Kentucky expanded Medicaid, the state was able to leverage that funding to cover Medicaid-eligible SUD treatment services, including, in some cases, drug testing. Services provided by family mentors are potentially billable to Medicaid, but are not billed at this time. The state uses Temporary Assistance for Needy Families (TANF) block grant funds to address barriers to treatment among families in START, such as transportation and housing. State general funds and Title IV-E Child Welfare Waiver Demonstration Grants also fund START's administration.

Similarly, **New Hampshire** leverages a variety of state funding and federal grant program dollars to support Project First Step and Strength to Succeed. As previously mentioned, Project First Step uses Title IV-E Waiver Demonstration Grant program and Child Abuse Prevention and Treatment Act (CAPTA) funds to support the

Below are federal funding sources that Kentucky, New Hampshire, and Virginia are using to address the needs of young children and families affected by opioid use.

- [21st Century Cures Act](#): Passed in December 2016, this act authorizes the Substance Abuse and Mental Health Services Administration (SAMHSA) to award up to \$1 billion in grants to states to combat the opioid epidemic.
- [Child Abuse Prevention and Treatment Act \(CAPTA\)](#): CAPTA authorizes the Administration for Children and Families (ACF) to provide formula grants to states to improve child protective service systems.
- [Maternal, Infant, and Early Childhood Home Visiting Program \(MIECHV\)](#): Through MIECHV, the Maternal and Child Health Bureau in partnership with ACF funds states, tribal entities, and territories to implement evidence-based, voluntary home visiting programs for pregnant women, children, and families.
- [Medicaid](#): Medicaid is a joint federal-state program that provides health care coverage to low-income populations, including children, pregnant women, seniors, and individuals with disabilities. The Centers for Medicare & Medicaid Services (CMS) also provides some targeted funding to states to develop and implement payment and care delivery innovations. For example, as part of a multi-pronged strategy to combat the opioid epidemic, CMS announced the [Integrated Care for Kids \(InCK\) Model](#), which will provide funding to selected states to implement a child-centered local service delivery and payment model.
- [Substance Abuse Prevention and Treatment \(SAPT\) Block Grant](#): This program, administered by SAMHSA, provides grants to states to support programming to prevent and treat substance use disorder.
- [Temporary Assistance for Needy Families \(TANF\) Block Grant](#): Administered by ACF, TANF provides funding to states to implement a wide range of benefits and services that provide economic help to low-income families with children.
- [Title IV-E Demonstration Waivers Program](#): Title IV-E is a federal entitlement program that reimburses states for a portion of their costs to support foster care, adoption assistance, and guardianship assistance programs. The Title IV-E Demonstration Waivers Program gives states more flexibility in using Title IV-E funds to test innovative approaches to child welfare service delivery and financing.

work of LADCs. Additional Project First Step funding sources include a Substance Abuse Prevention and Treatment (SAPT) Block Grant and state general funds. The Strength to Succeed program, including the expansion of evidence-based home visiting, is funded through the State Targeted Response to the Opioid Crisis Grant program under the 21st Century Cures Act. Medicaid and private insurance are also billed for eligible SUD treatment services provided to DCYF-involved families.

In **Virginia**, the Department of Behavioral Health and Developmental Services (DBHDS) supports additional services and supports that are coordinated with and complement those covered by Medicaid through ARTS. For example, DBHDS contracts with Oxford House International via the SAMHSA SAPT Block Grant to expand recovery housing options for individuals in treatment. Through a combination of state funds and SAMHSA grants, DBHDS provides supportive housing for pregnant and parenting women in OUD recovery – something DMAS is not able to do. DBHDS also administers Project LINK, a case management model of care that coordinates and connects women to existing services within their communities, and fill service gaps. The LINK model seeks to create a coordinated system of care for women who use substances.⁶⁶ Medicaid covers Medicaid-eligible services provided through Project LINK, while DBHDS supports staff time and program administration costs.⁶⁷

Opportunities to Support Children and Families Impacted by OUD

As states implement initiatives to combat the opioid epidemic, they are navigating complex system changes and collaborative partnerships to effectively meet the needs of children and families. Below are key opportunities and considerations for states working to improve services and supports for this vulnerable population.

