Ohio addiction policy scorecard

4

Children, youth and families

HPIO Addiction **Evidence** Project

November 2020

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Note on language HPIO uses to describe populations and individuals
HPIO follows the Associated Press (AP) Stylebook in its writing and capitalizes the name of certain races such as Black, Latino, Hispanic and Native American. Per AP Style, HPIO uses the term Latino. Latinx is a gender-neutral term that can also be used to describe this population. HPIO also uses people-first language that emphasizes the person over any certain characteristic, such as a disability or socioeconomic status.

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HPIO Addiction **Evidence** Project

This report is part of HPIO's **Addiction Evidence Project**. Since December 2017, HPIO has released four reports as part of this project:

- **Addiction Overview and Project Description** (12-page policy brief)
- **Ohio Addiction Policy Scorecard: Prevention, Treatment and Recovery** (40-page scorecard report)
- **Ohio Addiction Policy Scorecard: Overdose Reversal and Other Forms of Harm Reduction** (44-page scorecard report)
- **Ohio Addiction Policy Scorecard: Law Enforcement and the Criminal Justice System** (44-page scorecard report)

HPIO has also released four online resource pages, which are hubs for expert consensus statements and guidelines, evidence registries and model policies:

- **Prevention, Treatment and Recovery**
- **Overdose Reversal and Other Forms of Harm Reduction**
- **Law Enforcement and the Criminal Justice System**
- **Children, Youth and Families**

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4 Children, youth and families

Executive summary

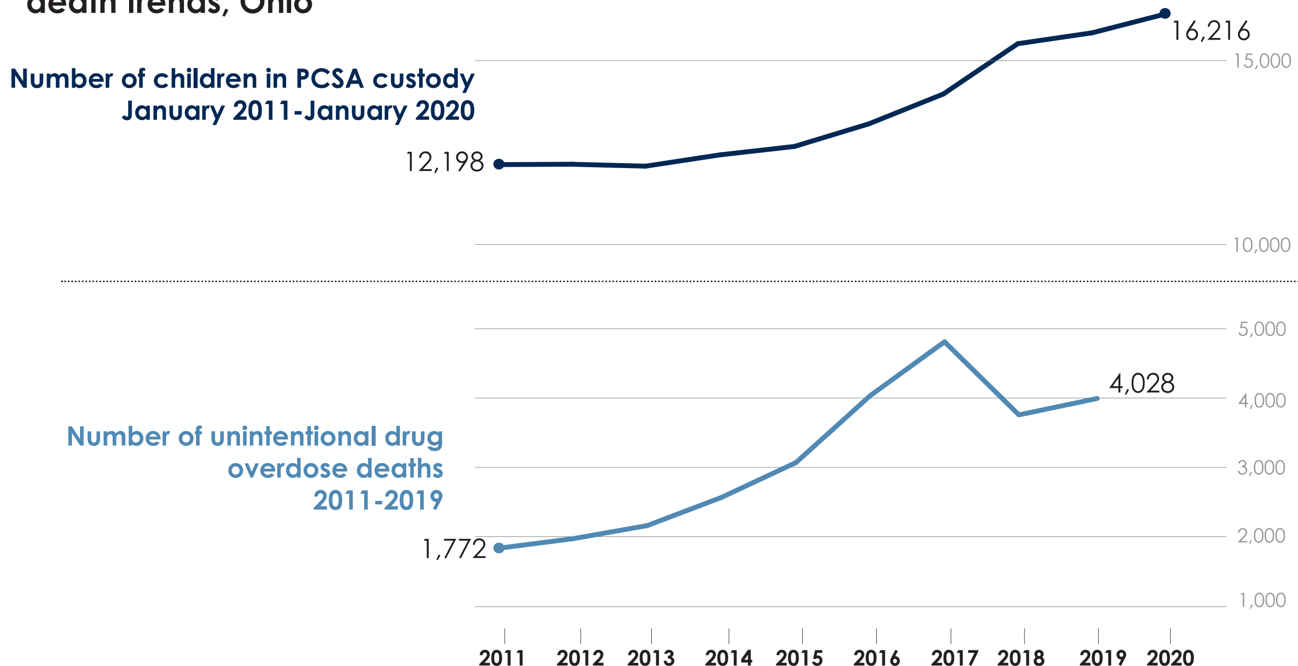
Ohio's sharp rise in drug overdose deaths from 2011 to 2017 was followed by a steady increase in the number of children entering the child protection system. As seen in Figure ES.1, these trends highlight the relationship between the opioid crisis and child maltreatment. Parents in active addiction face many challenges to providing a safe and stable environment for their children.

Parental substance use can harm children at every stage of development, from preconception to adolescence. Left unchecked, the consequences of addiction and family instability can lead to negative education, employment, health and criminal justice outcomes for children and their communities.

3 key findings for policymakers

- **Addiction's toll on families requires a comprehensive response.** Parental addiction can harm children in many ways. Ohio has launched multiple programs to address the needs of these children, but more can be done to keep families together, ameliorate childhood trauma and build resilience.
- **A hopeful moment for change.** Policymakers have prioritized child welfare. Recent state and federal reforms lay the groundwork for improved investments in prevention and substantive changes to the children services system.
- **Implementation and evaluation are critical next steps.** Policymakers should closely monitor implementation of these changes and evaluate their impact on outcomes such as out-of-home placements, child well-being, addiction treatment access and equity.

Figure ES. 1. **Public Children Services Agency (PCSA) custody and drug overdose death trends, Ohio**



Source for PCSA custody: Ohio's Interactive Children Services Dashbaord. Ohio Department of Job and Family Services. Accessed Oct. 2, 2020.
Source for overdose deaths: Ohio Department of Health, Public Health Data Warehouse. Accessed Oct. 30, 2020

Figure ES. 2. **Summary scorecard rating: Extent to which Ohio policies and programs align with research evidence and reach Ohioans in need**

Subtopic	Rating
Family-focused prevention	Weak
Addiction treatment and recovery for parents	Moderate
Prenatal drug exposure	Strong
Child protection services and the foster care system	Moderate
Kinship care	Strong
Multi-system youth	Strong

Note: Rating based on evidence alignment and implementation reach. See Part 5 for details.

Local children services agencies have struggled to keep pace with caseloads that rose 33% from 2013 to 2020. State policymakers have grappled with child protection reforms within the constraints of limited resources and the decentralized nature of Ohio's children services system.

Several hopeful developments, prior to the COVID-19 pandemic, indicate that Ohio may have turned the corner. For example, the number of Neonatal Abstinence Syndrome (NAS) cases fell in recent years, and the number of children removed from the home due to parental drug use declined slightly in 2019, after peaking in 2018.

This report reviews state-level policy changes related to the impact of addiction on children, youth and families enacted in Ohio from 2013 to 2019. It includes:

- **An inventory** of policy changes (legislation, rules and state agency initiatives, programs and systems changes)
- **A scorecard** that indicates the extent to which Ohio is implementing strategies that are proven effective by research evidence (see figure ES. 2)
- **Opportunities for improvement** to strengthen Ohio's response

What are the **strengths** of Ohio's policy response?

There has been a high volume of policy change in recent years designed to strengthen children services and help parents overcome addiction. The following strengths stand out:

- **Focus on child welfare.** The DeWine administration has prioritized child welfare, including the creation of the Office of Children Services Transformation. In addition, state agencies and other partners have launched programs for families struggling with addiction, such as Ohio START (Sobriety, Treatment and Reducing Trauma), MOMS (Maternal Opiate Medical Supports) and specialized dockets.
- **Foundation set for increased use of evidence-based prevention.** With resources and guidance from the federal government, state agencies have prioritized a set of rigorously-evaluated prevention models designed to improve child health, strengthen parenting skills and reduce child maltreatment, largely through home visiting.
- **Medicaid policies support access to care for parents and children.** Medicaid coverage extensions have increased access to care for pregnant women, some young adults formerly in the children services system and adults engaged in addiction treatment. Pending Medicaid reforms would further strengthen access.

What are the **gaps** in Ohio's policy response?

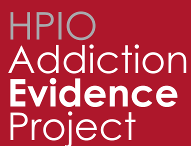
Despite these strengths, Ohio continues to struggle with child maltreatment and addiction. The following gaps remain:

- **Limited reach of early childhood evidence-based prevention programs**. While state agencies now support a coordinated set of effective home visiting models, these programs currently reach far too few families. For example, only 16.9% of the estimated number of Ohio families in need of home visiting were served through evidence-based models in 2019.
- **Local children services stretched thin and reforms needed.** Many Ohio communities have struggled to meet the rising demand for children services. Local children services agencies report increasingly complex needs of children in foster care, rising placement costs and burnout and secondary trauma among caseworkers.
- **Inequities in the child protection system.** There are a disproportionate number of African American and multiracial children in children services custody in Ohio.
- **Inconsistent approach to prenatal drug exposure.** Ohio does not have universal standardized screening protocols for substance and alcohol use in pregnant women, resulting in missed opportunities for referring women to intervention and treatment and possibly contributing to inequities.
- **Gaps in addiction treatment and recovery supports for parents.** Few treatment providers offer childcare or programs specifically tailored for pregnant or postpartum women, particularly in rural and Appalachian counties. The need for wrap-around care and recovery supports, such as recovery housing for families with children, also appears to be unmet in many communities.
- **Limited data and evaluation.** Lack of data on behavioral health system capacity makes it difficult to quantify unmet needs for addiction treatment for parents and pregnant women. Overall, policymakers lack solid data to determine which policies and programs should be scaled up and which should be revised or discontinued.

Opportunities for improvement

1. **Build upon current momentum to transform and strengthen Ohio's children services system.**
   a. Implement recommendations from the **Governor's Children Services Transformation Advisory Council**. Monitor progress on action steps and publicly report performance on intended outcomes.
   b. Ensure success of Ohio's **Family First Implementation Roadmap** through ongoing stakeholder engagement, relevant workforce development and rigorous quality assurance.
   c. Implement the **Child in Need of Protective Services (CHIPS)** framework as recommended by the Supreme Court of Ohio Advisory Committee on Children and Families.
   d. Prioritize assistance for kinship caregivers and foster families, including improved financial support and training.
   e. Continue to pursue structural reforms to address the needs of multi-system youth through state agency collaboration and data sharing, long-term resource allocation and effective quality incentives within Medicaid managed care.
2. **Extend evidence-based prevention to reach more families,** including primary prevention of child maltreatment, secondary prevention for families at elevated risk for poor outcomes due to parental substance use disorder and programs that support parenting skills and healthy child development for all families.
   a. Leverage collaboration among the Governor's Children's Initiative, Ohio Department of Health (ODH), Ohio Department of Job and Family Services (ODJFS) and Ohio Department of Medicaid (ODM) to achieve the goal of tripling the number of Ohio families served by evidence-based home visiting models. Report progress toward this goal on an annual basis.
   b. Monitor implementation of recommendations from the Governor's Advisory Committee on Home Visitation and the Maternal, Infant, and Early Childhood Home Visiting Needs Assessment update.
   c. Expand evidence-based parenting education programs, such as Triple P, to all Ohio counties.
   d. Increase the percent of children who participate in high-quality early care and education, including Head Start and other preschool programs.

3. **Ensure that pregnant women and parents have access to effective addiction treatment and recovery services.**
   a. ODM should move forward with plans to apply for a Centers for Medicare and Medicaid Services Section 1115 waiver to allow continuous Medicaid coverage for 12 months postpartum for women with substance use disorder.
   b. Increase the number of treatment providers that offer childcare, family-friendly residential treatment, recovery housing and two-generation family services.
   c. Increase the number of treatment providers that offer methadone and buprenorphine to pregnant women.
   d. Allocate resources to address unmet behavioral health needs in communities of color and rural and Appalachian counties.
   e. Increase the number of addiction treatment providers that report data into the new Ohio Behavioral Health Information System (OBHIS). Use OBHIS and Medicaid data to track changes in unmet need for addiction treatment over time.
4. **Improve screening, data surveillance and early intervention for prenatal drug exposure.**
   a. Develop or adopt standardized protocols for universal screening, brief intervention and referral to treatment for alcohol and substance use in pregnant and postpartum women.
   b. Encourage widespread implementation of the Ohio Perinatal Quality Collaborative (OPQC) **NAS protocol**.
   c. Standardize plans of safe care policies, processes and procedures, such as monitoring, across the state.
   d. Increase collaboration between ODM, ODH, Ohio Department of Mental Health and Addiction Services and the Ohio Hospital Association to improve data collection, information sharing and efforts to improve surveillance of NAS, fetal alcohol spectrum disorders, prevalence of pregnant women with substance use disorders and scope of unmet need.
5. **Assess and dismantle inequities resulting from racism and other forms of discrimination in the children services and court systems.**
   a. Allocate resources to address unmet needs for families of color and Appalachian families within the children services and court systems.
   b. Add race and ethnicity as filter categories on the ODJFS Families and Children Data Dashboard. Ensure this disaggregated data is available at the state and county levels, when applicable.
   c. Increase the number of drug courts and family dependency treatment courts that use the Racial and Ethnic Disparities Tool to reduce disparities in practices and outcomes. Require these specialized dockets to assess and report graduation rates by race and ethnicity.
   d. Require child welfare program evaluations to disaggregate data by race and ethnicity.
   e. Assess and improve cultural competence of service delivery staff, including public children services agency (PCSA) caseworkers, court staff and judges, early childhood home visitors and others who work directly with families.
   f. Engage families to ensure their voices are included in decision making.
   g. Identify additional opportunities to dismantle systemic racism and reduce inequities in child maltreatment. See **Connections between Racism and Health** for potential action steps.
6. **Increase use of evaluation to drive improvement and resource allocation** by prioritizing evaluation and fidelity monitoring for Family First programs and requiring that future projects include rigorous evaluation and transparent reporting of results.



