

DO NO HARM

Rebuilding Trust & Keeping Families Together



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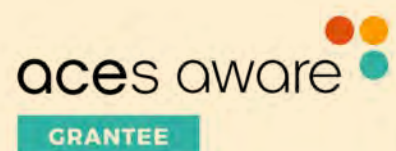
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For more information, visit the [ACEs Aware](#) website.



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LETTER FROM THE AUTHORS

The removal of children by the child welfare system is a burden that families who are Black, Indigenous, and People of Color (BIPOC) carry disproportionately. Through the lens of birth equity and reproductive justice, this disparity represents the failure of our systems of care. Birth equity is “the assurance of the conditions of optimal births for all people with a willingness to address racial and social inequalities in a sustained effort,” according to Dr. Joia Crear-Perry of the National Birth Equity Collaborative.¹ Advocacy for birth equity builds on reproductive justice, defined by one of its progenitors, Loretta Ross, as “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”² In fighting for birth equity and reproductive justice, we center communities who have been marginalized and over-surveilled.



This paper is written by two physicians working at the county hospital of San Francisco and one medical student at UCSF School of Medicine. Our medical training prepared us to look out for stigmata of abuse and to have a low threshold to call the CPS hotline, and only recently are we learning of the harm: disparate representation and outcomes by race in the child welfare system. Together we are moved to action by what we see in our clinical settings of Family Medicine and Pediatrics, especially during the perinatal and early childhood periods, and want to share our perspective and expertise to shift the power and outcomes of family-serving systems.

Heather Briscoe, MD, works primarily in the birth center, and is collaborating with a multidisciplinary team to disrupt racially disparate practices and improve the experience of parents impacted by substance use disorders. She has been part of a citywide effort to implement the use of Plans of Safe Care in hopes of reducing the need for CPS involvement. Snehal Murthy, MS, is a UCSF PRIME medical student and certified doula who has worked closely with pregnant and postpartum women who interact with CPS, as well as their community health workers and case managers working towards family reunification. Simone Vais, MD, is a Family Medicine resident whose primary interests include caring for people with substance use disorders, particularly in the perinatal and postpartum period. We recognize that while individual growth is important across our child facing programs and systems, we are all working within the confines of laws and systems that *must be transformed*.

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Introduction

Adverse Childhood Experiences (ACEs) and toxic stress are a root cause of some of the most harmful societal and health challenges facing our world today.³ The intergenerational accumulation of impacts for individuals, families, and communities, have resulted in a public health crisis, with the greatest impacts on already marginalized individuals and communities.⁴ The removal of children by the child welfare system is both a result and cause of Adverse Childhood Experiences (ACEs), and it is a burden that marginalized communities bear disproportionately.⁵

The child welfare system and other systems that intersect, and in some cases, sustain it—including law enforcement, health care, foster care, education, and juvenile justice—are steeped in a long history of racism and socioeconomic discrimination. Since its inception, our child welfare system has over-surveilled and disrupted marginalized communities, including communities of color, and those impacted by substance use disorders.^{6,7} Schools, police, social service agencies, medical professionals, and other community members who interact with children, are furthering systemic racism and classism, as their interactions with children and families are an essential part of child welfare's network for surveillance. "This institutional feature—a multi-organizational system of maltreatment surveillance—also creates conditions under which inequalities generated from one set of state actors can cause inequalities in proximate policy areas."⁸ As safety net hospital providers, we care for these families, and witness the harms that our systems

of surveillance cause them. Our duty to treat, and do no harm, is often challenged by the mandate to report, especially in cases where there is no imminent risk, or where there is subjectivity and room for bias.

In the case of neglect, the leading reason for child removal, we lean on child welfare to ensure the safety of children before looking to society and our safety nets to help meet families' basic needs. The child welfare system is not funded or designed to address the social determinants of health⁹—the social, physical, and economic conditions in the environment that contribute to a person's health, functioning, and quality of life. Clinics and hospitals and their community partners should focus on addressing social determinants of health and deliver care in an anti-racist and relational model, while leveraging community strengths to provide support for families. This would allow us to reserve child welfare resources for children who are truly in danger of maltreatment and not simply living in poverty.

It is a time of national racial reckoning and an opportunity to think critically about the structure of our child welfare system, and our participation (and thus complicity) in it. Racism, poverty, and surveillance collide with families' need for support in the delivery room, where we were seeing newborns removed from their birth parents for risk of neglect about once every month in our hospital. Separation of a newborn from its parent is both a result (for the parent) and cause (for the newborn) of Adverse Childhood Experiences (ACEs), and we have growing evidence^{4,10,11,12,13} of the downstream costs to the health of individuals, communities, and our society.



We can disrupt this cycle of generational ACEs by preventing unnecessary removals and creating alternative pathways for families to obtain the support they need. The Surgeon General of California's [Roadmap for Resilience](#)⁵ outlines strategies for decreasing ACEs and toxic stress in the healthcare setting. It recommends interventions at three levels: primary prevention—the avoidance of harm by promoting stable, safe, nurturing relationships; secondary prevention—early intervention to avoid harmful outcomes; and tertiary interventions—intended to be resilience optimizing and toxic stress mitigating. Importantly, interventions that are tertiary for one generation serve as primary prevention for subsequent generations. Investing in the family unit and strengthening protective factors can serve at each level of these prevention efforts.

In this paper, we will outline data which reveal inequities in the current child welfare system of California, review the evidence suggesting harms of over-surveillance and separation, and highlight policy actions and community-based solutions that have the potential to shift agency and resources to families who have been marginalized.

METHODS

Quotations from care team members were collected in response to standardized prompts solicited by email to a diverse group of staff and providers in San Francisco known to Dr. Briscoe. Dr. Vais and Ms. Murthy did outreach to system impacted families who were referred to us by trusted members of their care team for compensated listening sessions, but the few individuals who agreed to be interviewed were unable to make it to the scheduled listening sessions. Included quotations from impacted families were collected as part of a grant funded research project with Homeless Prenatal in collaboration with Solid Start. Ms. Murthy, Dr. Vais, and Dr. Briscoe completed a medical, legal, and social literature review and observed emerging themes, which are outlined in the solutions section.

Causes of Separation

In an unpublished review of newborns in our hospital from 2019-2020, the primary reasons for child welfare removing newborns from their parents included substance use, intimate partner violence, unstable housing, mental health disorders, and history of involvement with the

criminal justice or child welfare system. These challenges often correlate with poverty and the effects of systemic racism, and disproportionately result in child welfare involvement for BIPOC families. For example, while substance use is evenly distributed across racial demographics, in pregnancy, Black and Indigenous women are tested for it at higher rates,¹⁴ are referred to Child Protective Services (CPS) more often,¹⁵ and are more likely to have their newborn removed as a result.^{14,16} The consequences for parental substance use vary from state to state, county to county, hospital to hospital; ramifications range from surveillance to incarceration.

Results of Removal

The impact of a child's removal after a mandated report is profound. Broadly, forced separation perpetuates generational cycles of trauma¹⁷ and creates distrust between the medical system and the communities it seeks to serve.¹⁸ Families who distrust medical providers—either because they have experienced the removal of a child or know others in their community who have—are less likely to access medical care and entitlement resources such as housing and mental health treatment, which often leads to a higher likelihood of family stress and disruption.¹⁸

During the perinatal period in particular, distrust of the medical system undermines a valuable opportunity to engage families in care. In the case of substance use disorder (SUD), prenatal care presents a unique opportunity to engage in primary prevention strategies to buffer against the negative impacts of substance exposure and support and prepare an individual as they transition to parenthood. Prenatal visits provide health care teams time to get to know a family, engage community-based support, complete a Plan of Safe Care,¹⁹ and connect families to housing and recovery services, all of which can decrease the

likelihood that a report^a to child welfare will need to be made at birth. Unfortunately, a history of over-surveillance and family disruption has given safety net hospitals and other medical entities the reputation of “baby snatchers,”^b alienating patients from accessing essential care and perpetuating cycles of mutual distrust and trauma.²⁰

Call for Transformation

The extremely negative impacts of removing infants—disproportionately affecting BIPOC children—from their families, requires a significant disruption of the status quo. Health care systems have long contributed to the racial disparities in child welfare, including the disproportionate removal of BIPOC children. As Jamila Perritt, MD, MPH, put it, “the notion that medical providers are unbiased and objective, practicing within a profession free from the legacies of racism, genocide, and White supremacy, is fictitious.”²¹ As perpetrators of this problematic legacy, health care professionals must join with others in the community to prevent unnecessary removals. These efforts should include shoring up the resources and connections in marginalized communities, bringing people with lived experience to the table when designing and implementing solutions, and providing optimal support to parents and improving community conditions so that when families are experiencing challenges, they are able to safely stay together.

In the following sections, we aim to outline some of the inequities of our systems that lead to disproportionate removal of BIPOC children, the harms of this removal, and despite the complexity, the opportunities for disrupting the current system governing health care's interaction with child welfare.

a What triggers a mandated report varies by state

b Trainees who volunteer in our community have heard parents use this term to describe our hospital, and this same term has been used in community conversations authors have participated in.

PART I: The Problem

Section 1: Racial disparities, poverty, and reporting

“There are three types of associations between poverty and child maltreatment: maltreatment may be indirectly caused by parental poverty, detected because of parental poverty, or defined by parental poverty.”²²

Our aim is to focus our efforts on prevention strategies that serve to support families, bolster resilience, and mitigate risk well before child welfare is involved. We know that such primary prevention will help foster more resilient communities in which families can thrive without state intervention.^{23,24} However, in order to do so, we must step back and do the work to identify what causes us to suspect and report risk in the first place, and analyze critically the implicit and explicit biases entrenched in these perceptions.

The disproportionate involvement of child welfare in the lives of BIPOC families, including over-surveillance, is a direct manifestation of structural and systemic racism. The majority of children are removed from their families due to a finding of neglect or risk of neglect. Deliberately oppressive and racist policies have created the community conditions and resulting circumstances that are judged as at risk for neglect. For a thorough review of the data and literature on disproportionality in child welfare, look to [this report](#) by Robert Hill.²⁵ It is important to note that when controlling for socioeconomic factors, a large study in California did not show a substantial difference²⁶ in reporting by race. This finding likely reflects the impact of systemic racism on *wealth disparity*. For generations, systemic racism has denied

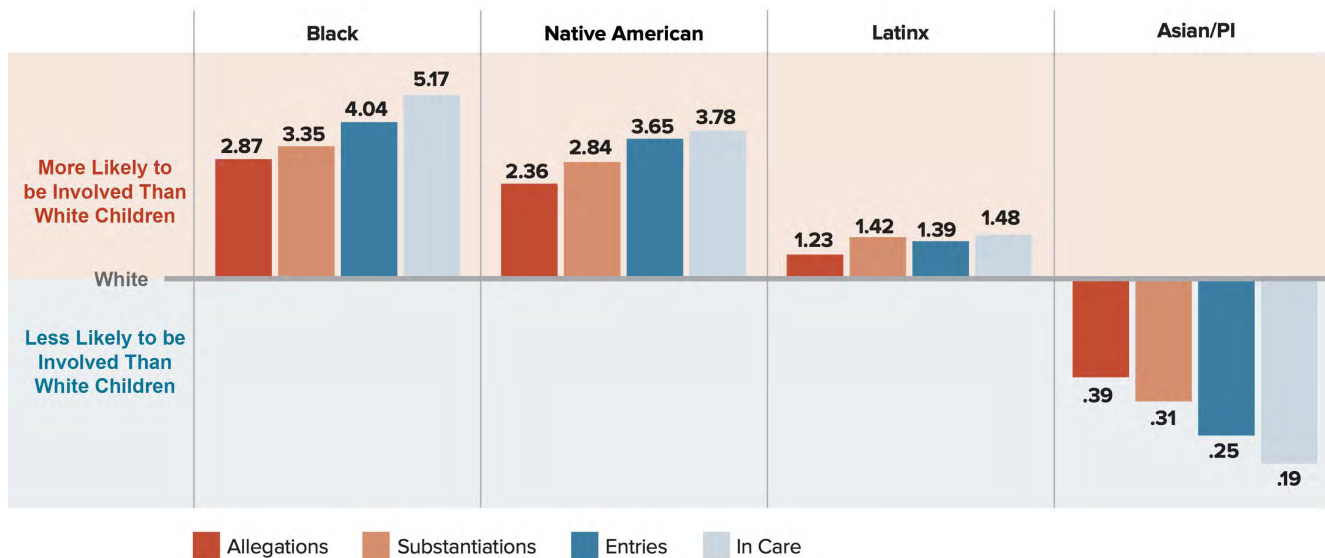
investments and services to communities of color, preventing wealth accumulation.²⁷ Unfortunately, factors like substance use, mental health concerns, criminal records, interpersonal violence, and housing instability are used as proxies for risk of child abuse— factors that are over-surveilled and overreported in communities impacted by poverty.²⁸

In California, one in every two Black and Native children will be the subject of a child welfare investigation in their lives, as compared to 26% of all California children.²⁹ The sheer number of families investigated speaks to our overuse of this system, which is in part due to problematic mandated reporting law.³⁰ In California, 21.5% of children in foster care are Black identifying, four times their percentage of the population of California children (5.4%). This overrepresentation of Black children in foster care is worst in California (see figure of 2019 Disproportionality Index for black children in foster care). Native Americans are similarly overrepresented with the percentage of Native children in care four times that of their percentage of the population (1.24% vs. 0.3%). Latinx children are 51.5% of the foster care population, comparable to the state’s population of Latinx children (48%). White children comprise 29.2% of the state’s children and only 20.9% in care, and Asian children, comprising 12.7% of the population, make up only 1.87% of the in-care population. These disparities warrant action and accountability, both of which have been a priority for child welfare for decades, yet little has changed.