Expand education and training of child-serving professionals. The various professionals involved in a child's care can better support the child when they understand each other's systems. Not only do health care providers need to understand how to screen for OUD and connect families to appropriate treatment, but they also need to understand the role of child welfare agencies, the state's reporting requirements for opioid exposure, and how to use plans of safe care for children. The child welfare and criminal justice systems also need an understanding of OUD, appropriate treatment approaches for children and families, and available OUD services and resources in their regions. Without this shared knowledge and education, families may be mandated to receive treatment services that are not appropriate or effective, or children may be removed from a home when it is not necessary, leaving children and families vulnerable to negative outcomes.

Foster a culture change within child-serving systems to remove stigma. The historical response to parental substance use has been to remove the child from the home. However, there is growing recognition that removals can be traumatizing for a child and perpetuate opioid use by the parent/caregiver. Additionally, a persistent stigma against medication-assisted treatment (MAT) for pregnant women persists among the health care provider and child welfare communities. MAT is an approach to OUD treatment that entails that use of a maintenance medication (e.g., methadone, buprenorphine, or naltrexone) in conjunction with psychosocial services. MAT has been shown to improve outcomes for pregnant and parenting women and their children.^{68,69} However, the stigma against MAT can delay treatment for women and children and lead to unnecessary out-of-home placements for children. Combatting the stigma and shifting the culture within these systems is critical to states' opioid response strategies.

Address silos between systems. The state agencies and systems serving children and families affected by OUD are typically fragmented, which can lead to missed opportunities for prevention and early treatment, and inhibit coordination between services for children and parents/caregivers. Facilitating information sharing and establishing formal connections between systems can help state agencies and systems better coordinate their efforts and improve care and outcomes for children and parents/caregivers. If a parent/caregiver screens positive

for OUD, having processes or systems in place that allow the parent/caregiver's provider to connect with the child's providers can ensure that the child is monitored for potential adverse effects. Also, integration between the child welfare, primary care, and behavioral health systems can facilitate access to effective services for the family, decrease the likelihood of out-of-home placements for the child, and help states track outcomes among this population.⁷⁰

Coordinate funding streams. Some federal and state funding streams are devoted to combatting the opioid epidemic, and each one has limitations on the populations it can serve or the services it can support. States can coordinate their available funds to maximize their limited resources and expand the reach of their opioid response programs. Coordinating the various funding streams can also reduce or avoid duplicative services across systems and agencies.

Lessons learned from past SUD epidemics

While this opioid epidemic has been one of the most deadly drug epidemics in the United States, it is by no means the first drug epidemic that states have addressed. As states develop and implement their responses to the current epidemic, they are building on experiences from past epidemics. State officials identified the following as key lessons learned:

- **Provide a continuum of care:** To promote long-term recovery and positive outcomes, families require services and supports that are appropriate in intensity and duration, and tailored to their specific needs. Establishing a full continuum of care of physical and behavioral health care can ensure that families receive appropriate care for wherever they are in their treatment and recovery process, and facilitate transitions between levels of care intensity, from residential treatment to community-based services.
- **Address the cyclical relationship between SUD and adverse childhood experiences (ACE):** SUD and ACEs are strongly correlated. ACEs can be a cause of SUD, and SUD is considered to be an ACE. Preventing and providing services to mitigate the impact of ACEs can be a crucial component to effectively combat SUD epidemics.
- **Prioritize rapid access to treatment for parents/caregivers:** Due to the intergenerational impact that SUD can have, giving parents/caregivers priority and rapid access to treatment can have a significant impact both in treating the parents/caregivers' SUD as well as preventing adverse outcomes for their children.
- **Enable treatment programs to serve all types of SUDs:** While certain drugs might be driving epidemics, states must also serve individuals who misuse other substances, such as alcohol or methamphetamines. Treatment programs that are not substance-specific or targeted to individuals with specific types of SUD allow states to meet the diverse needs of residents and help prevent other SUDs from rising to the level of an epidemic.
- **Meet families where they are:** To better engage families in treatment and support their recovery, families need to be met where they are. For example, while enrolling a mother in treatment following the birth of an infant with symptoms of substance exposure may be a high priority, the woman may not be receptive to treatment in the immediate, postpartum period because it can be an overwhelming time. Considering the timing and location of an intervention can increase parents/caregivers' willingness to receive services and supports that will ultimately benefit the whole family.