About the HPIO Addiction Evidence Project

This report is part of HPIO's **Addiction Evidence Project**, which provides policymakers and other stakeholders with information needed to address substance use disorders in a comprehensive, effective and efficient way. This scorecard report analyzes policies specific to children, youth and families. Other topics were addressed in previous reports.

Part 1	Prevention	Treatment	Recovery	
Part 2	Harm reduction	Overdose reversal	Data and evaluation	
Part 3	Law enforcement	Criminal justice reform	Children, youth and families	This report

Glossary

- **Child Abuse Prevention and Treatment Act (CAPTA) as amended by the Comprehensive Addiction and Recovery Act (CARA)**: CAPTA, a key piece of federal legislation addressing child abuse and neglect enacted in 1974, was amended by CARA in 2016 in response to the opioid epidemic. CARA was passed to help states address the effects of substance use on children and families and strengthen requirements in CAPTA, such as those for Plans of Safe Care.
- **Child protection system:** The government system charged with protecting children from maltreatment.
- **Children services:** Ohio's child protection system, which is administered by local-level Public Children Services Agencies (PCSAs).
- **Family First Prevention Services Act (Family First)**: A federal law signed in 2018, Family First includes major reforms designed to prevent child maltreatment and keep children safely with their families. The goal is to keep children with their parents or kin in the least restrictive, most family-like setting possible, signaling a shift away from foster care and congregate care facilities.
- **Grandfamilies:** Families in which grandparents, other adult family members or close family friends are raising children.[1] Another name for a type of kinship caregiver arrangement.
- **Kinship caregiver:** Adult kin with legal or physical custody of a child. These arrangements are either created between the birth parents and kin or through child welfare and court involvement with the family.[2]
- **Maternity homes:** A residence for pregnant women who are in the process of making an adoption plan.
- **Multi-system youth:** Children who require services from more than one child-serving system, including children services, developmental disabilities, mental health and addiction and juvenile justice.[3]
- **Permanency:** A legally permanent, supportive family for youth who have been involved in the child welfare system, specifically foster care. Permanency is achieved when the child has been reunited with their birth family, has been discharged to a legally finalized adoption or has been discharged to the care of a legal guardian.
- **Plans of Safe Care (POSC):** Federally-required plans designed to address the treatment and well-being of infants exposed to substances prenatally and their families. POSC implementation varies by state. In Ohio, plans are developed by caregivers, medical professionals and service providers, and they are overseen by PCSAs.[4]
- **Primary prevention:** Occurs when there is no problem present and aims to prevent a disease, injury or other negative outcome from occurring in the first place. Also referred to as universal prevention.
- **Secondary prevention:** Occurs at the first signs of a problem and aims to detect risk or health problems at an early stage and/or to slow or halt the progress of an existing condition, disease or injury. Also referred to as selective or indicated prevention.
- **Recovery housing:** Safe, healthy and substance-free living environments that support an individual's addiction recovery.[5]
- **Specialized dockets:** A court program designed to provide defendants with clinically-oriented interventions that reduce incidences of incarceration and give appropriate treatment alternatives to individuals with mental health and/or substance use problems. The aim of specialized dockets is to address underlying behavioral health issues to produce better outcomes for participants.[6]
- **The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act**: Congress passed the SUPPORT Act in 2018. It further amended CAPTA to authorize the U.S. Department of Health and Human Services to make grants to states to assist child welfare agencies and other service providers to facilitate collaboration in developing, updating, implementing and monitoring POSC.

Part 1. Purpose and process

The purpose of this scorecard is to provide policymakers and other stakeholders with the information needed to take stock of Ohio's policy response to the addiction crisis, particularly as it relates to the impact of addiction on children, youth and their families. Based on a review of research literature, this report identifies next steps to reduce the number of children in Ohio who are negatively affected by substance use disorder and to support recovery for their families and caregivers. More specifically, this report:

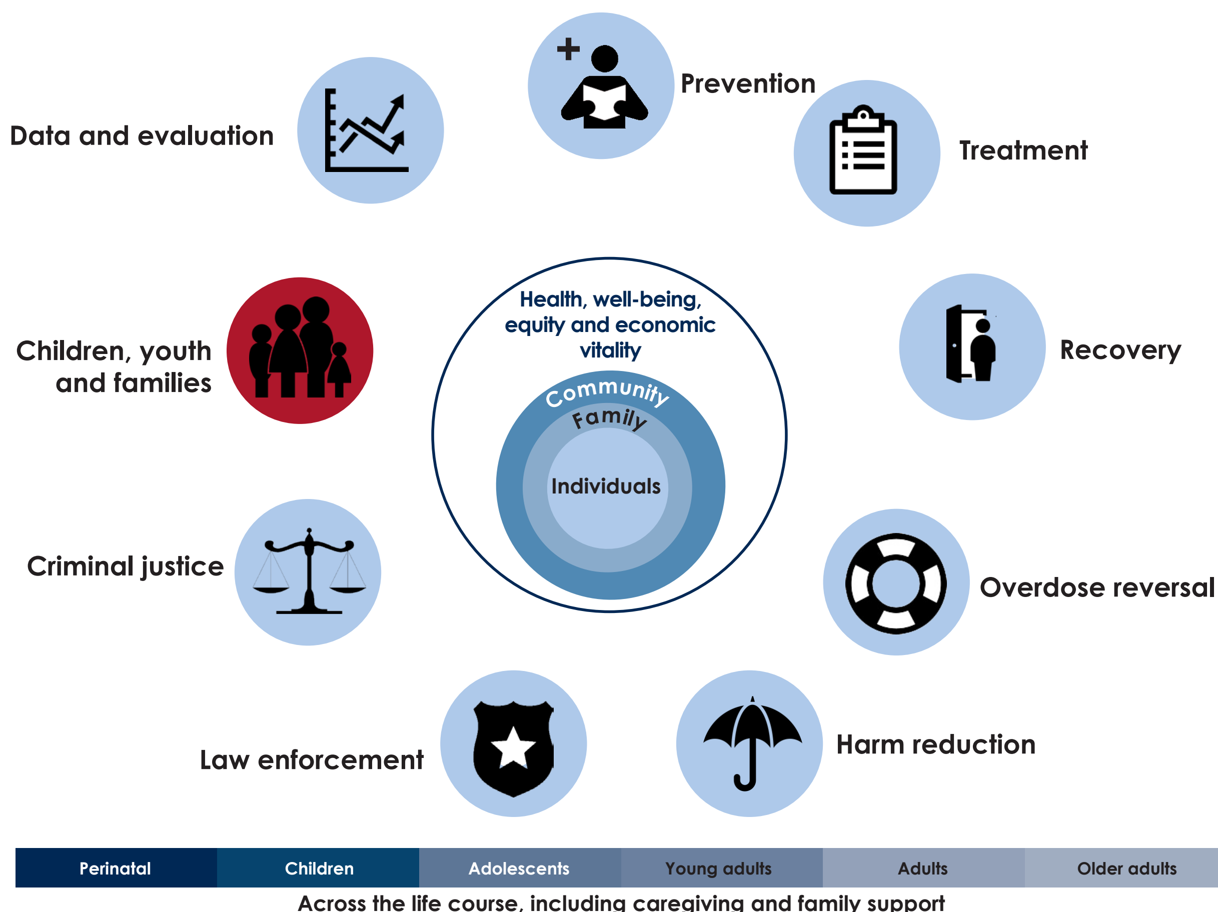
- Reviews addiction policy changes relevant to children, youth and families enacted in Ohio from 2013 to 2019
- Assesses the extent to which policy changes enacted between 2013 and 2019 align with evidence on what works
- Assesses the extent to which policies and programs are reaching Ohioans in need
- Identifies Ohio's policy strengths, challenges and opportunities for improvement

This report focuses on a key element of a comprehensive policy response to addiction, highlighted in figure 1: Children, youth and families. Stakeholders that serve children and their parents, including child protective services, foster parents and kinship caregivers are critical partners in addressing addiction. Other key partners include entities representing prevention, treatment, recovery, overdose reversal, harm reduction, law enforcement and the criminal justice system.

HPIO has previously released addiction policy scorecards relating to other elements in the framework: **Prevention, treatment and recovery**, **overdose reversal and other forms of harm reduction** and **law enforcement and the criminal justice system**.

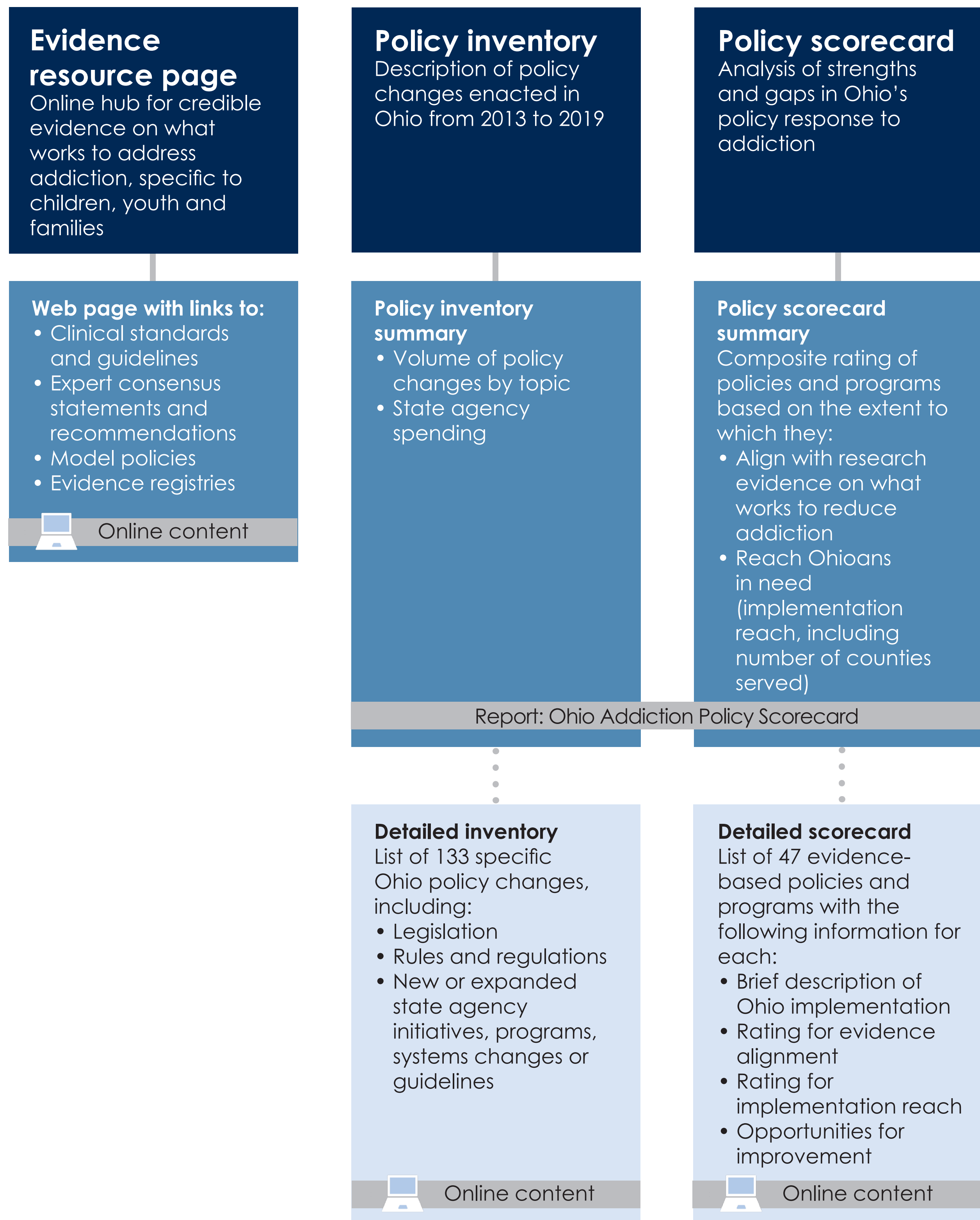
Figure 2 provides an overview of this report, as well as supplemental materials posted on the **HPIO website** that provide additional detail.

Figure 1. **Key elements of a comprehensive policy response to addiction**



Source: Health Policy Institute of Ohio adapted from Addiction Policy Forum (2017)

Figure 2. **HPIO Addiction Evidence Project: Children, youth and families**



Part 2. Key findings

Overview

This section identifies six opportunities to improve Ohio's response to families affected by addiction based on the following questions:

- What are the strengths of Ohio's policy response?
- What are the gaps in Ohio's policy response?

What are the **strengths** of Ohio's policy response?

Policymaker focus on child welfare

Governor DeWine and his administration have prioritized child welfare, including creation of the Office of Children Services Transformation and increased funding for local children services agencies and initiatives designed to improve child well-being. The General Assembly has also become increasingly responsive to concerns about addiction and child welfare in the wake of the opioid crisis, and state agencies have partnered to increase collaboration between behavioral health and family services.