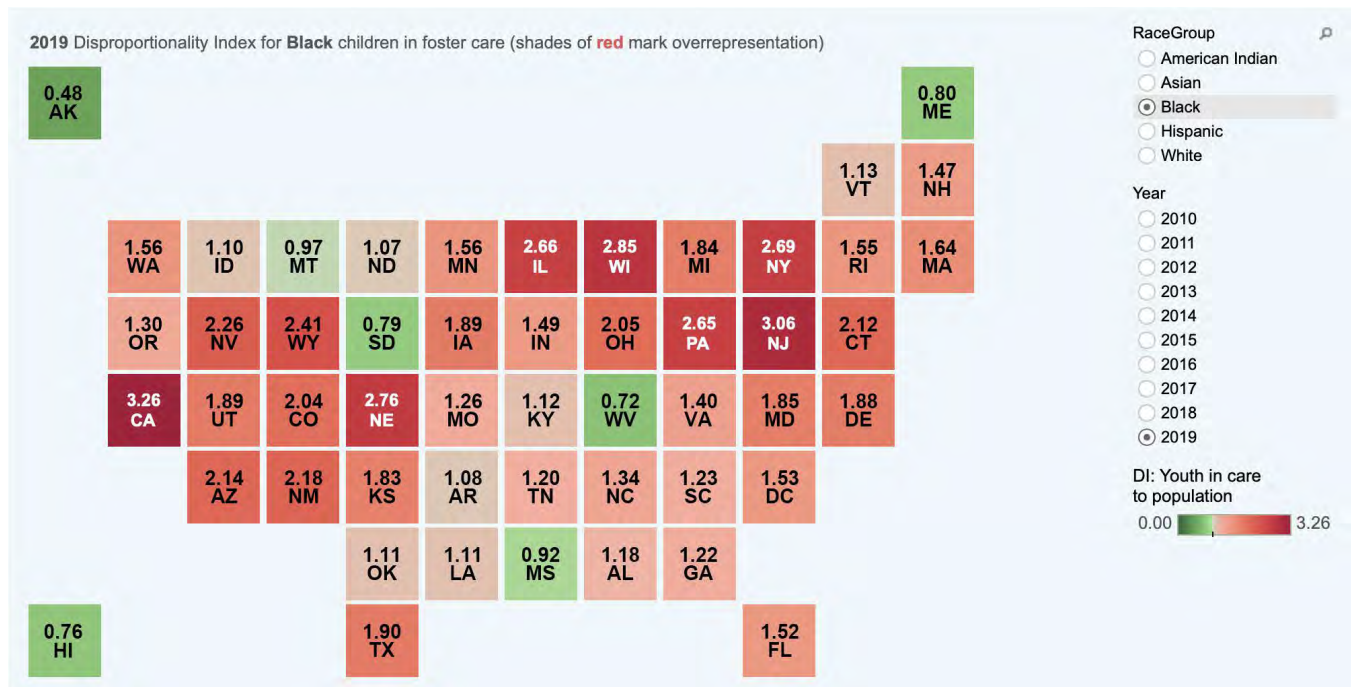
Racial Disparity Indices, January-December 2020

(General Population)

Baseline California Data Trends: Ethnic Group Disparity Compared with White Children Along Child Welfare Continuum



CCWIP report: [Continuum of Care Reform: The Promise, Progress and Moving Forward](#)



From the National Center for Juvenile Justice/AFCAR- Disproportionality Rates for Children of Color in Foster Care [Dashboard](#)

“The proximity of policing to clinical care is nowhere closer than on labor and delivery.”

—MISHKA TERPLAN, MD (OB/ADDICTION)

The majority of child removals are due to neglect, representing more than 85% of removals in California overall in 2020 and 87% of removals in San Francisco.³¹ The largest subset of these removals occur in infancy (about 20% in SF) and are due to maternal substance use, coupled with risk factors. Studies have shown Black women with substance use were up to 10 times as likely to be reported to child welfare, as were women living in poverty.³² In our hospital, the newborns removed are primarily white, due in part to the demographic of the opioid epidemic, despite them making up only 11% of the birthing demographic in our institution. Only 1 in 3 infants removed for parental substance use are ultimately reunified, and non-Hispanic Black infants have a significantly lower rate of reunification than non-Hispanic white children.³³

To understand the racial disparities in testing and reporting for substance use, it is important to highlight the Amnesty International report published in 2017,¹⁵ *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs*. This report outlines a history of “repressive drug control policies in the so-called ‘war on drugs’ and a political turn toward stigmatizing urban poverty,” and articulates how women have been prosecuted for their behavior in pregnancy along racially disparate lines. “The American Civil Liberties Union Reproductive Freedom project first documented prosecutions in 1990; by 1992, there were more than 160 prosecutions in 24 states. About 75% of the prosecutions were brought against women of color, though approximately 75% of the US population was white.” The vestiges of these racist and misogynistic practices remain baked into state and hospital policy and continue to perpetuate disparate racial and gender harms on the communities entrusted in our care. For example, until 2010, federal law only required reporting of “illegal” substance use but not alcohol exposure,³⁴ despite robust evidence that alcohol exposure is the most common prenatal exposure and associated with significant adverse effects in short and long-term.³⁵ Despite the change in

this law, providers are more likely to contact child welfare about illicit substance use than alcohol exposure.³⁶

Given the inequitable representation of BIPOC families in foster care and secondarily, the increased likelihood of being involved with the criminal justice system, many scholars and abolitionists view child welfare as an arm of the carceral complex and in need of radical transformation or elimination. “Residents of Black neighborhoods live in fear of state agents entering their homes, interrogating them, and taking their children as much as they fear police harassing them in the streets.”²⁹ Much of the racial disparity in the foster care system has been attributed to the over-surveillance of people living in poverty, and institutional racism.³¹ These racial disparities are amplified at each step—from allegation to substantiation to out-of-home placement. Thus, the distrust and anger of BIPOC communities toward the child welfare system is well founded.

Another structural factor that may contribute to racial disparities is the use of predictive analytics to inform risk models in our child welfare system, similar to those used in policing. Across the nation, the most common tool to ascertain risk and safety is the Structured Decision Making (SDM) tool.³² In California, ours includes a California Family Risk Assessment³⁷ which assigns an odds ratio (the odds that an outcome will occur given a certain exposure) to twenty items correlated with risk of maltreatment. The tool does not distinguish between previous versus current substance disorder, at times imprisoning parents in their past. It also assigns risk for even *voluntary* (not court mandated) services received. Research supports that the SDM is helpful in predicting maltreatment,³⁸ and many in child welfare feel having a risk stratification in addition to an investigator’s assessment has fostered a more objective determination and led to less biased decisions.

Legal scholars, however, urge caution in the application of these “objective” tools.³⁹ In

Automating Inequality, Virginia Eubanks describes the risk of using proxies to determine risk of harm, especially when “the choice of proxy variables, even the choice to use proxies at all, reflects human discretion,” thereby baking in bias (choosing a variable that has disparate representation, perpetuates the disparity).⁴⁰ The variables themselves are drawn from data collected *exclusively from public records*, which thereby engineers the surveillance of people living in poverty, and misses middle and upper class families, serving as an engine of poverty management. In our hospital, we realized one of the “risks” which triggered a urine toxicology test (absent prenatal care) was more common in Black identifying patients and would lead to increased testing of Black parents relative to others. Identifying and eliminating risk proxies (variables) seen disproportionately across racial subgroups is an opportunity for broader systems reform.

Section 2: Stigma of substance use disorder in pregnancy, fear of Child Welfare, and their impact on access to care

The population we have focused our research and efforts around are parent-baby dyads impacted by substances. Pregnant persons using substances are often shrouded in shame and secrecy, and the way we treat them can affirm or allay their fears of judgement and child removal. They are one of the most stigmatized groups in our society and medical providers have played a significant role in perpetuating this stigma.³⁶ Despite our knowledge that substance use disorder (SUD) is a chronic relapsing illness—strongly correlated with greater burden of ACEs³⁷—we continue to hold implicit beliefs that it is a moral failing. This is especially true for non-white parents, as evidenced by the criminalization of pregnant mothers who used crack (more often “inner city”) in contrast to the public health crisis of mothers who use opiates (more often white rural/suburban^{41,42}). Such beliefs manifest themselves in how we speak to and about patients, how we perceive their “fitness

to parent,” and how we choose whom to report to CPS.³⁶ By perpetuating this stigma, we impair our ability to take advantage of the pregnancy period to engage families in care and implement prevention strategies to mitigate the risk of child maltreatment, ACEs, and toxic stress.

One study examining the role of stigmatizing language on the care of mothers with opioid-use disorder found that though respondents supported opportunities for maternal recovery, they nevertheless blamed mothers for causing harm to their newborn.³⁶ 85% of respondents agreed the mother was “responsible for her opioid use,” her “addiction was caused by poor choices,” and that she “put her baby in danger”—revealing deeply held beliefs that addiction is a choice, rather than a chronic illness. These beliefs are particularly harmful when held by medical providers and other mandated reporters of child abuse, as they shape reporting decisions.³⁶

“I was very picky and cautious [about] what I told any doctor that I saw for prenatal care. Because the worst thing for a doctor to do is write down that you use drugs. Every single medical provider that I have ever encountered... looks at you instantly [and] assumes that you’re going to relapse... [They don’t] care that it has been four, or five, or six years since you ever did anything... It doesn’t matter what you have worked on...You’re a drug addict.”

—CLIENT AT THE HOMELESS PRENATAL PROGRAM, SAN FRANCISCO

Pregnancy is a powerful window of opportunity to engage parents in recovery from SUD. As providers of prenatal and pediatric care, we know parents want a better life for their children and are often motivated to make positive changes as their family grows. Parents who use substances often cut back or stop using when they become aware of their pregnancy.⁴³ Those who are unable to do so are deep in their substance use disorder and are even more in need of intensive high-touch, patient-centered, tertiary prevention strategies, and engagement.

Unfortunately, those very same people avoid or limit their care,³⁹ because they know that disclosing substance use, unstable housing, or other needs may trigger child welfare involvement. Instead, many “engage in a selective or constrained visibility, concealing their hardships, home life, and parenting behavior from potential reporters.” This fear of full disclosure of health information, while perhaps protecting families from child welfare reports, may preclude opportunities for assistance⁴⁴ and cause further marginalization. Furthermore, avoidance of prenatal care is worrisome to providers and child welfare alike and increases the likelihood of a newborn report or removal. In these ways, the position of health care providers as mandated reporters at times undermines their ability to form therapeutic relationships and engage patients in care to support their recovery and mitigate the risks to newborns.

Even for families who have established trusting provider relationships during the prenatal period, the birth hospitalization is often traumatic.⁴⁵ Many hospitals continue to use stigmatizing language and enact dehumanizing policies for patients with a history of substance use, which creates an atmosphere of judgement and distrust. For example, many parents are tested for substances on arrival at the hospital, despite being honest about their use or lack thereof, making it clear we do not trust them. Immediately after delivery, substance-exposed newborns are often whisked away to the Neonatal Intensive Care Unit (NICU) to be monitored for signs of withdrawal, and not allowed to breastfeed because the milk may contain harmful substances, or providers anticipate the parent might use again. Moreover, in subsequent days, infants exposed to opiates—whether prescribed or not—may exhibit signs of physiologic opioid withdrawal, and parents often struggle with profound guilt upon seeing

“Our data show clearly that most of the mothers we enroll in [Parent-Child Assistance Program](#) were themselves abused, neglected, and deprived children just a decade or two ago. Turning our backs on them because they are difficult to work with does not make their problems go away. It does ensure that these women will continue to experience a host of problems associated with intergenerational substance abuse, and continue to bear children who suffer in turn.”

their baby exhibit these symptoms. This guilt is exacerbated by hearing stigmatizing language used to describe themselves and their newborns, reinforcing feelings of shame and distrust. These traumatic experiences impact the course of an individual’s recovery in the postpartum period and their decision to seek care in future pregnancies.

The perinatal period is one of immense potential for positive change, or profound trauma, in which the consequences have the potential to span decades. As a society, we must dismantle the systems in which fear of losing their child precludes families from accessing care, which in turn leads to worse outcomes including traumatic birth hospitalization, and child removal. Instead, we must seek to build in its place a system guided by those with lived experiences and rooted in relationships, wherein expectant parents trust they can safely disclose their needs and be connected to essential resources in their community. Such interventions mitigate risk, reduce harm, and enable us to support families in achieving healthy birth outcomes, and in connecting to support before there is any need to make a report to child welfare.