Lessons learned from past SUD epidemics (continued)

- **Train child-serving staff through varied approaches:** Staff may need to be educated about the complex nature of SUDs, various treatment approaches, and other systems that are potentially involved in a family's care. Training and education child-serving professionals through a variety of mechanisms, such as group classes, one-on-one consultation support, and more informal training, are key to equipping them with the knowledge and skills to identify and support families affected by SUD.
- **Involve potential clients in program design and implementation:** Engaging parents/caregivers with a history of recovery can be critical to the design and implementation of any SUD program. They can provide key insights into critical components and services and guidance about ways to combat stigmas and reduce the perceived threat of child removal. This assistance can make programs effective in promoting long-term recovery.

Conclusion

Across the nation, state officials recognize that parental opioid use can have immediate and lifelong consequences on children's health and well-being. Supporting and meeting the needs of young children and families impacted by the opioid epidemic is a priority for all states. As policymakers work to combat the epidemic, states are implementing a wide-range of strategies designed to improve access to care, deliver care through models tailored to families' needs, and strengthen cross-agency collaboration.

Many of these strategies build on existing state efforts and can advance states' broader SUD policies and programming for parents/caregivers and young children. States face numerous barriers, such as fragmented systems, the high costs of interventions, and state laws that may delay families from seeking services. Kentucky, New Hampshire, and Virginia demonstrate how states can leverage and align their child-serving agencies and funding sources to create comprehensive approaches to preventing and mitigating the effects of parental OUD on young children.

Appendix: Selected Federal Funding Sources to Address the Opioid Epidemic

The following table provides an overview of select federal funding sources available to states to assist young children and families impacted by opioid use disorder (OUD).

Agency	Program Title	Description	FY 2018 Funds	First Authorized
New Funding Sources Available to Address OUD				
Administration for Children and Families (ACF)	Child Abuse Prevention and Treatment Act (CAPTA) Infant Plans of Safe Care	These funds help states improve their responses to help infants and their families affected by substance use disorder (SUD), including OUD. The funding prioritizes plans of safe care for infants exposed to substances, including meeting Comprehensive Addiction Recovery Act requirements. Grants are distributed to all states through a formula based on the number of children under age 19. This increased funding is provided to states as part of an existing grant program: CAPTA State Grants (see Existing Funding Sources).	\$60 Million	Child Abuse Prevention and Treatment Act of 1974
	Kinship Navigator Programs	Support to states and tribes to develop kinship navigator programs. These programs assist grandparents and other relatives caring for children as a result of parental OUD. The programs help relatives find and use existing community resources to address their health and social service needs, and the needs of the children they care for.	\$20 Million	Bipartisan Budget Act of 2018 (Family First Prevention Services Act)
Health Resources and Services Administration (HRSA)	Rural Communities Opioids Response Program	Grants to any public or private entity to support treatment and prevention of opioid overdose in rural counties at the highest risk of SUD (including OUD), hepatitis C, and HIV. Funding is available over five years.	\$100 Million	Consolidated Appropriations Act of 2018
Substance Abuse and Mental Health Services Administration	Medication Assisted Treatment (MAT) for Prescription Drug and Opioid Addiction Program	Grants to states, local governments, nonprofits, and tribes to increase access to MAT in states hardest hit by the opioid epidemic.	\$84 Million	Children's Health Act of 2000
(SAMHSA)	Services Grant Program for Residential Treatment	Two grant programs are available: <ul style="list-style-type: none"> The Services Grant Program for Residential Treatment for Pregnant and Postpartum Women is available to states, local governments, tribal 	\$29.9 Million	Comprehensive Addiction and Recovery Act of 2016