As a result, there has been a high volume of policy change in recent years designed to strengthen children services and improve outcomes for children at risk of maltreatment due to parental addiction, such as:

- **Initiatives of the Governor's office:** Executive orders establishing the Governor's Children's Initiative, the Governor's Children Services Transformation Advisory Council and the Governor's Advisory Council on Home Visitation
- **Comprehensive programs and initiatives designed to help families with parental substance use disorder:** Ohio START (Sobriety, Treatment and Reducing Trauma) and MOMS (Maternal Opiate Medical Supports) are significant collaborative programs that have expanded in phases over the past few years. Both programs include evidence-based components (such as Medication-Assisted Treatment [MAT] and peer support) and are currently being evaluated for effectiveness in improving addiction treatment and child welfare outcomes
- **Support for kinship caregivers:** Development of the kinship caregiver childcare benefit, 30 Days to Family intervention and the Ohio Kinship and Adoptive Navigator program (OhioKAN)
- **Services and systems change for multi-system youth:** Creation of the Multi-System Youth and Innovation Support Fund, Ohio Family and Children First Comprehensive Multi-System Youth Action Plan, Ohio Systems of Care Project Extension for Community Health Outcomes (ECHO) for Multi-System Youth and OhioRISE (Resilience through Integrated Systems and Excellence), which is a Medicaid managed care program planned for 2021
- **Innovative court programs:** The Ohio Supreme Court and other partners have developed interventions designed to improve outcomes for families involved in the court system due to drug-related crimes and/or child maltreatment, including 33 Family Dependency Treatment Courts (FDTCs)

Foundation set for increased use of evidence-based prevention

Ohio is well-positioned to extend the reach of evidence-based prevention programs to more families. With resources and guidance from the federal government, state agencies have prioritized a set of rigorously-evaluated prevention models designed to improve child health, strengthen family functioning, improve parenting skills and reduce child maltreatment, mostly through home visiting. For example, guidance and funding from the federal Family First Prevention Services Act (Family First) and the Maternal Infant and Early Childhood Home Visiting (MIECHV) program will support Governor DeWine's goal to triple the number of families served by evidence-based home visiting.

Medicaid policies support access to care for parents and children

Ohio has implemented several Medicaid coverage and eligibility changes that support access to evidence-based addiction treatment for parents with substance use disorder, including coverage of MAT and extension of coverage for adults with incomes up to 138% of the Federal Poverty Level. Pending reforms, including the Mom and Baby Dyad Care model and continuous 12-month postpartum coverage for women with substance use disorders, would further strengthen services for this population.[7] In addition, coverage has been extended to children placed with adoptive parents and independent foster youth.

What are the gaps in Ohio's policy response?

Not enough families reached by early childhood evidence-based prevention programs

While state agencies now support a coordinated set of effective home visiting models, these programs currently reach far too few families. Only 16.9% of the estimated number of Ohio families in need of home visiting were served through evidence-based (HomVEE) models in 2019.[8] Only 35 counties are implementing Triple P, an evidence-based parenting education program supported by the Ohio Children's Trust Fund (OCTF). In addition, many children in families with low incomes lack access to high-quality early childhood education. In fiscal year (FY) 2017, 36.6% of eligible children were enrolled in Head Start, and 13.9% of eligible children were served through state-funded Early Childhood Education slots.

Local children services stretched thin and reforms needed

The number of children in children services custody rose 33% from January 2013 to January 2020 (see figure 7 on p. 21). In Ohio, most child protection funding comes from local and federal sources, and many local communities have struggled to meet the rising demand. Local children services agencies report increasingly complex needs of children in foster care, rising placement costs and burnout and secondary trauma among caseworkers.

There are also gaps in support for foster families, including evidence-based training and financial support through medical leave and liability insurance policies. In addition, two recent reports outline specific challenges for the children services workforce and casework practice, kinship care, foster care and adoption:

- **Children Services Transformation Final Recommendations** (2020)
- **Foster Care Advisory Group Recommendations** report (2018)

Inequities in the child protection system

There are a disproportionate number of African American and multiracial children in children services custody in Ohio.

Inconsistent approach to prenatal drug exposure

Ohio does not have universal standardized screening protocols for substance use disorder and alcohol use in pregnant women. This reduces the accuracy of surveillance data, results in missed opportunities for referring women to intervention and treatment and may contribute to inequities. In addition, Ohio's Plans of Safe Care (POSC) regulations for infants exposed to substances prenatally are vague and do not include elements such as requirements for monitoring implementation of POSC found in other states' regulations. State agencies, however, are currently leading collaborative efforts to improve POSC in Ohio.

Gaps in behavioral health treatment and recovery supports for parents

Lack of data on behavioral health system capacity makes it difficult to quantify unmet needs for addiction treatment for parents and pregnant women. Available information, however, indicates that few treatment providers offer childcare or programs specifically tailored for pregnant or postpartum women. Rural and Appalachian counties are most likely to lack these services. Wraparound care and recovery supports, such as recovery housing for families with children, also appear to be unmet needs in many communities. Several Ohio counties lack comprehensive programs, such as Ohio START and MOMS.

Limited use of evaluation

Most of the policies and programs reviewed for this report (about 80%) did not include any

evaluation or outcome tracking components. While state agencies have partnered on some comprehensive evaluation efforts, there appear to be many situations where new policies or pilot projects are implemented without an outcome evaluation. When evaluations are conducted, the results are rarely made available to the public, resulting in missed opportunities to share the learnings from efforts around the state. Overall, policymakers lack solid data to determine which programs should be scaled up and which should be revised or discontinued.

Opportunities for improvement

1. **Build upon current momentum to transform and strengthen Ohio's children services system.**
   a. Implement recommendations from the **Governor's Children Services Transformation Advisory Council**. Monitor progress on action steps and publicly report performance on intended outcomes.
   b. Ensure success of Ohio's **Family First Implementation Roadmap** through ongoing stakeholder engagement, relevant workforce development and rigorous quality assurance.
   c. Implement the **Child in Need of Protective Services (CHIPS)** framework as recommended by the Supreme Court of Ohio Advisory Committee on Children and Families.
   d. Prioritize assistance for kinship caregivers and foster families, including improved financial support and training.
   e. Continue to pursue structural reforms to address the needs of multi-system youth through state agency collaboration and data sharing, long-term resource allocation and effective quality incentives within Medicaid managed care.
2. **Extend evidence-based prevention to reach more families,** including primary prevention of child maltreatment, secondary prevention for families at elevated risk for poor outcomes due to parental substance use disorder, and programs that support parenting skills and healthy child development for all families.

   a. Leverage collaboration among the Governor's Children's Initiative, Ohio Department of Health (ODH), Ohio Department of Job and Family Services (ODJFS) and Ohio Department of Medicaid (ODM) to achieve the goal of tripling the number of Ohio families served by evidence-based home visiting models. Report progress toward this goal on an annual basis.
   b. Monitor implementation of recommendations from the Governor's Advisory Committee on Home Visitation and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Needs Assessment update.
   c. Expand evidence-based parenting education programs, such as Triple P, to all Ohio counties.
   d. Increase the percent of children who participate in high-quality early care and education, including Head Start and other preschool programs.
3. **Ensure that pregnant women and parents have access to effective addiction treatment and recovery services.**
   a. ODM should move forward with plans to apply for a Centers for Medicare and Medicaid Services Section 1115 waiver to allow continuous Medicaid coverage for 12 months postpartum for women with substance use disorder.
   b. Increase the number of treatment providers that offer childcare, family-friendly residential treatment and recovery housing and two-generation family services.
   c. Increase the number of treatment providers that offer methadone and buprenorphine to pregnant women.
   d. Allocate resources to address unmet behavioral health needs in communities of color and rural and Appalachian counties.
   e. Increase the number of addiction treatment providers that report data into the new Ohio Behavioral Health Information System (OBHIS). Use OBHIS and Medicaid data to track changes in unmet need for addiction treatment over time.
4. **Improve screening, data surveillance and early intervention for prenatal drug exposure.**
   a. Develop or adopt standardized protocols for universal screening, brief intervention and referral to treatment for alcohol and substance use in pregnant and postpartum women.
   b. Encourage widespread implementation of the Ohio Perinatal Quality Collaborative (OPQC) **Neonatal Abstinence Syndrome (NAS) protocol**.

c. Standardize POSC policies, processes and procedures, such as monitoring, across the state.
d. Increase collaboration between ODM, ODH, Ohio Department of Mental Health and Addiction Services and the Ohio Hospital Association (OHA) to improve data collection, information sharing and efforts to improve surveillance of NAS, fetal alcohol spectrum disorders, prevalence of pregnant women with substance use disorders and scope of unmet need.

5. **Assess and dismantle inequities resulting from racism and other forms of discrimination in the children services and court systems.**
    a. Allocate resources to address unmet needs for families of color and Appalachian families within the children services and court systems.
    b. Add race and ethnicity as filter categories on the ODJFS Families and Children Data Dashboard. Ensure this disaggregated data is available at the state level and county level, when applicable.
    c. Increase the number of drug courts and family dependency treatment courts that use the Racial and Ethnic Disparities (RED) Tool to reduce disparities in practices and outcomes. Require these specialized dockets to assess and report graduation rates by race and ethnicity.
    d. Require child welfare program evaluations to disaggregate data by race and ethnicity.
    e. Assess and improve cultural competence of service delivery staff, including PCSA caseworkers, court staff and judges, early childhood home visitors and others who work directly with families.
    f. Engage families to ensure their voices are included in decision making.
    g. Identify additional opportunities to dismantle systemic racism and reduce inequities in child maltreatment. See **Connections between Racism and Health** for potential action steps.

6. **Increase use of evaluation to drive improvement and resource allocation** by prioritizing evaluation and fidelity monitoring for Family First programs and requiring that future projects include rigorous evaluation and transparent reporting of results.

Changes on the horizon

The following trends and policy changes should be monitored closely in coming years:

Hopeful trends

- NAS cases declined in 2017 and 2018, after rising steadily from 2006 to 2016.
- The number of children removed from the home due to parental drug use declined slightly in 2019, after peaking in 2018.
- Recent trends toward more children in kinship care and non-congregate settings are hopeful and may accelerate as a result of Family First.

New changes

- Family First implementation (see **fact sheet** for details) will continue in phases, building to full implementation in 2023.
- Implementation of the Nov. 2020 **Children Services Transformation Final Recommendations**.
- OCTF has received a federal grant to support the Prevention Mindset initiative, which brings cross-sector partners together to shift child welfare practices to focus more on upstream prevention.
- State agencies are leading new collaborative efforts to improve POSC implementation in Ohio, including the Practice and Policy Academy and Opioid Use Disorder, Maternal Outcomes, and NAS Initiative (OMNI).
- ODM plans to launch OhioRISE (see pages 31 and 34) in 2021, and other aspects of Medicaid managed care procurement and pending Medicaid policy changes may positively affect access to quality care for families.
- House Bill 8 was signed into law in October 2020 and will go into effect January 2021. The new law is designed to increase flexibility for foster family training.

Concerns

- The COVID-19 pandemic and economic recession may harm family well-being in many ways, such as disrupted access to services (behavioral health treatment, home visiting, child care, etc.), K-12 learning loss and increased education inequities, reduced reporting of child abuse and neglect, increased family violence and increased poverty.
- Preliminary data for some Ohio communities indicate that overdose death rates have increased in 2020. This may signal a troubling rise in the number of Ohioans struggling with addiction, which may result in increases in child abuse and neglect.

Part 3. Status of addiction and child well-being in Ohio

Overview

This section provides background and data to describe the current status of child well-being and addiction-related outcomes in Ohio. The following topics are discussed:

- Impact of parental addiction on child health and development
- Impact of parental addiction on Ohio's child protection system
- Data limitations

Impact of parental addiction on child health and development

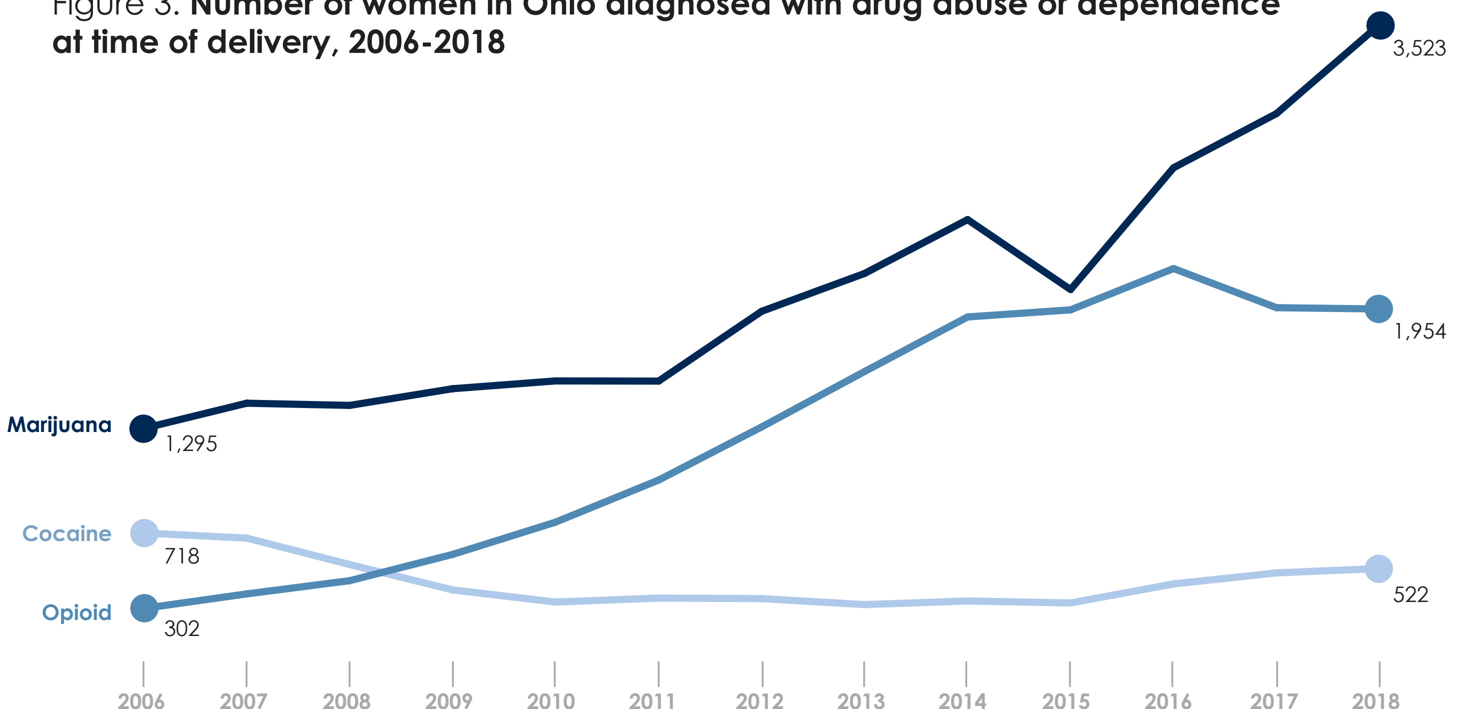
Parents in active addiction face many challenges to providing a safe, nurturing and stable environment for their children. Parental substance use can negatively affect children at every stage of development, from preconception to adolescence.