Section 3: Harms of separation may outweigh the possibility of harm which triggers removal

Harm to the newborn

The harms inflicted by separation of the newborn from their birth parent can begin to accumulate almost immediately, serving as the first of a compounding series of ACEs.⁴⁶ Newborn neural pathways and physiologic responses are regulated by close and nearly constant contact with their birth parents. Separation induces heightened autonomic nervous system (ANS) activity and cortisol levels—which utilizes excess calories and may compromise newborn growth and brain development during a critical period.⁴⁷ Additionally, early heightened activation alters homeostasis setpoints for life, with the most studied outcome being obesity, and likely hypertension, hypercholesterolemia, and diabetes, America's leading causes of mortality.^{9,10,26} Furthermore, physical separation compromises trust and adaptability to the newborn's cues between birth parent and newborn. Separation of even a week in the first two years has lasting negative consequences, including insecure/disorganized attachment and subsequent mental health problems.⁴⁸

The harms of separation continue to accumulate as newborns are placed into the foster care system. Research shows that young people who experience foster care have higher rates of delinquency, teen pregnancy, economic disadvantage, homelessness and incarceration than their peers.¹² Even children who are in and out of foster care within 30 days carry a residual trauma burden.¹³ Rates of abuse and neglect, including fatal abuse and neglect, are significantly higher in foster care than in children who aren't involved in the child welfare system.⁴⁹ However, the better comparison would be to compare children who have been in foster care, to children who similarly had experiences deemed to be neglect but *remained in their homes*. Doyle and peers, through complex modeling, were able to do just that.¹² They found the outcomes were still

better for those children with experiences deemed to be neglect who remained in their homes, when compared to outcomes of children in the foster system. The cause of these poor outcomes is not well defined, and likely involves a complex interplay of factors including trauma and identity loss, ACEs, and several psychosocial factors.⁵⁰

It is thought that poor outcomes for children in foster care may be due in part to a lack of stability and repeatedly broken attachment and trust; yet efforts to improve these factors have not dramatically improved outcomes.¹² The Adoption and Safe Families Act (ASFA)⁵¹ sought to mitigate these harms and improve placement stability. ASFA sets timelines for termination of parental rights, elevating a goal of permanency—second only to safety. Unfortunately, the effort to reduce transitions for the child creates a parallel process of seeking permanency outside of the family which can create barriers to reunification.⁵² The statutory time allotted for parents of a newborn to demonstrate a positive behavior change and regain custody of their child is just six months (though often extended). More often than not, this doesn't align well with the trajectory of recovery⁵¹ and has led many to advocate for the repeal of ASFA.^{53,54,55} Further, ASFA allows courts to permanently sever a child from their parents without “any requirement of a showing that the parents have harmed their children or that maintaining the relationship would be harmful to them.”⁵⁶



https://co-invest.org/wp-content/uploads/CCW_Co-Invest_Insights_DIGITAL_FINAL_060617-3.pdf

Harm to the parent

The process of removal profoundly impacts parents, particularly those with substance use disorders or generational trauma. The parents who make it through pregnancy using substances are extremely likely to have grown up with multiple ACEs and few protective factors (see figure in Part II: The Solution).^{57,58} When faced with the trauma and gut-wrenching guilt of having their own child removed from their care, their responses cannot be expected to be balanced or measured. Yet in those horrific moments, the health care and child welfare systems weaponize the maladaptive parental response as justification for removal. The justification for removal may be documented as a “caretaking impairment due to emotional instability/developmental status/cognitive deficiency.”⁵⁹

These moments test our commitment to reform. In these instances, tertiary prevention strategies aimed at supporting parents—including normalizing their experience by treating them with dignity, supporting bonding and breastfeeding, and applauding whatever progress they have made—promote parental resilience and motivate a commitment to recovery.^{60,61,62} Such tertiary prevention strategies aimed at parents will serve as primary prevention strategies for newborns, and work to mitigate the harms caused by cycles



of ACEs. On the other hand, a failure to implement a trauma-informed response can lead to deeply traumatic experiences for the parent-child dyad as well as the staff and providers involved in their care.^c

The trauma of the removal of a newborn is immense for anyone, and can completely derail a person newly in recovery. This experience is

^c The personal experience of the physician authors.

powerfully captured in an article by Kenny et al titled “*I felt for a long time like everything beautiful in me had been taken out.*”⁶³ The voices of people who have experienced this trauma make plain there is nothing comparable to the loss of a child. The article also outlines the secondary consequences of this traumatic separation: “increased use of drugs and alcohol... central in tending to the pain of separation... often synergistically reinforced by heightened structural vulnerability observed in increased exposure to housing instability, intimate partner violence, and initiation of injection drug use and sex work.”⁶² Grant and Graham et al found that “among women whose child had been removed from their care, the adjusted odds of having a subsequent birth increased nearly two-fold and the adjusted odds of having an *exposed* subsequent birth increased three-fold.”⁶⁴ Others have documented a rapid return to pregnancy following a traumatic removal by child welfare, usually before establishing a recovery mindset. One can easily see how the act of removing a newborn from a mother in early recovery could potentially create two generations of unhoused people,⁶⁵ given the considerable proportion of chronically unhoused people who are foster care graduates or have SUD.

Mandated reporters are told repeatedly to err on the safe side and call the child welfare hotline if there are any concerns about potential maltreatment including neglect. Mandated reporting law renders reporters unable to use their professional judgement, and leads to overreporting and distrust. Furthermore, due to the danger of mutual deference⁶⁶ between hospitals and courts, reports made purely out of obligation are given undue weight in the court system, with grave consequences to families. The child welfare system, which stands upon our country’s history of racism and oppression, does not allow for “no-strings-support” for families to build protective factors and avoid the harms of separation, which often outweigh the *possibility* of harm to a child. *First, do no harm.*

Section 4: Laws, policy, and prevention

The laws governing substance use and pregnancy / childbirth are complex, evolving over many years and interpreted variably in different states. In 1974, Congress passed the Child Abuse and Prevention Treatment Act (CAPTA), which has shaped the nationwide system of child welfare and foster care in place today.⁶⁷ In 2016, CAPTA was amended with the Comprehensive Addiction and Recovery Act (CARA) to address maternal SUD and the needs of licit and illicit substance-exposed infants. CARA requires appropriate referrals to residential treatment programs for pregnant and postpartum women. It also reemphasizes the mandate for a “Plan of Safe Care” (POSC—see table)⁶⁸ for all infants affected by any substance use to ensure treatment for the affected caregiver as well as for the newborn’s safety and well-being. Additionally, it mandates that states report tracked data.⁶⁹

PLAN OF SAFE CARE (POSC)⁶⁷

- ✓ A plan designed to ensure the safety and well-being of an infant with prenatal substance exposure following his or her release from the care of a health-care provider.
- ✓ Addresses the health and substance treatment needs of the infant and affected family or caregiver.
- ✓ May be designed by the state’s child protective or child welfare agency, but should involve input from parents or caregivers, the infant’s health-care professionals, the parents’ or caregivers’ substance use treatment service providers, and supportive adults identified by the parents or caregivers.

In California, CAPTA triggers a mandated report after a complete social work assessment determines that a substance-affected newborn is at risk. Pursuant to CARA, a Plan of Safe Care should be made to ensure the parents substance use disorder is addressed, and the dyad has a good plan of care, which ideally happens in pregnancy. Such a plan can create various supportive options for the parents and child. In the future, Family First Prevention Services Act funds can be directed to support the parent entering a residential recovery program with his/her newborn. If the risks are believed to be imminent, the child can be placed in foster care pending positive behavior changes. As noted above, the AFSA laws trigger deadlines to achieve permanency with the birth family, kinship care, or foster care. In the case of a newborn, the deadline is 6 months, though this is commonly extended given the cumbersome nature of the dependency court process.

Each state has varied interpretations of the CARA/CAPTA laws, which contributes to the complexity of decision-making around reporting. While the laws in California provide more pathways to keeping families together and supporting parents than those in some other states, practices at individual clinics and hospitals are often more antiquated, with heavy use of urine toxicology testing and child welfare reporting. California does not require the biologic testing of mothers or newborns with suspected substance exposure; yet many institutions, especially safety net hospitals, use biologic testing to identify and report at-risk families. Because safety net hospitals care for more BIPOC people, then consequently, this “test and report” practice contributes to the racial disparities in reports to child welfare.

In Margaret Loyd’s piece “Planning for Safe Care or Widening the Net,” California is among many states who get zero of the five components right in Loyd’s grading of their implementation of key aspects of the CAPTA/CARA legislation.³⁵ An important gap is that we do not have a true notification pathway to support prevention and public health concerns around parents experiencing SUD; rather we

have a *report with “risks”* process. A notification pathway⁷⁰ could support an uncoupling of services from child welfare in families who are supported adequately and do not have unmitigated risks that would warrant a report. Another opportunity is the Plan of Safe Care (POSC). California initially felt the Child Welfare Safety Plan met this obligation; in other words, there was only a POSC if there was a safety concern (i.e., child welfare was involved). This left children who were substance affected but not child welfare involved without the benefit of this tool, which is potentially a missed opportunity to bolster community-based support for these families. California has begun to revise its statewide guidance especially related to POSCs, but has room for further reforms.

There was hope that the Family First Prevention Services Act (FFPSA) of 2018⁷¹ would be part of the solution, as it shifts funds from foster care to prevention. Unfortunately, similar to the way California implements CAPTA, an open child welfare case is required to be eligible for prevention services under FFPSA. Rather than developing a family and community-centered system to provide families support--especially when the primary concerns are related to poverty or health matters that could be addressed with access to care and services--FFPSA continues to tie marginalized families to the stigmatizing and high-stakes child welfare system. Additionally, the qualifying services are few.⁷² True prevention would mitigate ACEs and build protective factors *before* an open case, and this prevention should be insulated from the child welfare system. For now, each touchpoint within the systems of care and emergency response units have to do the best they can within the confines of the state and federal law.



KEY POLICIES IN CHILD WELFARE

Child Abuse and Prevention Treatment Act (CAPTA) 1974⁷³	<ul style="list-style-type: none"> ✓ Established today's system of CPS and foster care ✓ Defines mandates to report
The Adoption and Safe Families Act (ASFA) 1997⁵⁰	<ul style="list-style-type: none"> ✓ Establishes timelines for termination of parental rights to reduce transitions for the child ✓ Creates additional barriers to reunification of family
Keeping Families and Children Safe Act 2003⁷⁴	<ul style="list-style-type: none"> ✓ Requires Safe Plan of Care established prior to discharge of newborn for at risk infants due to illicit substance use
Comprehensive Addiction and Recovery Act (CARA) 2016⁶⁸	<ul style="list-style-type: none"> ✓ Amendment to CAPTA to address maternal SUD and at-risk infants due to substance use ✓ Reauthorizes funding for residential treatment programs for pregnant and postpartum women ✓ Requires Plan of Safe Care (POSC)
Family First Prevention Services Act (FFPSA) 2018⁷⁰	<ul style="list-style-type: none"> ✓ Redirects federal child welfare funds to provide services to keep children safely with their families and out of foster care ✓ When foster care is required, federal reimbursement for care in family-based setting and certain residential treatment programs is provided

PART II: The Solution

Section 5: Promising practice examples, Plan of Safe Care initiative, and prevention

Primary prevention strategies are targeted at preventing harmful events from ever occurring. These strategies focus on investing in cross-sector policies and programs that promote stable, safe, and nurturing relationships and environments. Medicaid, which cares for BIPOC families disproportionately, could be the engine of our prevention and reform efforts.⁷⁵ Paramount to operationalizing the recommendations below, is the creation of support systems to enable families to remain united and empowered to thrive. Doing so will require deliberate shifting of power and resources through systems and policy reform which should be guided by communities⁷⁶ and those with lived experiences.⁷⁷

For decades, programs have bolstered support for families through visiting home nurses, peer support, and linkages to community-based resources. Part of the solution is in community building and meaningful access to resources and support outside of the child welfare umbrella.^{78,79,80} Health plans and county administrators should be funding local, family-centered initiatives to create pathways for linkage to community-based resources as both counties and communities benefit.^{81,82,83} Breaking the generational cycle of ACEs means not just preventing and mitigating trauma, but building resilient families and thriving communities.

Promising Programs and Benefits to the County & Community

Parent-Child Assistance Program (PCAP)

- ✔ Financial savings from reduced dependence on child welfare
- ✔ Reduced dependence on public assistance
- ✔ Increased employment
- ✔ Increased levels of education

Strong Communities for Children

- ✔ Decreased isolation by creating community among low-income and first-time mothers
- ✔ Enable communities to accept responsibility

Family Connects Durham

- ✔ Reduction in emergency room use by families

<https://depts.washington.edu/pcapuw/>

Melton GB, McLeigh JD. The Nature, Logic, and Significance of Strong Communities for Children. *Int Journal on Child Malt*. 2020;3(2):125-161. doi:10.1007/s42448-020-00050-w

<https://www.ccfhnc.org/programs/family-connects-durham/>

In reviewing promising practices for keeping families together, four concepts emerged:

→ Meeting parents where they are

Health care institutions have long approached care with a dogmatic and authoritative approach, but it is becoming clear that outcomes can be negatively impacted when reciprocal trust is lacking.^{84,85}

The most successful programs identified in our literature review were typically rooted in attachment and trauma theory, emphasizing relationship-centered care^{86,87} and centering the patient.^{88,89} The importance of cultural humility,⁹⁰ shared experience, and racial concordance^{91,92} in supporting families who have been harmed by our systems cannot be overemphasized. Going beyond our hospital and clinic walls is essential to meeting the patient where they are, and Public Health Nurses (PHN) through Nurse Family Partnership⁹³ have been the key evidence-based workforce most commonly utilized in the past, and increasingly peer navigators are bridging the gap. Through these practices and relationships, we can shift agency to the parent, and begin to rebuild trust.