Agency	Program Title	Description	FY 2018 Funds	First Authorized
	for Pregnant and Postpartum Women	<p>organizations, universities, and community organizations to expand access to residential treatment for low-income pregnant and postpartum women (within 12 months postpartum) and their children.</p> <ul style="list-style-type: none"> The State Pilot Grant Program for Treatment for Pregnant and Postpartum Women is available to Single State Agencies to support a family-centered continuum of care for pregnant and postpartum women with SUD, including OUD. Grants must use at least 75% of each award for services. No more than 15% of the funds can be used for residential treatment. 		
	State Opioid Response Grants	These grants are available to states, territories, and tribes to increase access to MAT, reduce unmet treatment needs, and reduce overdose-related deaths. \$50 million is designated for tribes, and 15% is for states with the highest age-adjusted OUD mortality.	\$100 Billion	Consolidated Appropriations Act of 2018
	State Targeted Response to the Opioid Crisis	These grants are awarded to states to expand OUD prevention and treatment services.	\$500 Million	21st Century Cures Act of 2016
Existing Funding Sources Available to Address OUD				
ACF	Child Abuse Prevention and Treatment Act (CAPTA) State Grants	State grants to improve state child welfare systems, distributed through a formula based on the number of children (age 18 and under) in the state. Additional funding directed at improving state responses to substance-exposed newborns was made available this year (see CAPTA Infant Plans of Safe Care under New Funding Sources).	\$85 Million*	Child Abuse Prevention and Treatment Act of 1974
	Regional Partnership Grants	Grants for inter-agency collaboration and program integration between child welfare and other agencies to support families affected by OUD.	\$20 Million	Child and Family Services Improvement Act of 2006
	Temporary Assistance for Needy Families (TANF)	Funds states to assist low-income families. Other than some restrictions on providing direct cash assistance to families, states have wide flexibility in how to spend the funds. Funding is distributed based on peak state expenditures for pre-TANF programs in FY1992-to-FY1995. To receive full funding, states must spend at least 75% of what they spent on pre-TANF programs in 1994.	\$16.5 Billion	Personal Responsibility and Work Opportunity Act of 1996
	Title IV-E Funding	Under Title IV-E of the Social Security Act, the federal government provides matching funds for eligible state and tribal welfare expenses, including many expenses related to foster care, adoption, and kinship guardianship. The federal match varies based on	\$6.2 Billion	Adoption Assistance and Child Welfare Act of 1980

Agency	Program Title	Description	FY 2018 Funds	First Authorized
		the type of service provided and, in some cases, a state's average per capita income. Some states also receive Title IV-E waivers to use Title IV-E dollars to test innovative child welfare service delivery and financing approaches. This waiver authority is currently set to expire in September 2019.		
Centers for Medicare & Medicaid Services (CMS)	Medicaid and Medicare	Reimbursement for OUD and SUD treatment services for Medicaid and Medicare enrollees. This is the largest federal investment in this treatment.	\$5.8 Billion	Social Security Amendments of 1965
HRSA	Title V Maternal and Child Health Block Grant	These state block grants support maternal and child health. States have significant flexibility in how to use the funds. Funding is distributed through a formula based on the number of low-income children in a state. States must match \$3 for every \$4 of federal funding provided.	\$651.7 Million	Social Security Act of 1935
HRSA and ACF	Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)	Funds states and tribes to develop and implement evidence-based home visiting programs that provide professional support to at-risk parents throughout pregnancy and early childhood by providing services in the home. Most MIECHV funds are distributed to states through a formula or a competitive cooperative agreement program. In three states, funding goes to nonprofit organizations instead of the state government agencies.	\$400 Million	Patient Protection and Affordable Care Act of 2010
Indian Health Services (IHS)	Alcohol and Substance Abuse Programs	Funds IHS alcohol and substance abuse treatment programs, including comprehensive care in IHS facilities.	\$227.8 Million	Snyder Act of 1921
SAMHSA	Substance Abuse Prevention and Treatment Block Grant	Flexible funds available to all states to implement and evaluate substance abuse prevention and treatment activities. Funding is distributed based on a formula calculated from measures of the population at risk, the cost of services, and the state's fiscal capacity.	\$1.78 Billion	Alcohol, Drug Abuse and Mental Health Services Administration Reorganization Act of 1992

* This amount includes the additional \$60 million that was made available through the CAPTA State Grants to support state implementation of Infant Plans of Safe Care (see New Funding Sources).

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