Prenatal drug exposure

The use of addictive substances during pregnancy, including alcohol, marijuana, opioids, cocaine and methamphetamines, have been shown to have both short- and long-term effects on the fetus. Most impacts are seen in the neurological development of the fetus into infancy and childhood.[9] However, prenatal drug exposure also affects fetal growth, infant language development and results in an increased risk that the infant will develop NAS or fetal alcohol spectrum disorders (FASDs).[10] In addition, smoking during pregnancy contributes to poor birth outcomes, such as preterm birth and low birth weight.[11]

Drug use. In 2016, an estimated 18,000 pregnant women in Ohio reported that they had used a substance during the month before their pregnancy (based on survey data).[12] That same year, 4,800 pregnant women received a drug abuse or dependence diagnosis at delivery, according to data reported by OHA. In 2018, the number of pregnant women receiving a drug abuse or dependence diagnosis increased to over 5,500 (see figure 3).[13]

Figure 3. **Number of women in Ohio diagnosed with drug abuse or dependence at time of delivery, 2006-2018**



Note: Individual may be diagnosed with more than one substance use disorder condition
Source: Ohio Department of Health and the Ohio Hospital Association

The rate of substance use disorder is even higher among pregnant women in the Medicaid population. In state fiscal year 2019, 14,068 women covered by Medicaid were diagnosed with substance use disorder within the year before they delivered their babies. This represents 22% of all women covered by Medicaid in Ohio who delivered a baby that year.[14]

Opioids. The number of pregnant women with an opioid abuse or dependence diagnosis increased six-fold since 2006, according to OHA data.[15] In 2018, over 1,900 Ohio women were diagnosed with opioid abuse or dependence at delivery.[16]

Non-opioid illicit drugs. Marijuana abuse or dependence diagnoses more than doubled over the past decade. In 2018, marijuana accounted for approximately 63% of substance use disorder diagnoses among pregnant women in Ohio.[17] The prevalence of marijuana use appears to be higher than other illicit substances, but pregnant women may be diagnosed with more than one substance use disorder. Cocaine abuse or dependence diagnoses among pregnant Ohio women decreased by approximately 27% from 2006 to 2018.[18] Notably, these diagnoses for pregnant women have been slowly increasing since 2015.[19]

Alcohol. In 2016-2018, approximately 16.3% of pregnant women in Ohio reported that they had consumed one or more drinks in the last 30 days, compared to 12.5% in the U.S. overall.[20]

Tobacco. Data from the Centers for Disease Control and Prevention indicates that in 2018, 13.1% of pregnant women in Ohio smoked during pregnancy. This was double the national percentage in 2018 (6.5%).[21]

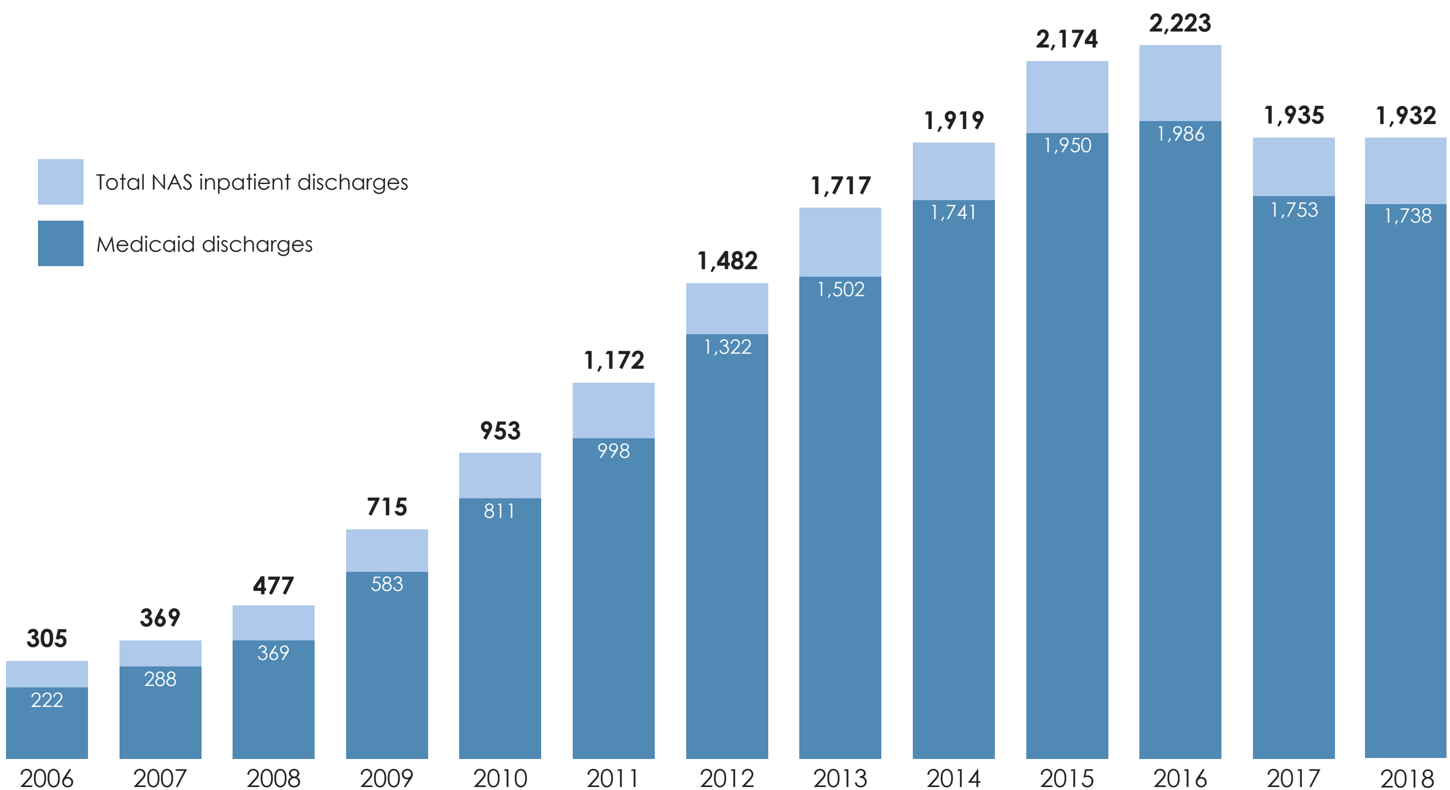
Neonatal Abstinence Syndrome

NAS is a condition associated with withdrawal in newborns exposed to certain substances, including opioids, during pregnancy.[22] Symptoms vary and are impacted by a variety of factors, such as length of use and type of substance. NAS is an expected result of prenatal substance use and is treatable, but severity of long-term impacts for the infant is unpredictable.[23]

The prevalence of NAS throughout the U.S. has increased along with the opioid epidemic.[24] While Ohio maternity units, newborn care nurseries and maternity homes are required to report the number of Ohio newborns who are diagnosed with NAS at birth, screening for NAS is not done in a consistent or universal way.[25]

In 2016, an estimated 2,223 Ohio newborns were hospitalized and discharged with an NAS diagnosis.[26] Over the past decade, the majority of Ohio newborns hospitalized for NAS have been Medicaid enrollees. In 2018, approximately 90% of newborns discharged from an NAS hospitalization were enrolled in Medicaid (see figure 4).[27]

Figure 4. **Ohio newborns hospitalized for NAS, 2006-2018**



Note: Hospitalizations occurred in Ohio hospitals
Source: Ohio Department of Health and the Ohio Hospital Association

Fetal Alcohol Spectrum Disorders

FASDs are conditions that can occur in children if alcohol is consumed during pregnancy. It is challenging to estimate how many individuals live with FASDs.[29] There is no known safe amount of alcohol consumption during pregnancy, and any alcohol consumption can pose a risk for the developing fetus.[30] Approximately 16.3% of pregnant women in Ohio had consumed one or more alcoholic drinks during the past 30 days in 2016-2018.[31] People with FASDs might have a variety of symptoms, such as low body weight, sleep issues, learning disabilities, vision or hearing problems, among many others.[32]

Adverse childhood experiences (ACEs)

ACEs are "potentially traumatic events" that occur during childhood (ages 0-17).[33] ACEs are generally grouped into three categories: abuse, neglect and household challenges, which includes substance use in the household.

Impact of ACEs. ACEs impact children's health and development through a physiological reaction to toxic stress. Also referred to as chronic or persistent stress, toxic stress results from prolonged activation of the body's fight-or-flight stress response. Children experiencing prolonged or severe adversity are more susceptible to experiencing allostatic overload resulting in changes to their nervous, endocrine and immune systems.[34] Over time, this "wear and tear" effect contributes to poor health outcomes, including cardiovascular, inflammatory and autoimmune diseases, as well as cognitive, mental and behavioral disorders.[35] The risk of developing poor outcomes increases in proportion to the number of ACEs to which a person is exposed.[36]

Ohio prevalence. Exposure to ACEs is a pervasive problem in Ohio, and parental addiction is a critical factor. HPIO analysis found that nearly two-thirds of Ohio adults have been exposed to ACEs and that substance abuse by a household member is one of the most common ACEs. In fact, 41% of Ohio adults with at least one ACE reported exposure to household substance abuse as a child. This analysis also found that, relative to other ACEs, household substance abuse was a significant predictor of adult health problems and behaviors such as smoking.[37]

Figure 5. **Prevalence of specific ACEs among Ohio adults who report at least one ACE, by type, 2015**

Abuse

Emotional abuse	57%
Physical abuse	26%
Sexual abuse	18%

Household problems

Substance abuse by a household member	41%
Divorce/separation of parents	36%
Domestic violence	26%
Mental illness of a household member	25%
Incarcerated household member	14%

Source: Data from the 2015 Behavioral Risk Factor Surveillance System was provided by the Ohio Department of Health's Division of Health Improvement and Wellness. Analysis by Ohio University, Voinovich School of Leadership and Public Affairs.

Parental addiction and multiple ACEs. ACEs tend to co-occur or cluster, meaning that individuals who are exposed to one ACE are often exposed to multiple ACEs.[38] Compared to their peers, children of parents who use drugs are three times more likely to be abused and four times more likely to be neglected.[39] Parental drug use also increases stressors in the home, such as financial and legal issues, including incarceration. All of these factors create unstable homes for children, leaving them without necessary structure and support.[40] These factors can impede healthy child development and increase the risk of a child developing a mental illness, such as depression, anxiety or post-traumatic stress disorder.[41]

Adolescent development and second-generation drug use

Adolescents with parents with substance use disorder, particularly those who have experienced child maltreatment or other trauma, may turn to substances themselves as a coping mechanism.[42] Research has established that exposure to household substance use as a child is a strong predictor of substance use later in life.[43] As shown in figure 6, child trauma can lead to drug use and second-generation addiction.

Building resilience to ameliorate trauma and prevent second-generation addiction

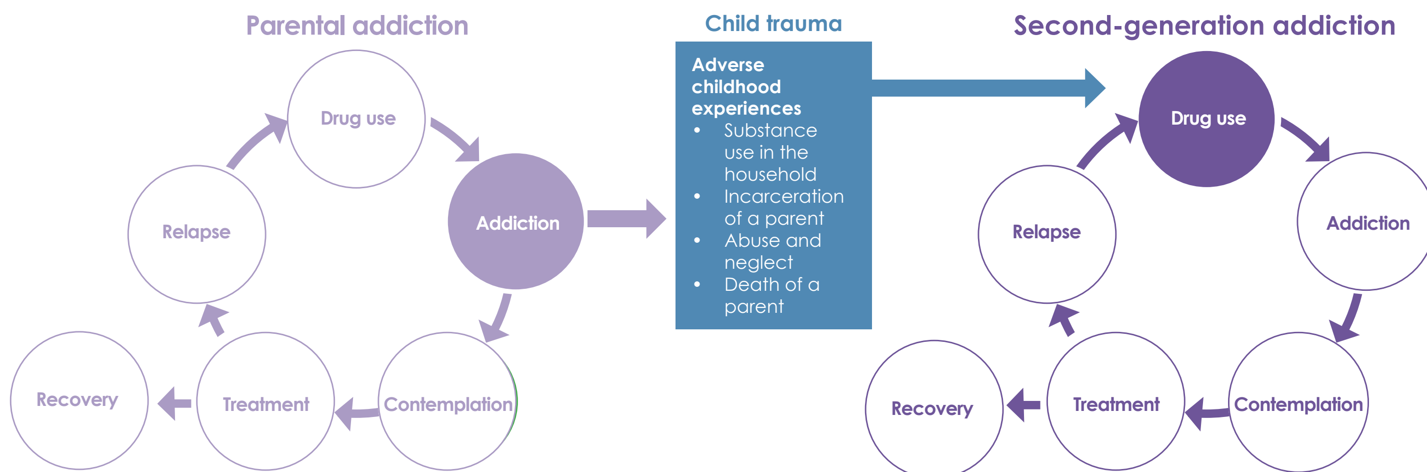
Primary prevention. Universal drug prevention programs can benefit all children and youth, including those at higher risk due to parental addiction. For addiction prevention strategies for children and youth, including K-12 prevention programs, see the first phase of the Addiction Evidence Project: **Prevention, Treatment and Recovery**.