Care innovations such as our local initiatives, Team Lily and Road to Resilience are examples of centering the parent and meeting them where they are. [Team Lily](#)⁹⁴ is a multidisciplinary team

that works with pregnant and postpartum women with significant barriers to care and provides wrap-around care with dignity and flexibility. Providing low-barrier care by providing services in nontraditional settings, or on a flexible schedule, makes it easier for patients with complex circumstances to get the care they need. [Road to Resilience](#)⁹⁵ leverages Peer Health Navigators to bridge pregnant and postpartum parents to the programming they need to support recovery from substance use disorders and ensure safety of the dyad. Many of the above programs are rooted in harm reduction,⁹⁶ which is better suited to our understanding of substance use disorders and allows one to celebrate progress toward improved health, and all of these examples hold the patient as central.

[Expecting Justice](#),⁹⁷ a Black lead cross-sector initiative, is piloting a program called [The Abundant Birth Project](#)⁹⁸ which provides pregnant Black and Pacific Islanders with supplemental income in an effort to mitigate stressors that lead to preterm birth and other poor outcomes. Efforts such as these are also likely to prevent child maltreatment and reduce the impact of ACEs by providing concrete support in a time of need, and bolstering parental resilience, which are both protective factors.^{59,60} An important

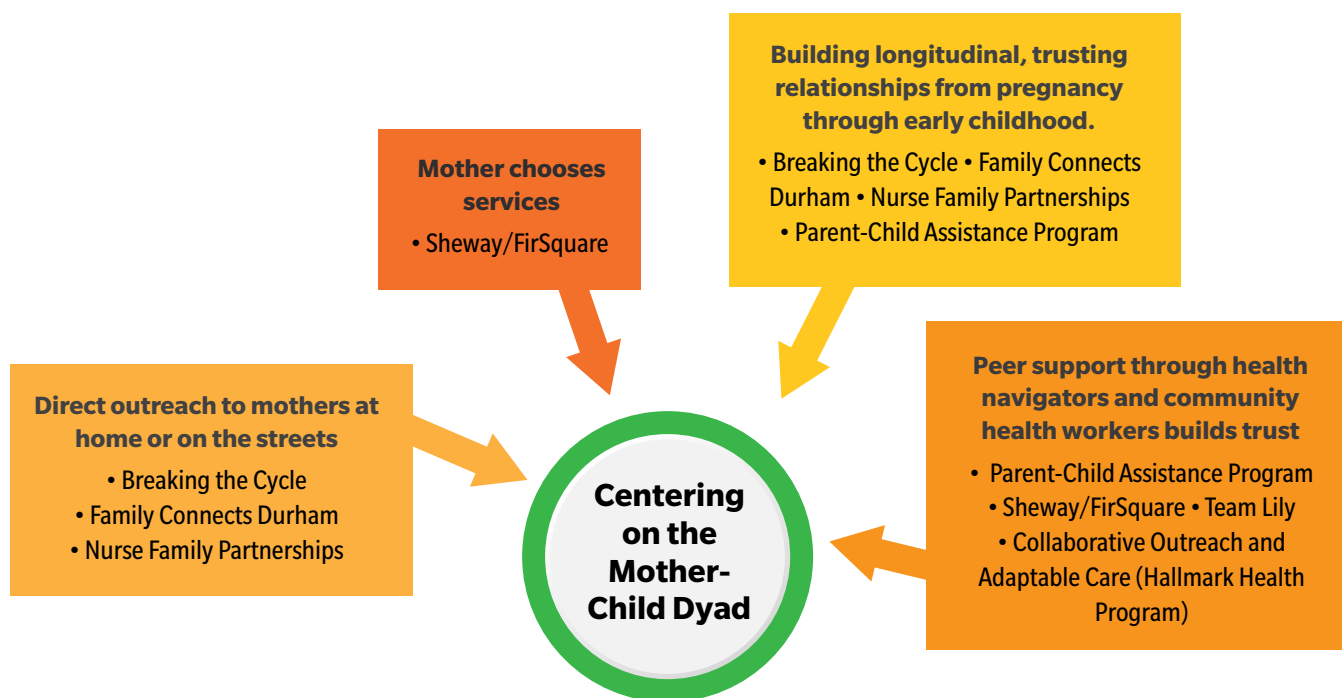
finding throughout the literature is that anti-poverty measures⁹⁹ have a powerful impact on rates of maltreatment and have the best evidence for maltreatment prevention. A young MFTi told me the story of a parent saying, “get your help up off’a me!” Let’s empower people to be the parents they want to be, by supporting them in the ways they identify, and respecting their autonomy and parental rights.



PROTECTIVE FACTORS (from Strengthening Families)^{59,60}

- ✓ **Parental resilience:** managing stress and functioning well when faced with challenges, adversity, and trauma
- ✓ **Social connections:** positive relationships that provide emotional, informational, instrumental, and spiritual support
- ✓ **Knowledge of parenting and child development:** understanding child development and parenting strategies that support physical, cognitive, language, social and emotional development
- ✓ **Concrete support in times of need:** access to concrete support and services that address a family's needs and help minimize stress caused by challenges
- ✓ **Social and emotional competence of children:** family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships

Examples of Promising Programs that Center Care on the Mother-Child Dyad^{92,93,100,101,102,103,104}



“I have seen the drive and resiliency of parents who have made the very deliberate and conscious decision to do everything in their power to be well and present for their kids and raise healthy families, against the odds. I have seen the passion and dedication of providers of all kinds (medical, behavioral, child welfare, community) who want that for the families they serve, too. I want to see systems in place that can truly rise to the challenge of meeting these families half way—of eliminating the structural barriers that they so often come up against. They deserve that much.”

—MARCY SPAULDING, MS, RN, PHN, PUBLIC HEALTH NURSE/CHARGE NURSE, BIRTH TO FIVE PROGRAMS, FAMILY & CHILDREN'S SERVICES NURSING UNIT

→ *Meaningfully engaging community support*

Meaningful community engagement is an equally important part of the solution. This has been exemplified by Family Connects Durham,⁸² Harlem Children's Zone,¹⁰⁵ and Strong Communities for Children³⁰ in South Carolina. Medical institutions have often been disconnected from the communities they serve and thus, from the resources and people dedicated to the wellness of the families who live there. Faith-based organizations and community-based organizations (CBOs), including Family Resource Centers (FRCs),¹⁰⁶ often have myriad offerings to support families that can prevent child maltreatment and removal. In cases where there is not a safety risk to a child, particularly where the issue is related to poverty, child welfare will commonly refer families to FRCs for support and case management. FRCs are invaluable community resources available to everyone, and do not require referral to child welfare or opening up of a child welfare case to qualify for their services. Crisis nurseries and respite care are additional resources that help keep children out of the child welfare system by supporting families with childcare in times of need.

It is important to ensure the entities you partner with are trusted by the people you serve by seeking community input before choosing whom to refer to or integrate into your Plans of Safe Care. Patient advisory boards and community-based organizations serving your clients/patients have a unique perspective to share. In academia, we are often beholden to what is evidence-based to inform decisions and funding streams. While it is critical that we look at impact, some of the most trusted partners doing work in our communities are not grant-funded or research-oriented and don't have the bandwidth or resources to look at data with the rigor needed to be evidence-based by academic standards. This contributes to a weakness of the FFPSA, which is that only evidence-based programs (in their clearinghouse) can seek reimbursement for preventative services,



leaving very few ways for many communities to divert these funds from foster care to prevention.

A wonderful example of community engagement was the SF BIPOC-Lead Family Justice Summit in fall of 2020. BIPOC community leaders organized a two-day gathering of over 50 San Francisco organizers, advocates, clinicians, lawyers, and people impacted by the child welfare system. They then spent much of a year distilling transcripts of these conversations into a [report](#)⁷⁵ which includes recommendations directed to multiple community stakeholders including schools, hospitals, and policymakers. Find your local BIPOC changemakers, engage them, and listen to them.

Mia Birdsong articulates the importance of community and chosen family in her book *How We Show Up*. Throughout stories of different family configurations, often LGBTQ or Black, the author makes a compelling case for broadening the definition of family and community-rooted support systems.¹⁰⁷ Child welfare should expand the definition of family, so that in the rare instance children are removed, they remain with familiar people, in familiar customs, with the highest chance of staying connected with their families. Complimenting the essential informal support of family and friends, a Community Health Worker (CHW) is more likely than traditional providers to have shared experiences, and more

“I have seen mother’s and families in the depth of addiction and despair benefit tremendously from having a navigator like myself. In building connection they feel supported, free from shame and guilt. Having someone believe in them and walk with them through the process without giving up on them when mistakes are made allows them to attain sobriety and live a happy and healthy life with their baby.”

—TERESA RONDONE (TEAM LILY PEER NAVIGATOR/CHW)

likely to be culturally concordant.¹⁰⁸ CHWs can bridge the gap between the patient and the professionals. For example, the Collaborative Outreach and Adaptable Care at Hallmark Health Program¹⁰³ created a multidisciplinary care team in Massachusetts to coordinate outpatient care for pregnant and postpartum women with opioid use disorder, and CHWs played a key role in regularly engaging with patients and helping them enroll in services and programs. Despite being mandated reporters, these CHWs were able to build trusting relationships that enabled women to disclose their challenges and social needs that they were less likely to share with their medical providers.¹⁰⁹ With a more holistic understanding of their patients’ strengths and challenges, the care team could develop actionable, realistic goals guided by their patients’ priorities, which encouraged families to remain involved with the program and seek help rather than disengage.

At our county hospital, we have seen parents who had declined much needed services begin to engage after a nod from a CHW who was able to earn their trust. This peer-based workforce is an indispensable asset which Medicaid recognizes as offering a reimbursable service. In 2020 with the passage of SB 803, California joined 47 other states which access Medicaid to reimburse for CHW (aka Peer Support Specialists) expenditures, so their role is expected to grow. As many of our clinics and hospitals work to diversify their workforce to reflect their patients, the peer health navigator workforce is often much closer to the community and can provide connections that are more culturally relevant and accessible. They also may be better able to meet the patient where they are, which can be immensely helpful for those who struggle to engage in traditional systems of care.

“I feel like I could go to [my case manager] for anything... Believe it or not, she was on the streets at one point. Like there is no judgment... If I say I can’t afford to get a new bottle this month, she is not going to be looking at me like I can’t afford my kid. She [says], ‘Maybe we can find you a bottle.’ If she can’t help me, she will know where to send me. I [appreciated] just getting to know her and knowing her story, and knowing how she started here at Homeless Prenatal.”

—CLIENT FROM THE HOMELESS PRENATAL PROGRAM

→ **Solutions during pregnancy and birth for parents experiencing substance use disorder**

For birthing parents with substance use disorders, pregnancy can be an incredibly motivating time. It offers the potential to break the cycle of trauma by harnessing the profound love of a parent for a newborn, by surrounding them with social support including a peer health navigator and/or a public health nurse, or community case manager, and offering the opportunity to enter drug treatment programming with their newborns.

Innovative care programs provide prenatal care wherever possible and recognize the challenges some face accessing traditional models of care. Outreach efforts by CHWs, doulas, and PHNs are critical to the success of these programs, in part because of the relationships they forge, which facilitate trust. When engaging with parents who have been racially marginalized or stigmatized, providers need to understand that trust is a two-sided coin. We cannot expect trust and alignment without affording trust. Listening to our patients, honoring their unique experiences and values, and trusting them is foundational to establishing alignment and trust. As we shift our culture to center around relationships and harm reduction, more people will feel safe disclosing substance use which will lead to more resources and support directed to families.

Traditionally, birth hospitals have not been the most welcoming to BIPOC birth parents,⁸⁴ or to those with substance use disorders.^{36,39} Doulas are increasingly supporting racially and otherwise marginalized women in navigating the process of birth—making sure their voice is heard and they feel safe and respected.^{110,111} Many institutions offer training in Relationship Centered Communication^{85,86} and Respectful Care¹¹² to develop the capacity of providers and staff in these healing models of care and to help create inviting spaces for parents. Because of the limited utility and racially disparate application,¹⁴ some clinics and hospitals are also narrowing indications for

urine toxicology testing to those that are essential to direct clinical care and favoring universal verbal screening with a validated screening tool. At our hospital, we found indications for urine toxicology that would lead to overrepresentation of Black birthing parents among those tested, and removed them. The more we can use non-stigmatizing language and practices that don't disadvantage any subgroup, the more welcome and safe families will feel.

One part of any plan should be finding ways to allow parents and babies to bond in the hospital and to support breastfeeding. With new evidence to support rooming-in and functional scoring¹¹³ of substance-exposed newborns, we have license to optimize early skin-to-skin contact and bonding of the dyad. This is an antidote to our earlier practice of separating parents and babies, which Ron Abraham of Fir Square was early to recognize as a contributor to withdrawal symptoms.^{114,115} Breastfeeding can be supported in most prenatal exposures, and in the cases of recent stimulants or illicit opiate use (in which there is a concern for stimulant contamination) there should be a pathway to breastfeeding if the parent is engaging in recovery planning, however nascent. Pumping and discarding until a urine toxicology is negative, usually 72 hours after exposure, is a way to support breastfeeding in a new mother entering recovery.

Further, the Plan of Safe Care (POSC), discussed above, can be used to understand the true needs of families and support substance-impacted or other socially complex families in creating a plan to optimize the safety and care of themselves and their child. Ideally created in collaboration with a patient and their care team during pregnancy, POSCs should be strength-based, and patient-centered. The birth parent sets their own goals, identifies the support they would like or have, and revisits their plan as their circumstances evolve. This process helps ensure a family has linkages to meaningful support prior to the birth of their newborn and builds essential trust and transparency. With connections rooted in

communities, there is a potential to mitigate risks that might lead to maltreatment or trigger a newborn child welfare call, and to support the new parent in being their best for their baby. Similarly, if child welfare is called, a robust POSC can facilitate keeping newborns with their parents by outlining the support and services to support a safe start. The Plan of Safe Care is by design a dynamic process and meant to leverage community and trusted connections in support of families impacted by substance use or other complex circumstances. New York has an excellent strength-based example of a POSC in the appendix of the Pregnancy and Substance Use Harm Reduction ToolKit.¹¹⁶

When there is a risk to a child's safety and a new dyad requires child welfare involvement, inviting their entire care team to inform a multidisciplinary decision ensures the team has a shared mental model and each fully understands the strengths and challenges of the dyad. These conversations should be well documented, and if a report is made, it should be clear who will be involved in the call. When a report is made, it is ideal to ask the parent(s) whom they'd like to have available to support them and to prepare them as much as possible before a case worker arrives for an investigation. It is difficult to advise families on what to expect, as many variables are considered and outcomes can be unpredictable to say the least, but we can affirm that we will be with them throughout the process in support of their parenting goals. Mapping out the process and timelines can at least give shape to the shadow in the room—the fear of unbearable loss. Increasingly, at least in San Francisco, child welfare is supportive of discharging a newborn to residential treatment if a solid safety plan is in place.

→ **Postpartum and early childhood solutions**

The early childhood window is a critical period of vulnerability and rapid development, and the postpartum period can be especially challenging for new parents. While a newborn can be motivating, it can also be exhausting and stressful, and potentially compounded by lost wages, postpartum depression, or relapse. This is not the time to check a box and walk away, and while the periodicity of well child visits engineers regular opportunities to check in on families and offer support, many families will require support between these visits with other members of the care team.

Nurse Family Partnership¹⁰² and similar Public Health Nurse (PHN) models¹¹⁷ have proven to be integral in meeting families' needs outside clinic walls. These trusting relationships are increasingly augmented by case managers or peer navigator/CHWs associated with local CBOs or FRCs who are able to support myriad needs in more nimble ways than a primary care provider typically can. Mandated reporting laws can create strain on these relationships, so it is important these services are engaged in without coercion. The more we can move our health care delivery systems toward an integrated all-in-one visit, the more likely it is that the family will get their social, emotional, and physical needs met, such as in the [Healthy Steps model](#).¹¹⁸ Even without an integrated clinic, offering flexibility around appointment and arrival times can go a long way in honoring our patients' efforts to seek care. Referrals to Early Intervention and the Infant Parent Program (IPP) are often recommended for substance-exposed newborns, and both can enhance the protective factor of *knowledge of parenting and child development*.

Regarding substance impacted newborns, more states should explore a *notification pathway*.⁶⁹ This could meet CAPTA reporting requirements by feeding aggregate data to child welfare, while maintaining anonymity of those families without safety concerns. This would allow the **uncoupling**

of supportive services from Child Welfare oversight in cases where there is no concern for imminent harm. One example is a [“Model Flowchart for a CAPTA Compliant Notification”](#) by Colorado Coalition to Protect Children and Family Rights.¹¹⁹ Some states house the notification pathway within child welfare, but legal advocates recommend notifications be made to a separate system from that used for reports of abuse.¹¹⁸ Importantly, the notification system provides a means of tracking population health to help ensure the needs of families impacted by substance use are met. This population data can help identify gaps in the network of resources and direct investments at the community level. If states create a notification pathway for families who qualify for a Plan of Safe Care and are adequately supported in their community (or for those at “risk of neglect” due to living in poverty), we could decrease the number of unnecessary reports to child welfare. Strategies such as Plans of Safe Care are examples of secondary prevention measures which, if disentangled from reporting, have the potential to help ensure families receive the support they need to mitigate ACEs and build protective factors.

Communication remains a tremendous challenge in the healthcare and social service settings. Understanding who is on a dyad’s care team, what they are working on, and how to reach them if the parent has consented, would help ensure we are able to mobilize a dyad’s trusted allies in times of need. This safety net is missing or lacking infrastructure in most of our current systems, which leads many to call child welfare when they are worried about a family’s ability to care for their children, or the conditions the family is experiencing. This concern is the driver of most calls to the child welfare hotline and could be addressed by building a notification pathway to support families without involving child welfare when there isn’t an imminent risk of safety to the child. Investing in patient-centered, HIPAA compliant care coordination technology, to allow communication across systems and with the patient is essential to leveraging community

support. Creating a notification pathway outside of child welfare to address SDOH needs would be a key step toward reducing unnecessary calls to child welfare.

Section 6: How do we better support families who will be involved with child welfare?

As systems of care, we need to advocate for early family support and treatment whenever possible to help families stay together and to not experience the stigma and trauma associated with child welfare intervention. However, when there is a safety concern for a child, we have an obligation to prepare families for child welfare engagement and support them through the process. We should share our understanding of the Safety Organized Practice (SOP) child welfare uses, and what to expect throughout the process. “Safety Organized Practice aims to address limitations of standard child welfare practice by providing tools, strategies and a framework for practice intended to achieve lasting behavior change by parents. SOP also promotes age-appropriate involvement of children/youth in their own cases, and development of natural support networks that will help ensure child safety both during and after child welfare involvement.”¹²⁰ Preparing and educating a family on what to expect from child welfare, can help a parent have a sense of agency in a process that is frightening and poorly understood.

Even with preparation, being investigated for child maltreatment is stressful, and can be especially retraumatizing for families who have been involved with the child welfare system. There are strategies to support families who have histories of trauma, which may include generational trauma, racial discrimination, being unhoused, intrapersonal violence, or any number of other experiences. Using person-first, non-stigmatizing language and centering the patient restores dignity and humanity.¹⁰⁷ As discussed above, leveraging trusted relationships can help mitigate anxiety and fear when the stakes are high, as in conversations

around safe discharge plans. These trusting relationships are often found amongst people with shared experiences, or cultural concordance, such as CHWs or parent advocates. Lastly, a Harm Reduction framework allows us to celebrate any progress made toward a healthier future and recognizes relapse as an expected part of the recovery journey. This is vastly different from the dichotomous framing of the War on Drugs, which still holds sway in our laws, policies, and practices, but can be helpful framing for teams involved in the care of a parent with SUD.

For most families, the threat of disruption can provoke a toxic stress response in both parents and children alike. This is especially true for people who have already experienced changes to the regulatory function of their neurologic, endocrine, immune, metabolic, and genetic systems due to a history of toxic stress & its physiologic consequences.²⁷ The toxic stress response can negatively affect pregnancy and can lead to parenting behaviors that adversely impact child health outcomes,¹²¹ making this an important target for secondary and tertiary prevention. Educating families about the toxic stress response, its impact, and ways to buffer their impact is key. There are evidence-based, integrative strategies that have been shown to “reduce stress hormones, reduce inflammation, and enhance neuroplasticity.” These include healthy relationships, high-quality, sufficient sleep, balanced nutrition, regular physical activity, mindfulness and meditation,¹²² access to nature, behavioral and mental healthcare (see figure). Ideally, parents with significant ACEs and toxic stress are supported to engage in these mitigating behaviors before Child Welfare is involved, with a trusted member of the care team.

Many systems, including child welfare, are working to educate their staff around how trauma and ACEs manifest, and a common language is taking root. The Trauma Informed Systems Initiative (TIS) in San Francisco is one promising example. This initiative, led by the San Francisco Department

of Public Health (DPH) and Oakland-based [Trauma Transformed \(TT\)](#),¹²³ focuses on reducing trauma through a Healing Organized practice, by educating staff and providers, and by reforming practices and policies in youth-serving systems of care. TT and DPH have trained over 17,000 people across multiple settings including health care, education, and community-based organizations throughout the greater Bay Area. How this and similar efforts will impact the patient/client’s experience remains to be seen. Our understanding of poverty and substance use has grown rapidly in recent years and our trainees are increasingly skilled at person-first destigmatizing language. It is essential we develop our workforce so that each conversation is undertaken with humility and care for a family’s trauma at the hands of our system, lest we continue to add to the cumulative burden.

For system involved parents, family defense lawyers working with interdisciplinary teams, such as [East Bay Family Defenders](#)¹²⁴ and [The Bronx Defenders](#)¹²⁵ are providing parents with quality representation, and decreasing the time to reunification and days in foster care.¹²⁶ Also, within the child welfare system there is promising evidence to support the use of Sobriety Treatment and Recovery Teams (START)¹²⁷ as these teams have been shown to increase the likelihood a family can stay together and sustain recovery by facilitating access to treatment and providing peer support. [Family Treatment Courts \(FTC\)](#) have a similar record of helping families with SUD stay together or by facilitating reunification.¹²⁸ FTC programming is voluntary and includes intensive case management, SUD treatment, and skills development. Lastly, [Casey Family Programs](#) highlights pilot programs¹²⁹ in which willing parents and foster parents partner to support reunification and long-term family strengthening and support. Advocating for these or similar programs when appropriate, as well as any support the patient/client feels aligned with, can help support them through the harrowing process of being involved with child welfare.

EXAMPLES OF PROMISING PROGRAMS

Community-Based Programs & Community Outreach

<p><u>Breaking the Cycle</u>¹⁰⁰</p> <p>Toronto, Canada</p>	<ul style="list-style-type: none"> ✓ Early intervention and community-based program for pregnant and parenting mothers who use substances, providing street outreach & home visitation services ✓ Grounded in relational, attachment, and trauma theory ✓ Successfully engaged homeless and substance involved women at earlier stage in pregnancy (about two-thirds engaged in first and second trimester); about 3 referrals made per woman, and over 50 percent of the referrals resulted in women successfully engaging with the referred providers
<p><u>Parent Child Assistance Program</u>⁸⁰</p> <p>Seattle, Washington</p>	<ul style="list-style-type: none"> ✓ Model based on relational theory, motivational interviewing, and harm reduction ✓ Case workers and paraprofessionals develop trusting and supportive relationships with families, conducting home visits 2x/month for three years ✓ Program has decreased child removals, increased access to treatment for SUD, and resulted in fewer subsequent births of substance-exposed infants (12% of mothers enrolled in PCAP had subsequent substance-exposed infant within 3 years, compared with 21% of similar mothers without intensive case management)
<p><u>Strong Communities for Children</u>⁸¹</p> <p>South Carolina</p>	<ul style="list-style-type: none"> ✓ Community engagement with community-based volunteers as outreach workers to support families, especially with young children; goal to enable communities to accept responsibility for parent support and child safety ✓ Outreach workers build on the resources that they have cultivated to promote the creation of volunteer-delivered support (occasional childcare, food banks, financial counseling, respite care) for families of young children in settings not commonly identified as providers of family support service (fire stations, faith communities, libraries) ✓ Demonstrated that programs can enlist communities in care for children and support for the children's parents and to sustain and deepen that involvement across several years; similar models adapted in other communities, such as fully implemented model in Tel Aviv, Israel ✓ Mobilization occurred in diverse communities, with the greatest success occurring in the most disadvantaged communities
<p><u>Sheway/FirSquare</u>⁹⁹</p> <p>Vancouver, Canada</p>	<ul style="list-style-type: none"> ✓ Community-integrated program with wrap-around services (peer support at drop-in to addiction and/or trauma counseling) with commitment to caring for dyad, based on mother's goals ✓ Mothers choose services to receive (SUD and trauma counseling, meal support, baby supplies, nutrition counseling, practical support navigating medical care/housing/social benefits, medical care for mother and child, parenting support, referrals to support groups & community resources) ✓ Successfully reduced substance use and homelessness among mothers, and reduced adverse obstetric outcomes (low birth weight, preterm delivery, caesarean section)
<p><u>Harlem Children's Zone</u>¹⁰⁴</p> <p>New York City, New York</p>	<ul style="list-style-type: none"> ✓ Provides programming from birth to college with support of local businesses, families, and institutions to break the cycle of generational poverty ✓ 97% of high school graduates get into college, with college completion rates much higher than the national average
<p><u>Trauma Transformed Initiative</u>¹²⁰</p> <p>Oakland, California (DPH)</p>	<ul style="list-style-type: none"> ✓ "Advances trauma-informed and healing-centered system change through community and cross-system collaboration that mitigates stress, trauma, and oppression impacting our communities" ✓ Training providers and staff to support organizational healing and structural inclusion practices