Early intervention and secondary prevention. Early intervention programs for young children can positively impact and alter the trajectory of their lives, reducing a child's risk of drug use and improving overall health, among other positive outcomes.[44] Secondary prevention services provided to families at risk for out-of-home placements can strengthen family functioning in ways that improve a wide variety of child health, social and education outcomes.

Protective factors. Protective factors are assets and resources that promote positive development, including the presence of positive relationships, safe environments and supports to ensure the healthy development of social and emotional skills.[45] They can

To learn more about ACEs prevalence, disparities and impact in Ohio, see HPIO's August 2020 policy brief, **Adverse Childhood Experiences (ACEs): Health impact of ACEs in Ohio**

Figure 6. **Connections between parental addiction, trauma and second-generation drug use**



Note: This diagram includes several examples of adverse childhood experiences (ACEs) that are most relevant to parental addiction. For a full list and more information about ACEs, see ***Health Impacts of ACEs in Ohio***, *HPIO*
Sources: Miramar Recovery Institute, "Breaking the Cycle of Addiction"; ***Health Impacts of ACEs in Ohio***, *HPIO*

prevent the negative effects of trauma by promoting resiliency, or the ability to overcome adversity. For example, the presence of an adult who makes a child feel protected or living in a safe neighborhood can mitigate the long-term consequences of ACEs.[46] Research suggests that the presence of protective factors can mitigate the harmful effects of ACEs, even for children who have been exposed to four or more ACEs.[47] Effective primary and secondary drug prevention strategies help to build protective factors for children and youth.

Trauma-informed care. Trauma-informed interventions, sometimes provided through involvement with the child protection system, help both parents and children by linking them with mental health treatment and other support services in a way that acknowledges their unique needs and helps them build coping skills.

Impact of parental addiction on Ohio's child protection system

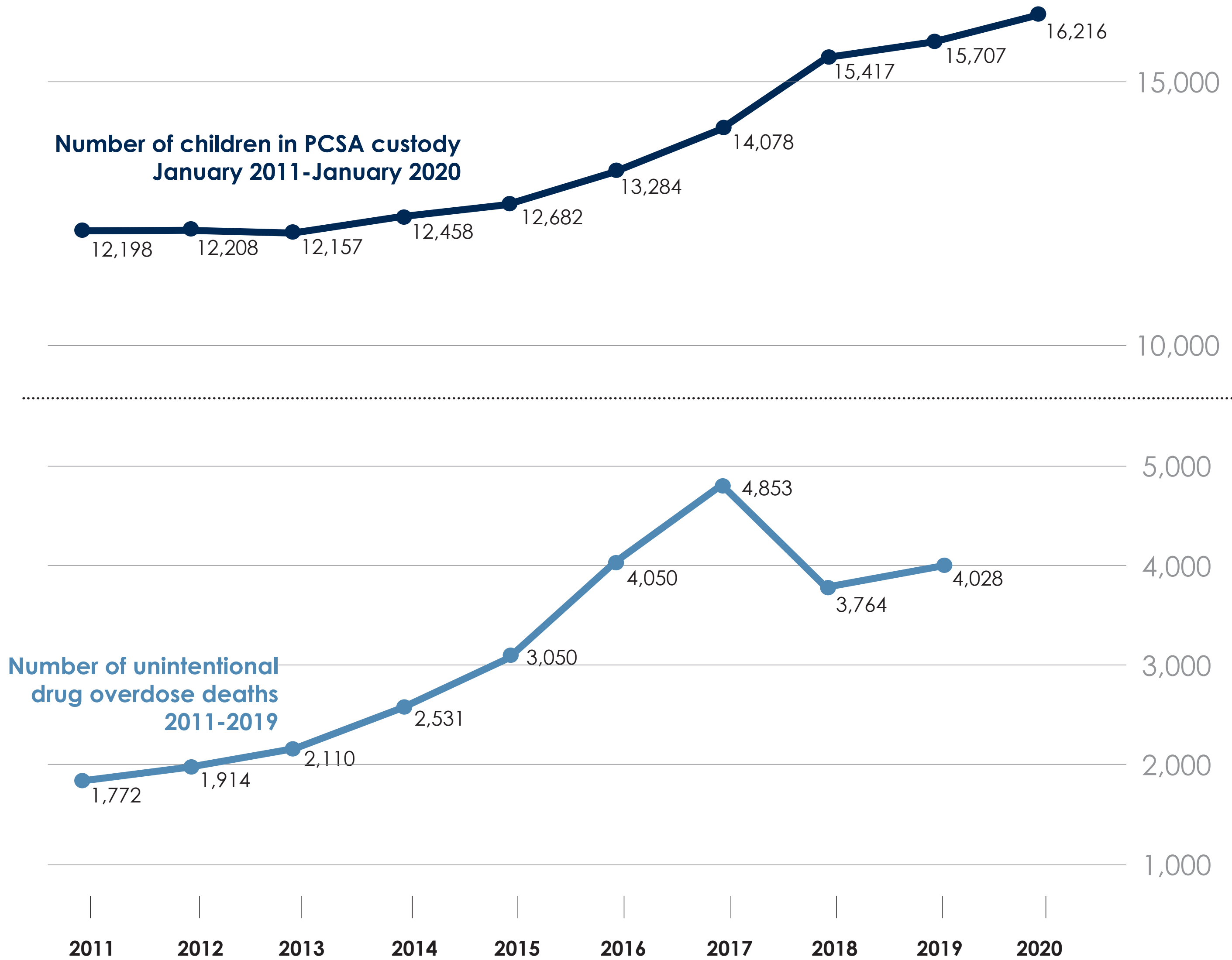
This section provides specific background on the child protection system, which is one component of broader efforts to improve child well-being within the context of Ohio's addiction crisis. Other critical sectors—behavioral health, public health and the criminal justice system—are described in previous **Addiction Evidence Project** scorecard reports.

Opioid crisis and child maltreatment

Trends indicate that there is a close relationship between Ohio's opioid crisis and growing numbers of children in need of protection services. Overdose deaths are a key indicator of the scope of Ohio's addiction challenge. From 2011 to 2019, the number of unintentional drug overdose deaths increased by 134% (see figure 7). While these deaths involved a wide variety of drugs, opioids were present in most; illicit fentanyl was involved in 73% of unintentional overdose deaths in 2018, often in combination with other drugs such as cocaine or heroin.[48]

The number of children in PCSA custody has followed a similar upward trajectory, lagging slightly behind the overdose trend. The number of children in PCSA custody rose 33% from January 2013 to January 2020. On Jan. 1, 2020, there were 16,216 Ohio children "in custody," which includes children in placements such as family foster care, kinship care, independent living, congregate care (e.g., residential centers, shelter care facilities, group homes, hospitals, nursing homes and detention facilities) and other settings.[49] This number reflects new children coming into the system and children who remain in custody. Children can exit custody through reunification with their parents, adoption or other guardianship or custody arrangements.

Figure 7. **PCSA custody and drug overdose death trends**



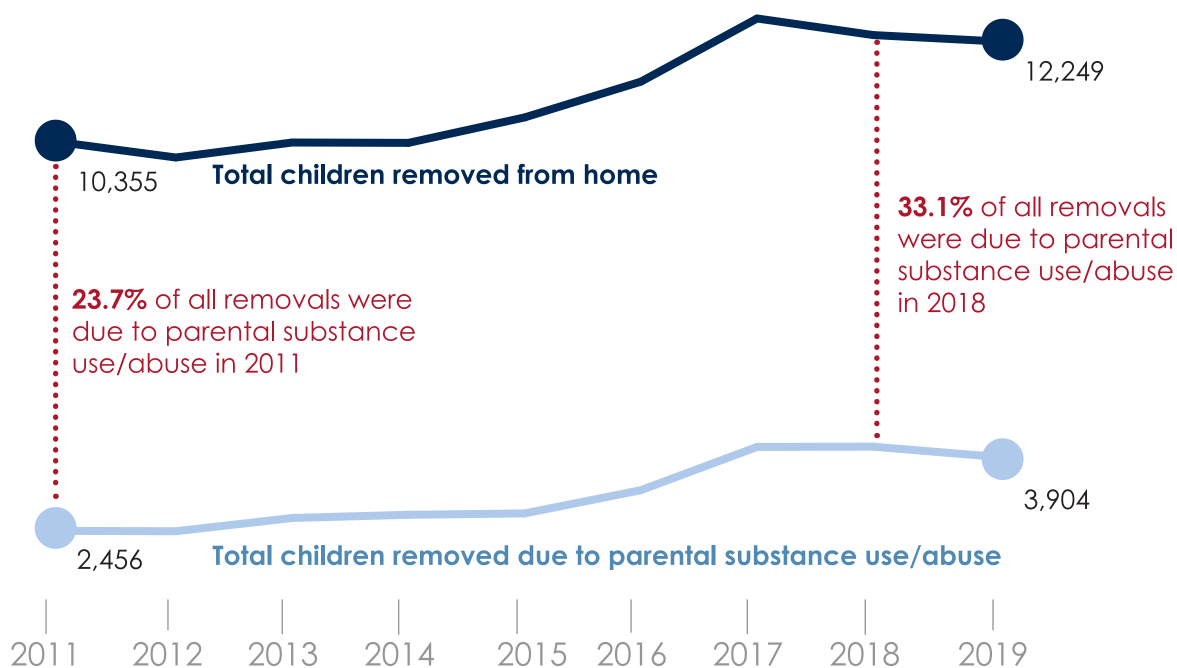
Source for PCSA custody: Ohio's Interactive Children Services Dashbaord. Ohio Department of Job and Family Services. Accessed Oct. 2, 2020.
Source for overdose deaths: Ohio Department of Health, Public Health Data Warehouse. Accessed Oct. 30, 2020.

Out-of-home placements due to parental addiction

Substance use in the home increases the chance that children will be placed outside of the home with a kinship caregiver, foster family or in residential treatment/congregate care.[50] In these cases, child protection agencies work with the family to create a plan for the long-term stability and well-being of the child, including permanency through family reunification or with permanent adoptive parents.[51]

In 2019, 3,904 Ohio children were removed from their homes due to parental substance use or abuse.[52] Figure 8 shows the number of children removed for this reason rose from 2011 to 2018 and then decreased slightly in 2019.

Figure 8. **Total number of children removed from the home and removed due to parental substance use/abuse, 2011-2019**

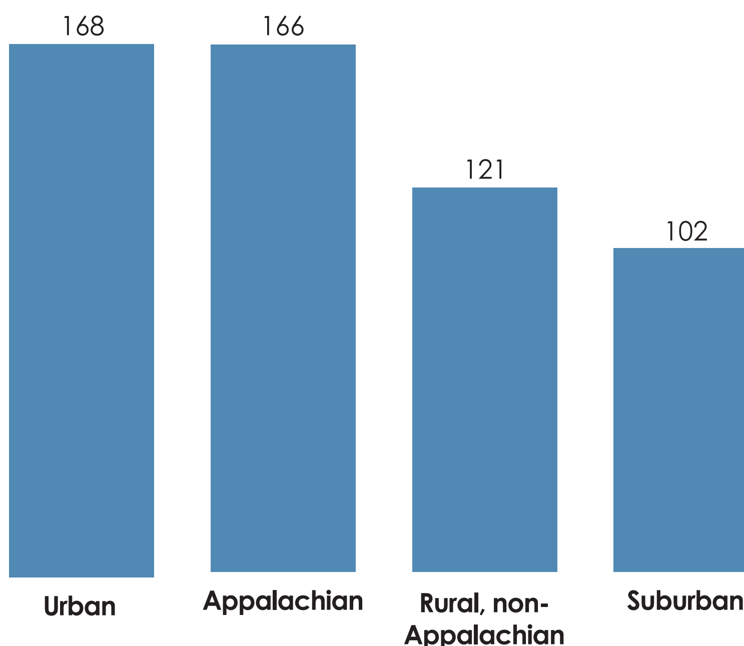


Note: Substance use/abuse may be one of multiple reasons for removal. As of Oct. 12, 2020, there had been 7,386 children removed from the home in 2020, including 2,496 children removed due to parental substance use/abuse.
Source: Data provided by the Ohio Department of Job and Family Services via email on Oct. 28, 2020.

Figure 9 shows the 2019 rate of children removed due to parental substance use/abuse per 100,000 children for different types of Ohio counties. Children living in urban and Appalachian counties were over 60% more likely to be removed from the home due to parental substance use/abuse than children living in suburban counties.

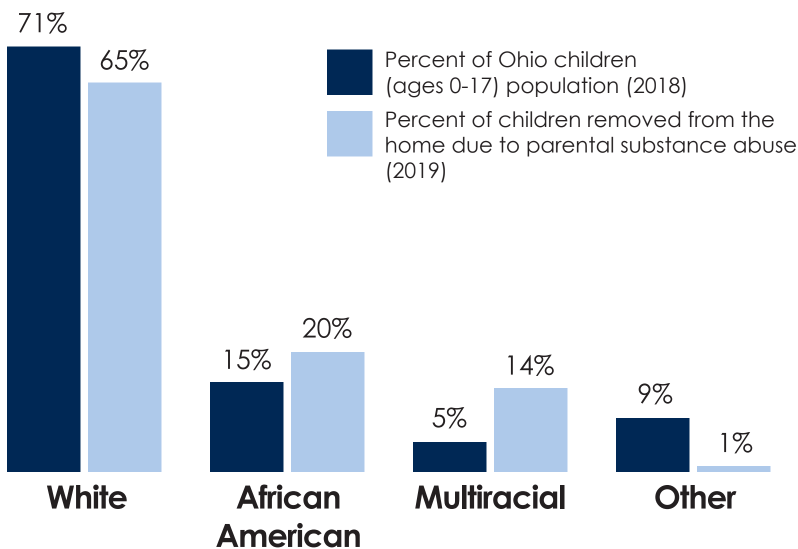
Figure 10 displays the percent of children removed from the home due to parental substance use/abuse by race, compared to the racial composition of Ohio's overall child population. Multiracial and African American children were disproportionately represented in these removals in 2019.