Direct Resource Support	
Expecting Justice ⁹⁶ San Francisco, California	<ul style="list-style-type: none"> ✓ Abundant Birth Project provides unconditional, direct cash aid (direct monthly income supplement of \$1,000–\$5,000 for duration of woman’s pregnancy and first two months of baby’s life) to Black and Pacific Islander pregnant persons to prevent preterm birth ✓ The strain of ongoing financial insecurity contributes to chronic stress and has a well-documented relationship with premature birth; Black and Pacific Islander parents experience greatest financial strain in San Francisco
Nurse Outreach Programs	
Family Connects Durham ⁸² Durham, North Carolina	<ul style="list-style-type: none"> ✓ Family-centered program with universal eligibility ✓ Visiting home nurse (VHN) makes 1–7 home visits to identify family’s needs and make meaningful linkages to CBO partners; also assess safety and educate parents about their newborn ✓ Parent and community ownership contributes to low-cost program with significant reduction in emergency room use by families (by 59% in the first 6 months, and 50% first year); demonstrated \$3 saved for \$1 spent on their program
Nurse Family Partnership ⁹² 40 states in USA	<ul style="list-style-type: none"> ✓ Nurse-home visitation program for first-time mothers and their children; provides preventive health and prenatal care for mother, health and development education for mother and child, and life coaching for mother and her family ✓ Mothers develop close relationships with nurses as trusted resources for advice, caring for their child, and providing a stable, secure future for both ✓ 48% reduction in child abuse and neglect, 56% reduction in ER visits for accidents and poisonings, 79% reduction in preterm delivery in women who smoke, 82% increase in months employed, improved developmental outcomes, fewer arrests of mother and child arrests at age 15
Child Welfare Based Programs	
Sobriety Treatment and Recovery Team (START) ¹³⁰ Kentucky	<ul style="list-style-type: none"> ✓ Child welfare-based program targeting families with at least one child under 6 years old who are in the child welfare system and have a parent with substance use as primary child safety risk factor ✓ Pairs child welfare worker trained in family engagement with family mentors (peer support employees in long-term recovery); uses a system-of-care and shared decision-making approach with families, treatment providers, and courts ✓ Rapid access to intensive SUD treatment services to safely maintain child placement at home when possible ✓ Improved sobriety rates from 47% to 66%, and rate of children remaining with their parents throughout START improved from 31% to 55%
Programs Based in Medical Centers	
Team Lily ⁹³ San Francisco, California	<ul style="list-style-type: none"> ✓ With harm reduction methods and acknowledgement of the harms caused by the healthcare system, the program helps pregnant women to engage in prenatal care in a patient-centered way ✓ Most newborns in San Francisco who were able to discharge to treatment together were nearly all supported by Team Lily, PHNs, or Family Treatment Court; a high percentage of Team Lily graduates have demonstrated sustained recovery
Collaborative Outreach and Adaptable Care at Hallmark Health Program ¹⁰³ Boston, Massachusetts	<ul style="list-style-type: none"> ✓ One among several public health programs developed through collaboration among 4 community hospitals to provide support for mothers with SUD, including healthcare navigation, longitudinal relationships with mothers, and peer support groups ✓ CHWs and multidisciplinary staff implement individualized prenatal and postnatal plans that are driven by patient’s needs, and provide linkage to treatment providers, parenting resources, and community resources ✓ 50% reduction in ED visits 180 days after enrollment; nationally recognized as successful model based in medical home for engaging mothers with SUD



Section 7: Restructuring our approach to better serving the community

Black, Latinx, and Pacific Islander/Native American children are still greatly overrepresented in the child welfare system including in San Francisco and California, despite improvements over the last decades. In a recent publication by Harleman et al, they affirm that “the inequities in birth outcomes experienced by Black individuals are driven by historical and structural injustice that can only be remedied through relationships that shift power, that is, through the application of a critical race lens to relationship-centered care.”⁸⁵ We have an opportunity to stem the tide of children flowing into our foster care system by organizing around pregnancy and early childhood as opportunities for prevention strategies aimed at supporting families and mitigating risks that may lead to child welfare involvement. This direct investment in families, neighborhoods, and communities is likely to be more effective in child neglect prevention and to have lasting positive effects on families and generations to come. Focusing on protective factors to prevent and mitigate ACEs gives families and their care team a sense of agency. Only by breaking the cycle of trauma our systems inflict,

and acknowledging our complicity in past harms, can we begin the long process of healing. Through investing in relationships and the wellness of the communities we serve, we can begin to restore eroded trust and lay the foundation for families to flourish.

As we move forward, we should look beyond trauma-informed care to healing-centered engagement as outlined by Shawn Ginwright.¹³¹ “Without more careful consideration, trauma-informed approaches sometimes slip into rigid medical models of care that are steeped in treating the symptoms, rather than strengthening the roots of well-being.” The roots of well-being start with the protective factor of meaningful connection, especially for families wrestling with substance use disorders.¹³² Clinics and hospitals should not be the center—rather, the patient or client should be the center. We need to look to people with lived experience and hire them as subject matter experts to help us reform our systems to better serve our communities. We are at a tipping point in history, and to be on the right side of it, we must take deliberate steps toward healing historic and current trauma.

PART III: Takeaways & Recommendations

Individual: Shifting agency and power— Meeting families where they are

- ✓ Cultural humility and community input are cornerstones.
- ✓ Center the individual and community in discussions of what is of greatest importance in meeting their needs (such as when completing a POSC, or setting goals)
- ✓ Build relationships with and invest in the community through community-directed efforts.
- ✓ Review recommendations from the [SF BIPOC Family Justice Summit](#)⁷⁵
- ✓ Be accountable to the communities you serve by being transparent, providing race-stratified data; allow communities to determine the metrics of interest.
- ✓ Seek and compensate for the expertise of people impacted negatively by our systems.
- ✓ Offer families at risk of neglect the funds afforded to foster/resource parents (in addition to needed support) for a period of stabilization before pursuing removal for neglect.
- ✓ Make a public apology for disparate harms against marginalized races and stigmatized groups to begin to repair relations.
- ✓ Offer flexibility in timing, location, and duration of services provided, and be empathic and trauma-informed when circumstances prevent a person's timeliness or meaningful engagement

Systems: Identifying and Removing Barriers to Access

- ✓ Review models that remove barriers to care by conducting statewide comparative research.
- ✓ Use toxicology tests sparingly and in a way that doesn't disadvantage or advantage any race or other identity.
- ✓ Evaluate new and established initiatives to ascertain impact and replicability.
- ✓ Support the development of a broad array of SUD residential and outpatient treatment options including models of *harm reduction and family treatment*.
- ✓ Invest in patient-centered technology to allow ease of HIPAA-compliant communication between patients and their care teams (access and coordination).
- ✓ Leverage community health workers with lived experience and cultural concordance in providing accessible support and linkages.

Systems: Building professional, allied professional, and system capacity

- ✓ Train providers, staff, and students how to be patient-centered; inform them about resources available in the community (and how to serve as an intermediary to those resources); and teach them how to advocate for patients (including advocating for revisions in law and policy).
- ✓ Recruit, hire, promote and retain staff and providers who reflect your patient demographic and have shared experiences.
- ✓ Train a community workforce such as CHW or peer navigators to support families where they are, make successful linkages, and navigate our systems of care.
- ✓ Train mandated reporters about meaningful linkages to support families when there is not a concern for the imminent safety of the child.
- ✓ Train providers and staff who care for patients impacted by substance use about SUD, Medication Assisted Treatment (MAT), and manifestations of stigma and discrimination.
- ✓ Train all who interact with patients/clients on trauma-informed care
- ✓ Ensure all staff/providers understand the importance of structural racism and poverty as it relates to ACEs, health outcomes, and experience of our systems of care & surveillance.

Policy & Advocacy: Policy Reforms

- ✓ Create a notification pathway for substance affected newborns for the state of California—make community linkages and meet the CAPTA mandate to report (in aggregate) without creating an opportunity for surveillance
- ✓ Develop data collections systems with metrics useful to providers, clients, and communities, and be accountable.
- ✓ Fund a true prevention pathway—outside of the child welfare system. Child welfare could subcontract with local community-based organizations to support families before they enter the system (if FFPSA funds could be used for *at-risk* families, without a case#).
- ✓ Review all policies/procedures (including the SDM) with a race equity tool such as GARE or Race Forward to ensure these policies aren't disadvantageous to persons of any race or due to other stigmatized identities/social determinants of health.
- ✓ End permanency timelines of AFSA or create a modified schedule for parents in recovery.
- ✓ California should join other states in having a non-discrimination clause to protect pregnant persons from discrimination related to residential treatment for SUD availability.
- ✓ Fund/expand a public housing option for parent(s) pending reunification (currently family housing and eligibility are lost when child(ren) are removed).
- ✓ PLEASE REVIEW THE RECOMMENDATIONS BY [AMNESTY INTERNATIONAL](#)¹³³ and [MOVEMENT FOR FAMILY POWER](#)¹³⁴
- ✓ Review the *Columbia Journal of Race and Law: Strengthened Bonds: Abolishing Child Welfare and Re Envisioning Child Well-being*¹³⁵

Conclusion

We hope this paper will be among the many things that move you to action within your sphere of influence. As a society, we cannot maintain the status quo, given the historic and ongoing burden placed on BIPOC families, and families wrestling with poverty or substances. We must first reflect on our individual privileges and biases and accept that there have been and will continue to be mistakes made along the path to a more conscientious future. In our workspaces, we should use an anti-racist tool to review standard workflows and policies to ensure no groups are advantaged or disadvantaged. Partner with the BIPOC community and impacted parents as you design the future. Integrate CHWs/Peer Navigators/Doulas/PHNs into your care teams to ease access and relationship-building for families. The largest challenges for our society are 1) to create an alternative to child welfare's differential response to better address social needs with trusted community partners (for the majority of neglect calls) & 2) to address mandated reporting laws. Anyone who is concerned about a child's safety will make a report, regardless of a mandate. What needs to end is reporting solely because of a mandate, and not due to provider concern, especially given what we are learning about mutual deference.

In the meantime, training staff, peers, and yourself on Relationship Centered Communication, Trauma-Informed Care, and Cultural Humility can demonstrate commitment to a culture shift. We can shift toward a culture of listening to and trusting our patients/clients and, thus, treating

them with dignity and respect. Create safe spaces for curiosity and feedback and opportunities for learning from one another when we make missteps with our wording or assumptions. Learn and educate your staff and peers about the wide range of substance use, medication assisted treatment, and the principles of harm reduction. Similarly, make sure everyone in your program understands the historic racism that has disadvantaged BIPOC families for generations.

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Endnotes

- 1 Jackson FM, Rashied-Henry K, Braveman P, et al. A Prematurity Collaborative Birth Equity Consensus Statement for Mothers and Babies. *Matern Child Health J*. 2020;24(10):1231-1237. doi:10.1007/s10995-020-02960-0
- 2 Reproductive Justice. Sister Song. Accessed August 25, 2021. <https://www.sistersong.net/reproductive-justice>
- 3 Miller TR, Waehrer GM, Oh DL, et al. Adult health burden and costs in California during 2013 associated with prior adverse childhood experiences. Kaess M, ed. *PLOS ONE*. 2020;15(1):e0228019. doi:10.1371/journal.pone.0228019
- 4 Merrick MT, Ford DC, Ports KA, Guinn AS. Prevalence of Adverse Childhood Experiences From the 2011-2014 Behavioral Risk Factor Surveillance System in 23 States. *JAMA Pediatr*. 2018;172(11):1038-1044. doi:10.1001/jamapediatrics.2018.2537
- 5 *Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health*. State of California: Office of the Surgeon General
<https://osg.ca.gov/wp-content/uploads/sites/266/2020/12/Part-I-1.-Framing-the-Public-Health-Crisis-of-ACEs-and-Toxic-Stress.pdf>
- 6 Gourdine RM. We Treat Everybody the Same: Race Equity in Child Welfare. *Soc Work Public Health*. 2019;34(1):75-85. doi:10.1080/19371918.2018.1562400
- 7 O'Flynn M. The Adoption and Safe Families Act of 1997: Changing Child Welfare Policy Without Addressing Parental Substance Abuse. *J Contemp Health Law Policy*. 2000;16(1):32.
- 8 Edwards F. Family Surveillance: Police and the Reporting of Child Abuse and Neglect. *RSF Russell Sage Found J Soc Sci*. 2019;5(1):50. doi:10.7758/rsf.2019.5.1.03
- 9 Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *Am J Prev Med*. 1998;14(4):245-258. doi:10.1016/S0749-3797(98)00017-8
- 10 Felitti VJ, Anda RF. The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders and sexual behavior: implications for healthcare. In: Lanius RA, Vermetten E, Pain C, eds. *The Impact of Early Life Trauma on Health and Disease*. Cambridge University Press; 2010:77-87. doi:10.1017/CBO9780511777042.010
- 11 Bellis MA, Hughes K, Ford K, Ramos Rodriguez G, Sethi D, Passmore J. Life course health consequences and associated annual costs of adverse childhood experiences across Europe and North America: a systematic review and meta-analysis. *Lancet Public Health*. 2019;4(10):e517-e528. doi:10.1016/S2468-2667(19)30145-8
- 12 Doyle JJ. Child Protection and Child Outcomes: Measuring the Effects of Foster Care. *Am Econ Rev*. 2007;97(5):1583-1610. doi:10.1257/aer.97.5.1583
- 13 Sankaran VS, Church C. Easy Come, Easy Go: The Plight of Children who Spend Less than Thirty Days in Foster Care. *Univ Pa J Law Soc Change*. 2017;19:31.
- 14 *Clinical Drug Testing of Pregnant Women and Newborns (March 2019)*. National Advocates for Pregnant Women Accessed May 12, 2021. <https://mk0nationaladvoc87fj.kinstacdn.com/wp-content/uploads/2019/10/NAPW202522Clinical20Drug20Testing20of20Pregnant20Women20and20Newborns252220March202019.pdf>
- 15 *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA*. Amnesty International; 2017. Accessed May 12, 2021. <https://www.amnesty.org/download/Documents/AMR5162032017ENGLISH.pdf>
- 16 Kokaliari ED, Roy AW, Taylor J. African American perspectives on racial disparities in child removals. *Child Abuse Negl*. 2019;90:139-148. doi:10.1016/j.chiabu.2018.12.023
- 17 Jackson Foster LJ, Beadnell B, Pecora PJ. Intergenerational pathways leading to foster care placement of foster care alumni's children: Intergenerational pathways. *Child Fam Soc Work*. 2015;20(1):72-82. doi:10.1111/cfs.12057
- 18 Hanna MD, Boyce ER, Yang J. The Impact of Historical Trauma and Mistrust on the Recruitment of Resource Families of Color. *Adopt Q*. 2017;20(1):65-82. doi:10.1080/10926755.2016.1149536
- 19 Plans of Safe Care | National Center on Substance Abuse and Child Welfare (NCSACW). Accessed October 18, 2021. <https://ncsacw.samhsa.gov/topics/plans-of-safe-care.aspx>
- 20 When Should a Child Be Taken from His Parents? | *The New Yorker*. Accessed August 25, 2021. <https://www.newyorker.com/magazine/2017/08/07/when-should-a-child-be-taken-from-his-parents>
- 21 Perritt J. #WhiteCoatsForBlackLives—Addressing Physicians' Complicity in Criminalizing Communities. *N Engl J Med*. 2020;383(19):1804-1806. doi:10.1056/NEJMp2023305
- 22 Roberts DE. *Shattered Bonds: The Color of Child Welfare*. Basic Books; 2002.
- 23 Ungar M. Contextual and Cultural Aspects of Resilience in Child Welfare Settings. <https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.459.8375&rep=rep1&type=pdf>
- 24 Landau J. Communities that care for families: The LINC Model for enhancing individual, family, and community resilience. *Am J Orthopsychiatry*. 2010;80(4):516-524. doi:10.1111/j.1939-0025.2010.01054.x
- 25 Hill RB. Synthesis of Research on Disproportionality in Child Welfare: An Update. http://www.citizenreviewpanelsny.org/documents/disproportionality_paper_bob_hill.pdf

- 26 Gilbert LK, Breiding MJ, Merrick MT, et al. Childhood Adversity and Adult Chronic Disease. *Am J Prev Med.* 2015;48(3):345-349. doi:10.1016/j.amepre.2014.09.006
- 27 Solomon D, Maxwell C, Castro A. *Systematic Inequality and Economic Opportunity*. https://cdn.americanprogress.org/content/uploads/2019/08/06141408/StructuralRacismEconOpp-report.pdf?_ga=2.144949364.1763730789.1634676372-335543424.1634676372
- 28 The Disparate Impact of Surveillance. The Century Foundation. Published December 21, 2017. Accessed October 19, 2021. <https://tcf.org/content/report/disperate-impact-surveillance/>
- 29 Putnam-Hornstein E, Ahn E, Prindle J, Magruder J, Webster D, Wildeman C. Cumulative Rates of Child Protection Involvement and Terminations of Parental Rights in a California Birth Cohort, 1999–2017. *Am J Public Health.* 2021;111(6):1157–1163. doi:10.2105/AJPH.2021.306214
- 30 Kimbrough-Melton RJ, Campbell D. Strong Communities for Children: A Community-wide Approach to Prevention of Child Abuse and Neglect. *Fam Community Health.* 2008;31(2):100–112. doi:10.1097/01.FCH.0000314571.28410.98
- 31 CCWIP reports. Retrieved (12/2020) from University of California at Berkeley Child Welfare Indicators Project
- 32 Chasnoff IJ, Landress HJ, Barrett ME. The Prevalence of Illicit-Drug or Alcohol Use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida. *N Engl J Med.* 1990;322(17):1202–1206. doi:10.1056/NEJM199004263221706
- 33 Sanmartin MX, Ali MM, Lynch S, Aktas A. Association Between State-Level Criminal Justice–Focused Prenatal Substance Use Policies in the US and Substance Use–Related Foster Care Admissions and Family Reunification. *JAMA Pediatr.* 2020;174(8):782. doi:10.1001/jamapediatrics.2020.1027
- 34 Substance Exposed Infants Statutory Summary. https://ncsacw.samhsa.gov/files/CAPTA_SEI_Statutory_Summary.pdf
- 35 Fetal Alcohol Exposure. <https://www.niaaa.nih.gov/sites/default/files/publications/Fetal-Alcohol-Exposure.pdf>
- 36 Lloyd MH, Luczak S, Lew S. Planning for safe care or widening the net?: A review and analysis of 51 states’ CAPTA policies addressing substance-exposed infants. *Child Youth Serv Rev.* 2019;99:343–354. doi:10.1016/j.childyouth.2019.01.042
- 37 Schiff DM, Stoltman JJK, Nielsen TC, et al. Assessing Stigma Towards Substance Use in Pregnancy: A Randomized Study Testing the Impact of Stigmatizing Language and Type of Opioid Use on Attitudes Toward Mothers With Opioid Use Disorder. *J Addict Med.* 2021; Publish Ahead of Print. doi:10.1097/ADM.0000000000000832
- 38 LeTendre ML, Reed MB. The Effect of Adverse Childhood Experience on Clinical Diagnosis of a Substance Use Disorder: Results of a Nationally Representative Study. *Subst Use Misuse.* 2017;52(6):689–697. doi:10.1080/10826084.2016.1253746
- 39 Glaberson SK. Coding Over the Cracks: Predictive Analytics and Child Protection. *Fordham Urban Law J.* 2019;46(3):58.
- 40 Paris R, Herriott AL, Maru M, Hacking SE, Sommer AR. Secrecy Versus Disclosure: Women with Substance Use Disorders Share Experiences in Help Seeking During Pregnancy. *Matern Child Health J.* 2020;24(11):1396–1403. doi:10.1007/s10995-020-03006-1
- 41 Cohen A. When Does a Drug Epidemic Get Treated as a Public-Health Problem? *The Atlantic.* Published August 12, 2015. Accessed October 19, 2021. <https://www.theatlantic.com/politics/archive/2015/08/crack-heroin-and-race/401015/>
- 42 Harp KLH, Bunting AM. The Racialized Nature of Child Welfare Policies and the Social Control of Black Bodies. *Soc Polit Int Stud Gen State Soc.* 2020;27(2):258–281. doi:10.1093/sp/jxz039
- 43 Addressing the Specific Needs of Women for Treatment of Substance Use Disorders. Substance Abuse and Mental Health Services Administration https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-06-04-002.pdf
- 44 Fong K. Concealment and Constraint: Child Protective Services Fears and Poor Mothers’ Institutional Engagement. *Soc Forces.* 2019;97(4):1785–1810. doi:10.1093/sf/soy093
- 45 Greenfield M, Jomeen J, Glover L. What is traumatic birth? A concept analysis and literature review. *Br J Midwifery.* 2016;24(4):254–267. doi:10.12968/bjom.2016.24.4.254
- 46 Thakur N, Hessler D, Koita K, et al. Pediatrics adverse childhood experiences and related life events screener (PEARLS) and health in a safety-net practice. *Child Abuse Negl.* 2020;108:104685. doi:10.1016/j.chiabu.2020.104685
- 47 Bergman NJ. The neuroscience of birth—and the case for Zero Separation. *Curationis.* 2014;37(2):4 pages. doi:10.4102/curationis.v37i2.1440
- 48 Howard K, Martin A, Berlin LJ, Brooks-Gunn J. Early mother–child separation, parenting, and child well-being in Early Head Start families. *Attach Hum Dev.* 2011;13(1):5–26. doi:10.1080/14616734.2010.488119
- 49 Chill, Paul, Burden of Proof Begone: The Pernicious Effect of Emergency Removal in Child Protective Proceedings (October 2003). Family Court Review, Vol. 41, p. 457, October 2003, Family Court Review, Vol. 42, p. 540, July 2004—Republished, Available at SSRN: <https://ssrn.com/abstract=1886506>.
- 50 Rafeedie J, Hudson SM, Deavenport-Saman A, Rao S, Rogers K, Roberts S. Decision-making in foster care: A child-centered approach to reducing toxic stress in foster children. *Child Youth Serv Rev.* 2019;96:10–16. doi:10.1016/j.childyouth.2018.11.023
- 51 Camp D. H.R.867—105th Congress (1997–1998): Adoption and Safe Families Act of 1997. Published November 19, 1997. Accessed August 31, 2021. <https://www.congress.gov/bill/105th-congress/house-bill/867>

- 52 Humphrey KR, Turnbull AP, Turnbull HR. Impact of the Adoption and Safe Families Act on youth and their families: Perspectives of foster care providers, youth with emotional disorders, service providers, and judges. *Child Youth Serv Rev*. 2006;28(2):113-132. doi:10.1016/j.chilyouth.2005.02.011
- 53 Adler L. The Meanings of Permanence: A Critical Analysis of the Adoption and Safe Families Act of 1997, 38 *Harv. J. on Legis*. 1. *Harv J Legis*. 2001;38(1):1-36
- 54 Stein TJ. The Adoption and Safe Families Act: Creating a False Dichotomy between Parents' and Childrens' Rights. *Fam Soc*. 2000;81(6):586-590. doi:10.1606/1044-3894.1070
- 55 Sempek AN, Woody RH. Family Permanence Versus the Best Interests of the Child. *Am J Fam Ther*. 2010;38(5):433-439. doi:10.1080/01926187.2010.522492
- 56 Guggenheim M. How Racial Politics Led Directly to the Enactment of the Adoption and Safe Families Act of 1997: The Worst Law Affecting Families Ever Enacted by Congress. *Columbia J Race Law*. 2021;11(3):711-732. doi:10.52214/cjrl.v11i3.8749
- 57 Gannon M, Short V, LaNoue M, Abatemarco D. Prevalence of Adverse Childhood Experiences of Parenting Women in Drug Treatment for Opioid Use Disorder. *Community Ment Health J*. 2021;57(5):872-879. doi:10.1007/s10597-020-00661-0
- 58 Canfield M, Radcliffe P, Marlow S, Boreham M, Gilchrist G. Maternal substance use and child protection: a rapid evidence assessment of factors associated with loss of child care. *Child Abuse Negl*. 2017;70:11-27. doi:10.1016/j.chiabu.2017.05.005
- 59 Roscoe JN, Lery B, Chambers JE. Understanding child protection decisions involving parents with mental illness and substance abuse. *Child Abuse Negl*. 2018;81:235-248. doi:10.1016/j.chiabu.2018.05.005
- 60 Grella CE, Needell B, Shi Y, Hser Y-I. Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *J Subst Abuse Treat*. 2009;36(3):278-293. doi:10.1016/j.jsat.2008.06.010
- 61 Carlson BE. Best Practices in the Treatment of Substance-Abusing Women in the Child Welfare System. *J Soc Work Pract Addict*. 2006;6(3):97-115. doi:10.1300/J160v06n03_08
- 62 Carlson BE, Matto H, Smith CA, Eversman M. A Pilot Study of Reunification following Drug Abuse Treatment: Recovering the Mother Role. *J Drug Issues*. 2006;36(4):877-902. doi:10.1177/002204260603600406
- 63 Kenny KS, Barrington C, Green SL. "I felt for a long time like everything beautiful in me had been taken out": Women's suffering, remembering, and survival following the loss of child custody. *Int J Drug Policy*. 2015;26(11):1158-1166. doi:10.1016/j.drugpo.2015.05.024
- 64 Grant T, Christopher Graham J, Ernst CC, Michelle Peavy K, Brown NN. Improving pregnancy outcomes among high-risk mothers who abuse alcohol and drugs: Factors associated with subsequent exposed births. *Child Youth Serv Rev*. 2014;46:11-18. doi:10.1016/j.chilyouth.2014.07.014
- 65 *San Francisco Homeless Count & Survey: Comprehensive Report 2019*. Applied Survey Research Accessed October 22, 2021. https://hsh.sfgov.org/wp-content/uploads/2020/01/2019HIRDReport_SanFrancisco_FinalDraft-1.pdf
- 66 Presler C. Mutual Deference Between Hospitals and Courts: How Mandated Reporting from Medical Providers Harms Families. *Columbia J Race Law*. 2021;11(3):733-766. doi:10.52214/cjrl.v11i3.8750
- 67 Myers JEB. A Short History of Child Protection in America. *Fam Law Q*. 2008;42(3):14.
- 68 *Plans of Safe Care for Infants With Prenatal Substance Exposure and Their Families*. Child Welfare Information Gateway; 2019. <https://www.childwelfare.gov/pubPDFs/safecare.pdf>.
- 69 Comprehensive Addiction and Recovery Act (CARA) | CADCA. Accessed May 12, 2021. <https://www.cadca.org/comprehensive-addiction-and-recovery-act-cara>
- 70 Module 3: Determining Who Needs a Plan of Safe Care. <https://ncsacw.samhsa.gov/files/posc-module-3.pdf>
- 71 *The Family First Prevention Services Act*. Children's Defense Fund; 2018. Accessed September 11, 2021. <https://www.childrensdefense.org/wp-content/uploads/2018/08/family-first-detailed-summary.pdf>
- 72 The California Evidence-Based Clearinghouse for Child Welfare. Accessed October 21, 2021. <https://www.cebc4cw.org/>
- 73 *About CAPTA: A Legislative History*. Child Welfare Information Gateway <https://www.childwelfare.gov/pubPDFs/about.pdf>
- 74 Keeping Children and Families Safe Act of 2003. Published online 2003:3.
- 75 Brown ECB, Garrison MM, Bao H, Qu P, Jenny C, Rowhani-Rahbar A. Assessment of Rates of Child Maltreatment in States With Medicaid Expansion vs States Without Medicaid Expansion. *JAMA Netw Open*. 2019;2(6):e195529. doi:10.1001/jamanetworkopen.2019.5529
- 76 *San Francisco Family Justice Summit Report 2020-2021*. Accessed October 18, 2021. https://bixbycenter.ucsf.edu/sites/bixbycenter.ucsf.edu/files/Family%20Justice%20Summit%20Report.pdf?utm_medium=press+release
- 77 Malawa Z, Gaarde J, Spellen S. Racism as a Root Cause Approach: A New Framework. *Pediatrics*. 2021;147(1):e2020015602. doi:10.1542/peds.2020-015602
- 78 Chen M, Chan KL. Effects of Parenting Programs on Child Maltreatment Prevention: A Meta-Analysis. *Trauma Violence Abuse*. 2016;17(1):88-104. doi:10.1177/1524838014566718
- 79 Cohen N, Katz C. Preventing child maltreatment: Key conclusions from a systematic literature review of prevention programs for