Figure 9. **Rate of Ohio children removed from the home due to parental substance use/abuse per 100,000 children, by county type, 2019**



Note: County typology from the Ohio Medicaid Assessment Survey
Sources: Data on children removed from the home from Ohio's Interactive Children Services Dashbaord. Ohio Department of Job and Family Services. Accessed Oct. 8, 2020. Population data from U.S. Census ACS 5-year estimates

Figure 10. **Percent of children removed from the home due to parental substance use/abuse, compared to Ohio child population (ages 0-17), by race, 2018 and 2019**



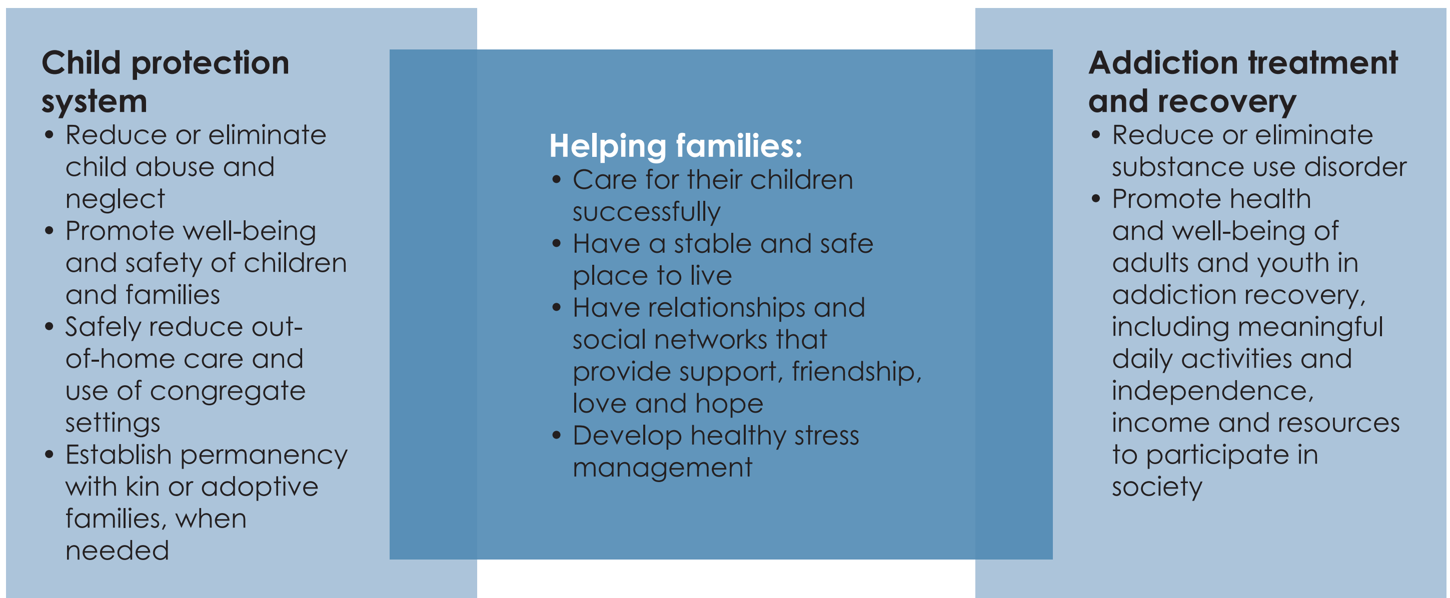
Note: Substance use/abuse may be one of multiple reasons for removal from the home.
Sources: U.S. Census data as analyzed by KidsCount Data Center and removal data provided by the Ohio Department of Job and Family Services

Connections between child protection and behavioral health

Given the large number of children involved in the child protection system due to parental drug use, many families receive services from both child welfare agencies and behavioral health treatment providers. Strong collaboration between child welfare and addiction treatment and recovery organizations is therefore critical. Both systems share the common goal of helping families care for their children successfully (see figure 11). However, each system approaches this aim with a different lens.

The overarching purpose of the child protection system is to eliminate child abuse and neglect, and at times this can result in termination of parental rights as a last resort to achieve permanency. The primary purpose of the behavioral health treatment and recovery system, on the other hand, is to provide care for adults and youth with substance use disorder. For example, recovery coaches in the behavioral health system may work with parents to regain custody of their children who were removed from the home due to neglect.

Figure 11. **Aims of the child protection system and addiction treatment and recovery**



Sources: *How the Child Welfare System Works*. Washington, DC: Child Welfare Information Gateway, 2013; "Treatment Plans and Goals for Substance Use." Serenity at Summit. Accessed July 27, 2020; "Recovery and Recovery Support." SAMHSA. Accessed July 27, 2020.

Ohio's children services system

Child protection agencies are designed to investigate reports of possible child abuse and neglect and provide services to families. These agencies also arrange for children to live with kin or foster families when they are not safe at home and arrange for reunification, adoption or other permanent family connections for children leaving foster care.[53]

In Ohio, child protection is referred to as the "children services" system and is administered by PCSAs.

County-administered, state-supervised system. Unlike most other states, Ohio has a decentralized child protection system.[54] This means that PCSAs have the responsibility for funding and administering child protection services, including foster care. There are 85 PCSAs in Ohio, including two multi-county agencies. Most PCSAs are part of a county department of job and family services, although a few are stand-alone agencies or have a hybrid structure.[55] ODJFS plays a supervisory role, including provision of technical assistance to PCSAs and monitoring services for compliance with federal and state laws, rules and policies.

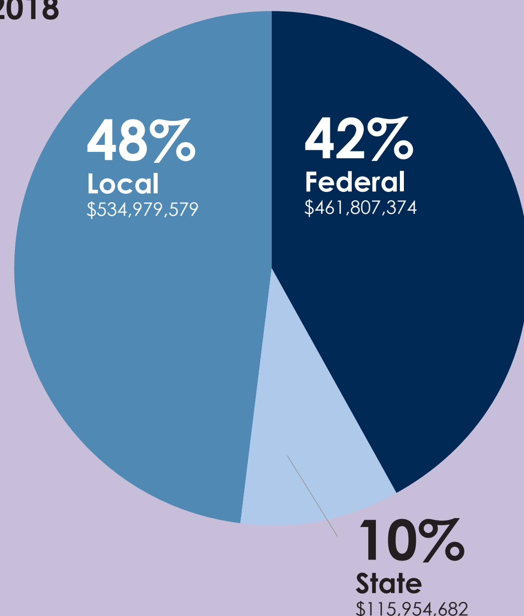
Funding sources. In Ohio, most child protection funding comes from local and federal sources.[56] In 2018, only 10% of Ohio children services spending was derived from state sources (see figure 12).[57] Due to increased demand for services in the wake of the opioid crisis[58], PCSAs have sought additional local and state revenue. The two most recent state budgets (2018-2019 and 2020-2021) increased state funding for PCSAs.

Local funding remains pivotal and varies widely across counties; as of 2018, 48 counties maintained a children services levy.[59] Local children services agencies report increasingly complex needs of children in foster care, rising placement costs and burnout and secondary trauma among caseworkers.[60]

Key trends and disparities. In addition to rising caseloads, the following data highlights important aspects of Ohio's children services system:

- There has been a shift toward greater use of kinship care, which is considered the most desirable out-of-home placement option for most children. Between 2014 and 2018, the percentage of children placed in kinship homes increased from 18% to 26%, while the percentage that went to licensed foster homes decreased.[61]
- Young children, ages 3 and below, represented almost 30% of all children in PCSA custody on Jan. 1, 2020.[62]
- African American children are disproportionately involved in the children services system. While non-Hispanic Black children make up only 15% of all Ohio children, ages 0-18, African American children represented 30% of all children in PCSA custody in 2018.[63]

Figure 12. **Public children services spending, by revenue source, Ohio, 2018**



Source: Public Children Services Association of Ohio Factbook, 14th edition 2019

For more Ohio children services data, see:

- **ODJFS Families and Children Data Dashboard**
- **PCSAO Factbook**

Data limitations

To make future policy decisions about child welfare and addiction, policymakers need good information about the scope of these problems and any changes that result from policies and programs implemented over the past decade.

Child maltreatment. While administrative data from ODJFS' State Automated Child Welfare Information System (SACWIS) provides timely information about families involved in the children services system, it is more difficult to assess the actual prevalence of child maltreatment in Ohio. Some cases go unreported (an increased concern during the COVID-19 pandemic), and poverty, racism and other forms of discrimination may affect which families are reported and how their cases proceed within the system.[64]

In addition, the ODJFS **Children Services Dashboard** provides useful information, but could be strengthened by providing the option to disaggregate data by race, ethnicity and other factors, and by providing more information about the characteristics of children removed from the home due to parental substance use.

Prenatal drug exposure and behavioral health treatment for pregnant women and parents. Ohio lacks comprehensive, accurate data on pregnant women with substance use disorder and the capacity of the behavioral health treatment system to meet the needs of these families. OHA is required to report to ODH the annual total numbers of infants with NAS, children with FASDs and pregnant women who received a drug abuse or dependence diagnosis at delivery. However, because there is no universal screening for these conditions, OHA reporting likely underestimates the scope of the problems. Similar data from ODM finds far higher numbers of pregnant women diagnosed with substance use disorder, underscoring the inadequacy of Ohio's current public health surveillance.

In addition, no state entity comprehensively tracks the accurate number of pregnant women or parents needing and receiving addiction treatment services. OMHAS assesses the number of Ohioans receiving treatment and the number in need of treatment, including specific reporting for pregnant women and women with dependent children, through the new Ohio Behavioral Information Health system, a component of the Community Data Warehouse. The Ohio Behavioral Health (OBH) System (previous system in place until Oct. 2020) experienced a significant decrease in reporting over the last several years, meaning that it fails to capture services from many providers. For example, according to OBH, only 393 pregnant women received addiction treatment in 2018. Given that Medicaid reported that 14,068 pregnant women were diagnosed with substance use disorder in state fiscal year 2019, the OBH data appears to provide a significant undercount.

Equity and child welfare

Socioeconomic status and geography influence the likelihood that a child will become involved in the child protection system:

- National research finds that children with single parents and from lower-income families and rural communities experience higher rates of child maltreatment.[65]
- Ohio data indicate that children in urban and Appalachian counties are more likely to be removed from the home due to parental substance use than children in suburban or rural non-Appalachian counties (see figure 9 on page 22).

Racial disparities also play a role:

- An analysis of the proportion of children in Ohio from racial and ethnic groups in foster care compared to the child population overall found that African American/Black children were more disproportionately represented than any other group.
- This analysis also found that the rate of disproportionality for African American/Black children was higher in Ohio than in the U.S. overall, indicating that other states have been more effective in limiting racial disparities in foster care than Ohio.[66]
- Ohio data indicate that multiracial children also have higher rates of children services involvement. More specifically, African American and multiracial children are over-represented in the percent of children removed from the home due to parental drug use (see figure 10 on page 23).

Possible reasons for these disparities include higher rates of poverty among families of color and racial bias within the child protection system (e.g., implicit bias among caseworkers).[67]

Policymakers should therefore consider strategies to address these disparities, including allocation of prevention resources to Appalachian counties and communities of color and policy changes to dismantle racism. The following resources provide relevant guidance:

- **Connections between Racism and Health** (HPIO)
- **Ohio COVID-19 Minority Health Strikeforce Blueprint** (Gov. Mike DeWine)
- **Ohio's Executive Response: A Plan of Action to Advance Equity** (Gov. Mike DeWine)
- **Race and Rural Equity** (Groundwork Ohio)

Part 4. Policy inventory summary

Overview

This section highlights key findings from the policy inventory, including the volume of addiction-related policy changes that impact the well-being of children, youth and families.

A complete list of specific policies, programs and services, including descriptions and links for more information, is available in the **Detailed Policy Inventory**.

Inventory process and methodology

To develop the policy inventory, HPIO researchers conducted a structured review of policy changes that occurred at the state level from 2013–2019 (the 130th, 131st, 132nd and the first half of the 133rd General Assemblies). The search did not include any legislation, regulation or executive branch activity that occurred in 2020. See the appendix for a list of the search terms used.