- practitioners. *Child Abuse Negl.* 2021;118:105138. doi:10.1016/j.chiabu.2021.105138
- 80 Daro D, Donnelly AC. Child Abuse Prevention: Accomplishments and Challenges. In: *The American Professional Society on the Abuse of Children Handbook on Child Maltreatment*. 2nd ed. ; 2002. <https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.186.2244&rep=rep1&type=pdf>
- 81 Cost Savings | PCAP. Accessed May 19, 2021. <https://depts.washington.edu/pcapuw/what-is-pcap/cost-savings>
- 82 Melton GB, McLeigh JD. The Nature, Logic, and Significance of Strong Communities for Children. *Int J Child Maltreatment Res Policy Pract.* 2020;3(2):125-161. doi:10.1007/s42448-020-00050-w
- 83 Family Connects Durham | Center for Child & Family Health. Accessed May 19, 2021. <https://www.ccfhnc.org/programs/family-connects-durham/>
- 84 Lee Y-Y, Lin JL. How much does trust really matter? A study of the longitudinal effects of trust and decision-making preferences on diabetic patient outcomes. *Patient Educ Couns.* 2011;85(3):406-412. doi:10.1016/j.pec.2010.12.005
- 85 McLemore MR, Altman MR, Cooper N, Williams S, Rand L, Franck L. Health care experiences of pregnant, birthing and postnatal women of color at risk for preterm birth. *Soc Sci Med.* 2018;201:127-135. doi:10.1016/j.socscimed.2018.02.013
- 86 Hardeman RR, Karbeah J, Kozhimannil KB. Applying a critical race lens to relationship-centered care in pregnancy and childbirth: An antidote to structural racism. *Birth.* 2020;47(1):3-7. doi: <https://doi.org/10.1111/birt.12462>
- 87 Beach MC, Inui T, Relationship-Centered Care Research Network. Relationship-centered care. A constructive reframing. *J Gen Intern Med.* 2006;21(Suppl 1):S3-S8. doi:10.1111/j.1525-1497.2006.00302.x
- 88 Carter EB, EleVATE Women Collaborative, Mazzoni SE. A paradigm shift to address racial inequities in perinatal healthcare. *Am J Obstet Gynecol.* 2021;224(4):359-361. doi:10.1016/j.ajog.2020.11.040
- 89 Rising SS. Centering pregnancy. An interdisciplinary model of empowerment. *J Nurse Midwifery.* 1998;43(1):46-54. doi:10.1016/s0091-2182(97)00117-1
- 90 Tervalon M, Murray-García J. Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *J Health Care Poor Underserved.* 1998;9(2):117-125. doi:10.1353/hpu.2010.0233
- 91 Greenwood BN, Hardeman RR, Huang L, Sojourner A. Physician–patient racial concordance and disparities in birthing mortality for newborns. *Proc Natl Acad Sci.* 2020;117(35):21194-21200. doi:10.1073/pnas.1913405117
- 92 Ma A, Sanchez A, Ma M. The Impact of Patient-Provider Race/Ethnicity Concordance on Provider Visits: Updated Evidence from the Medical Expenditure Panel Survey. *J Racial Ethn Health Disparities.* 2019;6(5):1011-1020. doi:10.1007/s40615-019-00602-y
- 93 Nurse-Family Partnership—Helping First-Time Parents Succeed. Nurse-Family Partnership. Accessed September 11, 2021. <https://www.nursefamilypartnership.org/>
- 94 SFG: Team Lily | Obstetrics, Gynecology & Reproductive Sciences. Accessed October 22, 2021. <https://obgyn.ucsf.edu/san-francisco-general-hospital/team-lily>
- 95 Epiphany Center. Epiphany Center. Accessed October 22, 2021. <https://www.theepiphanycenter.org>
- 96 Harm Reduction Principles. National Harm Reduction Coalition. Accessed September 11, 2021. <https://harmreduction.org/about-us/principles-of-harm-reduction/>
- 97 Expecting Justice. Accessed October 22, 2021. <https://www.expectingjustice.org/>
- 98 Abundant Birth Project—Expecting Justice. Accessed October 22, 2021. <https://www.expectingjustice.org/abundant-birth-project/>
- 99 Kovski NL, Hill HD, Mooney SJ, Rivara FP, Morgan ER, Rowhani-Rahbar A. Association of State-Level Earned Income Tax Credits With Rates of Reported Child Maltreatment, 2004–2017. *Child Maltreat.* Published online January 19, 2021:107755952098730. doi:10.1177/1077559520987302
- 100 Sharing the Journey: The Sheway Model of Care. Presented at the: <http://www.vch.ca/Documents/Sheway-Model-of-Care-Sharing-the-Journey.pdf>
- 101 Racine N, Motz M, Leslie M, Pepler D. Breaking the Cycle Pregnancy Outreach Program. *J Assoc Res Mothering.* 2009;11(1):12.
- 102 PCAP | Parent-Child Assistance Program. Accessed October 22, 2021. <https://depts.washington.edu/pcapuw/>
- 103 Campbell KA, MacKinnon K, Dobbins M, Jack SM, for the British Columbia Healthy Connections Project. Nurse-Family Partnership and Geography: An Intersectional Perspective. *Glob Qual Nurs Res.* 2020;7:233339361990088. doi:10.1177/2333393619900888
- 104 COACHH: Collaborative Outreach and Adaptable Care at Hallmark Health. Presented at the: June 22, 2016. Accessed May 19, 2021. <https://www.mass.gov/doc/hallmark-health-qipp-presentation/download>
- 105 Harlem Children's Zone |. Harlem Children's Zone. Accessed September 11, 2021. <https://hcz.org/>
- 106 Family Resources Centers. Family Resource Centers Network of California. Accessed September 11, 2021. <https://frcnca.org/>
- 107 Birdsong M. Chapter 4: I Love You Till Ashes or Dirt: Family Beyond Blood and Law. In: *How We Show Up*. Hachette Books.
- 108 Katigbak C, Van Devanter N, Islam N, Trinh-Shevrin C. Partners in Health: A Conceptual Framework for the Role of Community Health

- Workers in Facilitating Patients' Adoption of Healthy Behaviors. *Am J Public Health*. 2015;105(5):872-880. doi:10.2105/AJPH.2014.302411
- 109 Hodgins FE, Lang JM, Malseptic GG, Melby LH, Connolly KA. Coordinating Outpatient Care for Pregnant and Postpartum Women with Opioid Use Disorder: Implications from the COACHH Program. *Matern Child Health J*. 2019;23(5):585-591. doi:10.1007/s10995-018-2683-y
- 110 Mehra R. How Full-Spectrum Doula Care for Low-Income Californians During Pregnancy and Early Parenthood Can Improve Their Health and Reduce Costs to the State. Scholars Strategy Network. Accessed October 21, 2021. <https://scholars.org/contribution/how-full-spectrum-doula-care-low-income>
- 111 Wint K, Elias TI, Mendez G, Mendez DD, Gary-Webb TL. Experiences of Community Doulas Working with Low-Income, African American Mothers. *Health Equity*. 2019;3(1):109-116. doi:10.1089/heq.2018.0045
- 112 Respectful Maternity Care: The Universal Rights of Women and Newborns. The White Ribbon Alliance; 2019. Accessed May 19, 2021. <https://www.healthynewbornnetwork.org/hnn-content/uploads/Respectful-Maternity-Care-Charter-2019.pdf>
- 113 Grossman MR, Lipshaw MJ, Osborn RR, Berkwitz AK. A Novel Approach to Assessing Infants With Neonatal Abstinence Syndrome. *Hosp Pediatr*. 2018;8(1):1-6. doi:10.1542/hpeds.2017-0128
- 114 Abrahams RR, Kelly SA, Payne S, Thiessen PN, Mackintosh J, Janssen PA. Rooming-in compared with standard care for newborns of mothers using methadone or heroin. *Can Fam Physician*. 2007;53(10):1722-1730.
- 115 Hodgson ZG, Abrahams RR. A rooming-in program to mitigate the need to treat for opiate withdrawal in the newborn. *J Obstet Gynaecol Can J OGC J Obstet Gynecol Can J OGC*. 2012;34(5):475-481. doi:10.1016/s1701-2163(16)35245-8
- 116 *Pregnancy and Substance Use Harm Reduction Toolkit*. Accessed September 11, 2021. http://fileserv.idpc.net/library/Preg_Subst_Use_Harm_Reduction_Toolkit.pdf
- 117 Molloy C, Beatson R, Harrop C, Perini N, Goldfeld S. Systematic review: Effects of sustained nurse home visiting programs for disadvantaged mothers and children. *J Adv Nurs*. 2021;77(1):147-161. doi:10.1111/jan.14576
- 118 Racovites N. HealthySteps Outcomes Summary. HealthySteps. Accessed October 21, 2021. <https://www.healthysteps.org/resource/healthysteps-outcomes-summary/>
- 119 Model Flowchart for a CAPTA Complaint Notification. Accessed May 12, 2021. <https://static1.squarespace.com/static/57126eff60b5e92c3a226a53/t/5f84bb53928d1e1cc91a53f4/1602534229325/Model+Flowchart.pdf>
- 120 Safety Organized Practice (SOP) Toolkit | CalSWEC. Accessed May 19, 2021. <https://calswec.berkeley.edu/toolkits/safety-organized-practice>
- 121 Johnson SB, Riley AW, Granger DA, Riis J. The Science of Early Life Toxic Stress for Pediatric Practice and Advocacy. *PEDIATRICS*. 2013;131(2):319-327. doi:10.1542/peds.2012-0469
- 122 Bhusan D, Kotz K, McCall J, et al. *The Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health*. Office of the California Surgeon General; 2020. doi:10.48019/PEAM8812
- 123 Trauma Transformed. Accessed October 22, 2021. <https://traumatransformed.org/>
- 124 East Bay Family Defenders—Homepage. East Bay Family Defenders. Accessed October 21, 2021. <https://eastbayfamilydefenders.org/>
- 125 The Bronx Defenders. Accessed October 21, 2021. <https://www.bronxdefenders.org/>
- 126 Gerber LA, Pang YC, Ross T, Guggenheim M, Pecora PJ, Miller J. Effects of an interdisciplinary approach to parental representation in child welfare. *Child Youth Serv Rev*. 2019;102:42-55. doi:10.1016/j.childyouth.2019.04.022
- 127 Huebner RA, Posze L, Willauer TM, Hall MT. Sobriety Treatment and Recovery Teams: Implementation Fidelity and Related Outcomes. *Subst Use Misuse*. 2015;50(10):1341-1350. doi:10.3109/10826084.2015.1013131
- 128 Family Treatment Courts | National Center on Substance Abuse and Child Welfare (NCSACW). Accessed October 22, 2021. <https://ncsacw.samhsa.gov/topics/family-treatment-courts.aspx>
- 129 Birth and Foster Parents. Casey Family Programs. Published May 1, 2020. Accessed October 22, 2021. <https://www.casey.org/birth-and-foster-parent-partnerships/>
- 130 Franzen M. START. Children and Family Futures. Accessed October 22, 2021. <https://www.cffutures.org/start/>
- 131 Ginwright S. *The Future of Healing: Shifting from Trauma Informed Care to Healing Centered Engagement*. Kinship Carers Victoria; 2018. Accessed May 12, 2021. <http://kinshipcarersvictoria.org/wp-content/uploads/2018/08/OP-Ginwright-S-2018-Future-of-healing-care.pdf>
- 132 *Everything You Think You Know about Addiction Is Wrong* | Johann Hari—YouTube. Accessed May 12, 2021. <https://www.youtube.com/watch?v=PY9DclMGxMs>
- 133 USA: Criminalizing pregnancy: policing pregnant women who use drugs in the USA. Amnesty International. Accessed October 22, 2021. <https://www.amnesty.org/en/documents/amr51/6203/2017/en/>
- 134 Ground Zero. Movement for Family Power. Accessed October 22, 2021. <https://www.movementforfamilypower.org/ground-zero>
- 135 Strengthened Bonds: Abolishing the Child Welfare System and Re-Envisioning Child Well Being. *Columbia J Race Law*. 2021;11(2). Accessed October 22, 2021. <https://journals.library.columbia.edu/index.php/cjrl/issue/view/789>