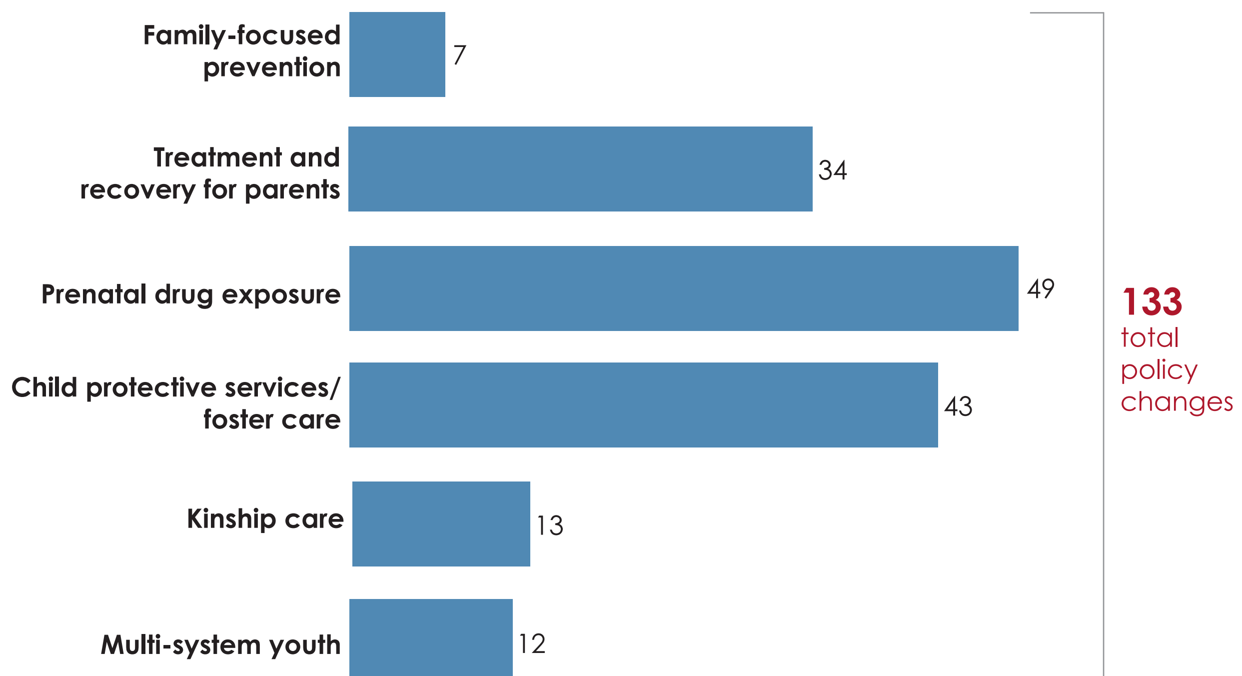
Of the policy changes identified, 46% were legislative changes, 11% were rules or regulations and 43% were new or expanded state agency initiatives, programs, systems changes or guidelines.

Volume of policy changes, by topic

Figure 13 displays the number of addiction-related policy changes implemented between 2013 and 2019 that impact the well-being of children, youth and families.

Overall, policy changes within child protective services, including system changes and supports for foster youth, received the largest amount of policy attention. Prenatal drug exposure also received significant attention.

Figure 13. **Number of addiction-related policy changes in Ohio*, by topic, 2013–2019**



*The bars add up to more than the total policy changes listed in the figure because several policy provisions counted for multiple topics.

Part 5. Policy scorecard summary

Overview

The policy scorecard summary tables in this section rate Ohio's children, youth and family policies and programs related to addiction on a three-point scale (see key below) based on the extent to which they:
- Align with research evidence on what works to reduce addiction-related harms, and
- Reach Ohioans in need (implementation reach, including number of counties served)

In addition, the scorecard summary tables in this section highlight key strengths and gaps related to evidence alignment and implementation reach or utilization of evidence-based services. High-priority opportunities for improvement are listed in the right-hand column, and additional opportunities are described in the **Detailed Policy Scorecard**.

Scorecard process and methodology

To develop the list of evidence-based policies and programs in the scorecard, HPIO consulted rigorous reviews of available research literature, including:
- **Expert consensus statements and recommendations** from independent expert panels convened by organizations such as the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of Drug Court Professionals
- **Best practice guidelines** from associations and federal agencies such as the Child Welfare Information Gateway and the National Center on Substance Abuse and Child Welfare
- **Evidence registries and clearinghouses**, such as the California Evidence-Based Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development and What Works for Health

HPIO then reviewed the inventory to identify policies and programs implemented in Ohio that were relevant to the specific evidence-based approaches. Finally, the Institute assessed the extent to which Ohio's efforts align with the evidence and are being implemented in a widespread way. Although guided by specific criteria (see appendix), this assessment was largely qualitative.

HPIO sought and received input from state agencies and other stakeholders to ensure that the description of policy implementation was accurate, although information about the number of Ohioans reached or fidelity to evidence-based models was not always available. See the appendix for further description of limitations.

As shown in figure 14, Ohio's policies were rated "moderate" or "strong" in most areas, indicating relatively good alignment with research evidence and/or reach across the state for specific topics related to child welfare and parental addiction.

Key: Scorecard summary rating for evidence alignment and implementation reach*

Rating	Description
Strong	Most policies, programs and services in this category are consistent with evidence on what works, and some are being implemented in a widespread way.
Moderate	Many policies, programs and services in this category are consistent with evidence on what works, but overall implementation reach may be limited.
Weak	For many of the policies, programs and services in this category, alignment with evidence and/or implementation reach is weak, mixed or unknown.

*See appendix for scoring methodology. See **Detailed Policy Inventory** for list of specific policies, programs and services reviewed.

Figure 14. **Children, youth and families scorecard summary**

		Strengths	Gaps	Opportunities for improvement
Weak	**Family-focused prevention** *Home visiting, early childhood education, parenting education*	• In 2019, every Ohio county was covered by at least one home visiting model identified as evidence-based by HomVEE • Ohio has a robust quality rating system for early care and education (Step Up To Quality) with required participation by all early childhood education programs funded by ODE • There are state-funded Early Childhood Education programs in 79 Ohio counties and Head Start programs in 87 counties • OCTF funds Triple P evidence-based parenting education in 35 counties and launched the Prevention Mindset initiative in 2020	• The reach of evidence-based home visiting programs and publicly-funded early childhood education programs in Ohio is small • Only 16.9% of estimated families in need of home visiting services in Ohio were served through HomVEE models in 2019 (as calculated by HRSA) • In FY 2017, 36.6% of eligible children were enrolled in Head Start, and 13.9% of eligible children were served through state-funded Early Childhood Education slots (as reported by **Groundwork Ohio**)	• Increase the number of eligible families receiving evidence-based home visiting, with a particular focus on parents with SUD and communities with elevated levels of risk for child maltreatment • Increase state and philanthropic funding for pre-k programs so that more eligible children can participate in high-quality programs • Expand the use of Triple P across the state • Leverage the OCTF Prevention Mindset initiative to strengthen collaboration between state agencies
Moderate	**Addiction treatment and recovery for parents** *Early identification of child maltreatment, access to addiction treatment and wraparound services for mothers, family-centered treatment, court specialized dockets and recovery coaches*	• Pregnant women are identified as a priority population for publicly-funded community behavioral health services • Ohio Medicaid policies, such as coverage of MAT, Mom and Baby Dyad Care model and system improvements through the pending SUD treatment 1115 waiver request • **256 specialized dockets** (covering 64 counties), including 180 drug courts and 33 family dependency treatment courts. Initiatives to improve specialized docket outcomes include the Safe Babies Court Team model and the Racial and Ethnic Disparities (RED) Tool	• Programs designed for families with parental drug use (OhioSTART, MOMs and SAPT Women's Set-Aside) do not reach all counties • Minimal access to MAT in some counties • Small number of addiction treatment providers who offer child care or residential settings with beds for client children • Lack of data on behavioral health treatment capacity • Unmet need for wraparound services, particularly recovery housing for families with children	• Move forward with plans to apply for a CMS Section 1115 waiver to allow women with SUD to maintain 12-month postpartum Medicaid coverage • Increase the number of treatment providers that offer childcare and residential treatment facilities that allow parents to bring their children • Increase the number of treatment providers that offer methadone and buprenorphine to pregnant women • Assess and increase the supply of certified recovery housing that accommodates families with children

Acronyms:
HomVEE: Home Visiting Evidence of Effectiveness
ODE: Ohio Department of Education
OCTF: Ohio Children's Trust Fund
HRSA: Health Resources and Services Administration
SUD: Substance Use Disorder
MAT: Medication Assisted Treatment
CMS: Centers for Medicare and Medicaid Services

Figure 14. **Children, youth and families scorecard summary** (cont.)

		Strengths	Gaps	Opportunities for improvement
Strong	**Prenatal drug exposure** *Universal SUD screenings, assessments and treatments for pregnant women and infants; home visiting and early intervention; contraception access and POSC*	• Hospitals and other delivery providers are required to report the number of infants born with NAS. Required reporters are also compelled to report children ≤5 years with FASDs • As of 2019, children under age 3 diagnosed with NAS and FASDs are eligible for Early Intervention services through DODD's Help Me Grow program • Several cross-system programs are in place to support mothers and babies with NAS, as well the OMNI and Practice and Policy Academy initiatives to improve POSC implementation	• Ohio does not require universal screening of pregnant women for alcohol or substance use or universal screening of infants for NAS or FASDs • Ohio's POSC regulations do not include requirements for monitoring implementation of POSC	• Develop or adopt standardized protocols for universal screening, brief intervention and referral to treatment for alcohol and substance use in pregnant and postpartum women • Encourage implementation of OPQC's **NAS protocol** • Standardize POSC processes, such as monitoring, across the state
Moderate	**Child protection services and the foster care system** *Out-of-home placement prevention, foster parent training, financial and other supports for foster youth and multidimensional foster care*	• For phase one of the Prevention Plan required by Family First, Ohio has selected four well-supported programs/ services (PAT, HFA, MST and FFT), as well as Ohio START, which is currently under review for evidence of effectiveness • The 2013-2014 state budget required Medicaid coverage for children placed with adoptive parents and independent foster care adolescents • The Independent Living Initiative assists older aged foster youth and those who recently aged out of foster care with developing life skills and training/work supports • Ohio has CASAs serving 54 counties	• Specific challenges for PCSA workforce, casework practice, foster care and adoption process outlined in **Children Services Transformation Initial Findings** report • Specific challenges to recruit, retain and support foster caregivers outlined in **Foster Care Advisory Group Recommendations** report • Evidence-based programs selected for Family First are currently not available in a widespread way across the state • Current foster parent training model is not evidence-based • Ohio does not have a family and medical leave insurance program for families of foster and adopted children	• Implement recommendations from the Children Services Transformation final report • Ensure that ODH, ODJFS and ODM coordinate efforts to implement home visiting programs they fund, such as HFA and PAT • Increase the use of evidence-based models in foster care training • Assess extent to which current per diem rates meet the financial needs of foster families • Evaluate effectiveness of the Bridges program and make improvements as needed • Expand CASA programs so that children in every county have access

Acronyms:
NAS: Neonatal Abstinence Syndrome
FASDs: Fetal Alcohol Spectrum Disorders
DODD: Ohio Department of Developmental Disabilities
POSC: Plans of Safe Care
OPQC: Ohio Perinatal Quality Collaborative
PAT: Parents as Teachers
HFA: Healthy Families America
MST: Multi-Systemic Therapy
FFT: Functional Family Therapy
CASA: Court Appointed Special Advocate

Figure 14. **Children, youth and families scorecard summary** (cont.)

		Strengths	Gaps	Opportunities for improvement
Strong	**Kinship care** *Guardianship laws, adjusted safety standards, financial and other supports for kinship caregivers and trainings for caseworkers*	• The Kinship Permanency Incentive Program provides time-limited incentive payments to kinship caregivers to defray the costs of the initial placement and help with ongoing support • ODJFS launched the Ohio Kinship and Adoptive Navigator Program (OhioKAN) to support the needs of Ohio's kinship and adoptive caregivers	• Specific challenges for kinship care outlined in **Children Services Transformation Initial Findings** report • Not enough families helped by the kinship caregiver child care benefit • The **30 Days to Family** intervention is currently only implemented in 16 counties • No dedicated funding to address unmet needs for mental health services for kinship caregivers	• Implement kinship care recommendations from the Children Services Transformation final report • Prioritize assistance for kinship caregivers, including improved access to the caregiver childcare benefit and mental health services • Evaluate the 30 Days to Family intervention and expand to more counties if found to be successful
Strong	**Multi-system youth** *Cross-system collaboration, joint system assessments and case data management, interventions for justice-involved youth, interventions for foster care youth with mental health needs and family reunification interventions*	• The SFY 2020-2021 budget appropriated new funding to create the Multi-System Youth and Innovation Support Fund • In Jan. 2020, OFCF released a comprehensive **Multi-System Youth Action Plan** with specific recommendations • Ohio law requires data sharing among state agencies impacting multi-system youth. In January 2020, OFCF released a comprehensive **Multi-System Youth Action Plan** with specific recommendations • In Sept. 2020, ODM announced the launch of OhioRISE, a managed care initiative designed to improve behavioral health access and outcomes for multi-system youth	• ENGAGE 2.0 focuses on increasing and supporting access to Mobile Response Stabilization Services for multi-system youth. It is only in 13 counties • Currently, only one county offers a juvenile drug docket and five others offer juvenile treatment dockets • The DYS Ohio Youth Assessment System screens for substance abuse, mental health and personality needs of justice-involved youth, although this does not appear to be a joint assessment across systems	• Implement recommendations of the 2020 **OFCF Multi-System Youth Action Plan** and reconvene the Joint Legislative Committee for Multi-System Youth to assess the impact of system improvements made in 2019 and 2020 • Continue efforts to strengthen state agency collaboration and data sharing and identify sources of sustainable, long-term funding for multi-system youth • Move forward with plans to implement OhioRISE, including use of a single, validated assessment tool across systems • Evaluate ENGAGE 2.0 and expand to more counties if found to be successful

Acronyms:
ODJFS: Ohio Department of Job and Family Services
OFCF: Ohio Family and Children First
ODM: Ohio Department of Medicaid
OhioRISE: Resistance through Integrated Systems and Excellence
DYS: Ohio Department of Youth Services

Current child welfare policy landscape

Greater awareness among Ohio policymakers of the connections between addiction and child welfare, in addition to federal reforms such as the Family First Prevention Services Act (Family First) (see **fact sheet**), have led to a series of policy changes in Ohio's children services system. Figure 15 highlights significant child welfare policy changes. A comprehensive list of policy changes is provided in the **policy inventory**.

2019 and 2020 have been pivotal years for initial planning and implementation of Family First and the Governor's initiatives. Going forward, it will be important to assess whether these programs and policies are implemented as intended, monitor the extent to which they are reaching families throughout the state and evaluate if they are effective in achieving the desired outcomes.

Strategies at the intersection of addiction and child welfare

Some policies reviewed in the scorecard were specific to child protection, with implications for families affected by addiction. Other policies addressed behavioral health, with implications for pregnant women and parents in treatment and recovery. This section provides data on the reach of strategies that specifically address the intersection of child welfare and parental addiction.

Comprehensive programs for families with parental addiction

State agencies have partnered on programs specifically designed to help families with parental drug use and children in PCSA custody or otherwise at risk of maltreatment. Ohio START and MOMS are two significant efforts that were launched in response to the opioid crisis and have been expanded in phases over the past few years. Both programs include evidence-based components (such as MAT and peer support) and are currently being evaluated for effectiveness in improving addiction treatment and child welfare outcomes.

Ohio START. Ohio START is a children's services-led initiative designed to improve outcomes for families affected by child maltreatment and substance use disorder, including prevention of out-of-home placements and child maltreatment. START is implemented by family-centered teams of caseworkers, behavioral health providers and family peer mentors. Ohio's program is an affiliate of the national START model, which has been identified as a promising program by child welfare experts.[67] The initial 2017 pilot project was launched by then Ohio Attorney General Mike DeWine, and the Public Children Services Association of Ohio (PCSAO) currently leads the program. Ohio START is funded primarily by federal sources, in partnership with several state agencies and private funders. As of Oct. 2020, Ohio START is being implemented in 46 counties (see figure 16) and has served 948 children.[68]

MOMS. MOMS is a healthcare provider-led initiative for pregnant women with substance use disorder designed to improve maternal and fetal health outcomes, improve family stability and reduce costs of NAS to Ohio Medicaid. MOMS is implemented by a care coordination team that includes obstetrics, behavioral health, MAT, pediatrics and Medicaid managed care. MOMS 1.0 was launched as a pilot in 2013 by the Governor's Office of Health Transformation, ODM and OMHAS. A subsequent phase of the project (MOMS+) is coordinated by the Ohio Perinatal Quality Collaborative and state agency partners. Federal grants are the primary funding source. As of 2020, MOMS programs have been implemented in 20 counties (see figure 16). Six hundred women participated in 2018.

Figure 15. **Significant child welfare policy changes (state and federal), 2013-2022**

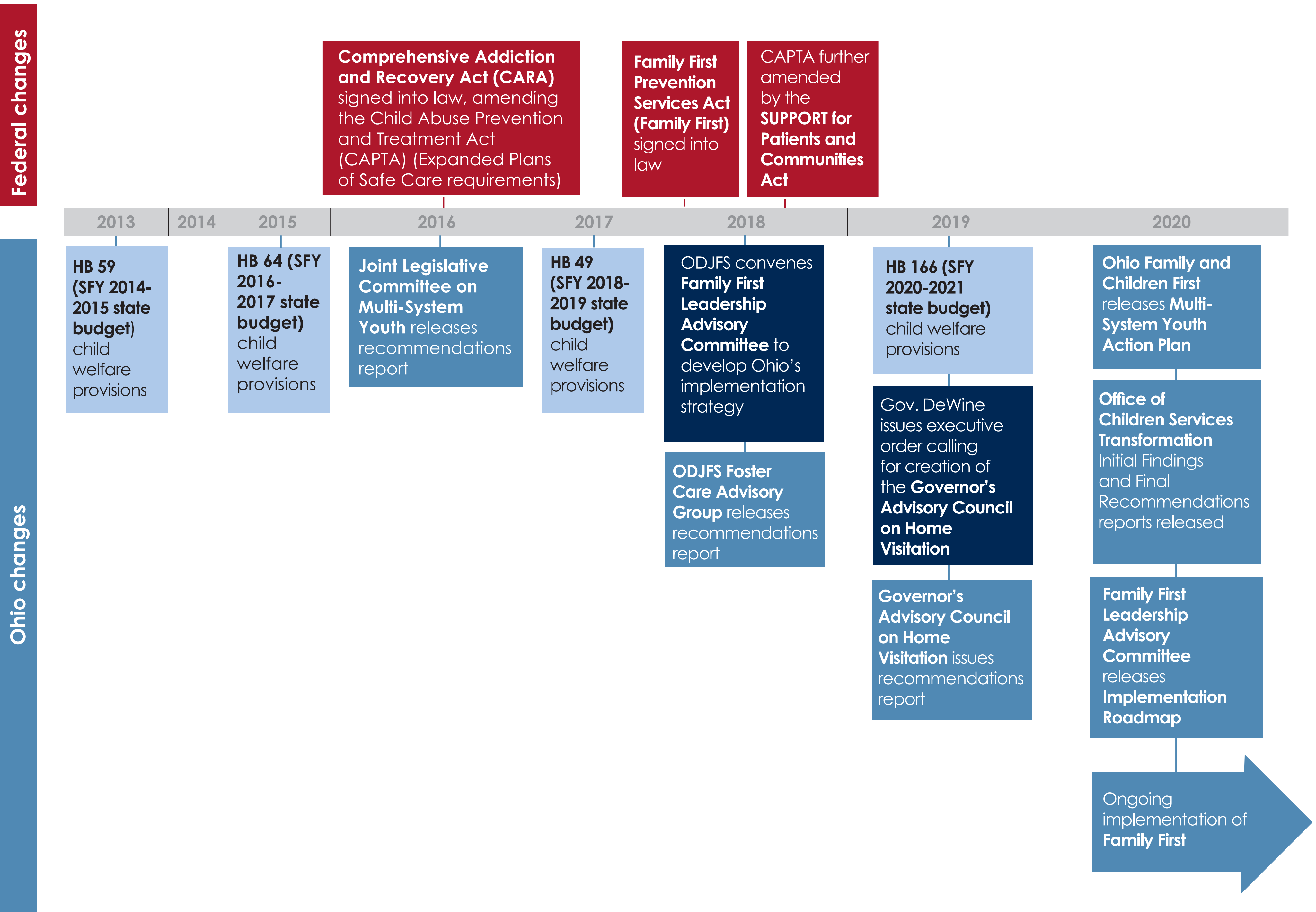
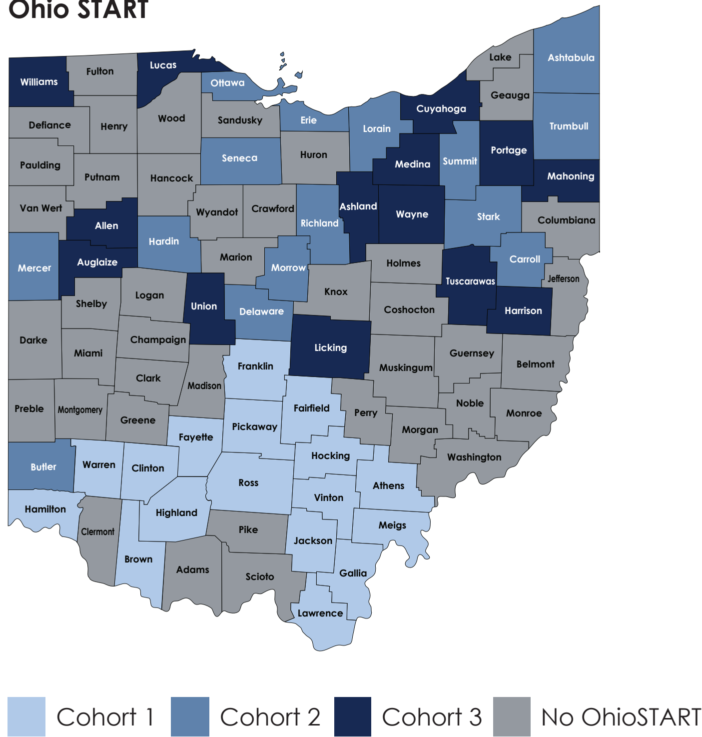
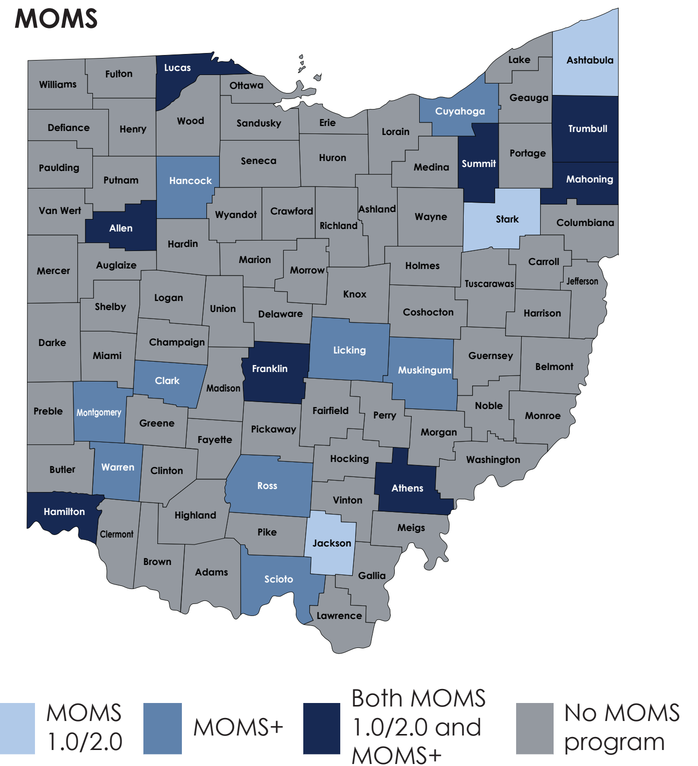


Figure 16. **Reach of Ohio START and MOMS (as of September 2020)**



Source: Public Children Services Association of Ohio



Source: Ohio Department of Mental Health and Addiction Services and The Ohio Colleges of Medicine Government Resource Center

Medicaid coverage

Addiction treatment access for parents. Medicaid is a major source of funding for behavioral health treatment for pregnant women and parents with low incomes in Ohio. In 2016, for example, Medicaid covered 49.5% of buprenorphine (a medication used in MAT) administered in Ohio.[69] In state fiscal year (SFY) 2019, 14,068 women covered by Medicaid were diagnosed with substance use disorder within the year before they delivered their babies.[70]

Ohio has implemented several policy changes related to Medicaid coverage and eligibility that support access to behavioral health care. Ohio Medicaid covers evidence-based addiction treatment services, including MAT. Pregnant women with incomes up to 205% of the Federal Poverty Level (FPL) are eligible for Medicaid in Ohio, while parents with incomes up to 138% FPL may qualify.[71]

The 2020-2021 state budget included $30.54 million ($10.06 million from the state General Revenue Fund) for services designed for mothers with substance use disorder and their infants. Ohio Medicaid plans to request CMS approval to allow pregnant women who have been diagnosed with substance use disorders to have 12 months of continuous eligibility following delivery, up from the current 60-day Medicaid cut-off. In addition, Ohio Medicaid will be designing a new "dyad care" model that includes coordinated services for babies with NAS.[72] As of Oct. 2020, implementation of these initiatives has been delayed by the COVID-19 pandemic.

Healthcare access for children. In 2019, an estimated 36% of Ohio children (ages 0-18) were covered by Medicaid.[73] As of Sept. 2020, there were a total of 35,146 children in children services care enrolled in Medicaid (primarily children in foster care).[74] Given the trauma experienced by many children affected by parental addiction, access to physical and mental health care for youth involved in the children services system is particularly important. Ohio policymakers have leveraged Medicaid policy changes to improve access to care for these children. For example, the SFY 2013-2014 budget extended Medicaid coverage to children placed with adoptive parents and independent foster care adolescents.[75] In Sept. 2020, ODM announced the launch of **OhioRISE**, a managed care initiative designed to improve behavioral health access and outcomes for multi-system youth and prevent custody relinquishment.

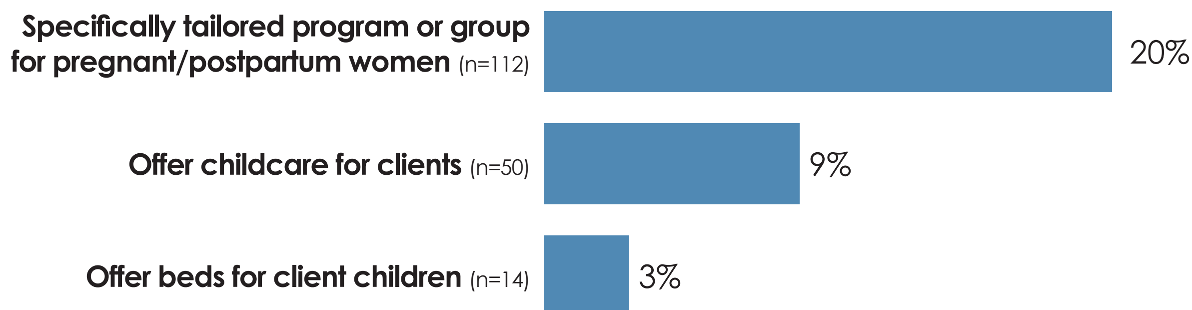
Treatment and recovery services tailored for pregnant women and parents

Pregnant women and parents of young children face unique challenges to accessing treatment and maintaining recovery. Services tailored to meet their needs are critical, but somewhat rare. Recovery housing, childcare, transportation, education and employment assistance are significant unmet needs.[76]

In 2019, 20% of 554 Ohio treatment providers that participated in the 2019 National Survey of Substance Abuse Treatment Services (N-SSATS) reported that their facility offered a program or group specifically tailored for pregnant or postpartum women. Childcare was less common; 9% of providers reported offering childcare for clients and 3% indicated residential beds for clients' children (see figure 17).[77] Previous analysis found that rural and Appalachian counties were less likely than suburban and urban counties to have these services.[78]

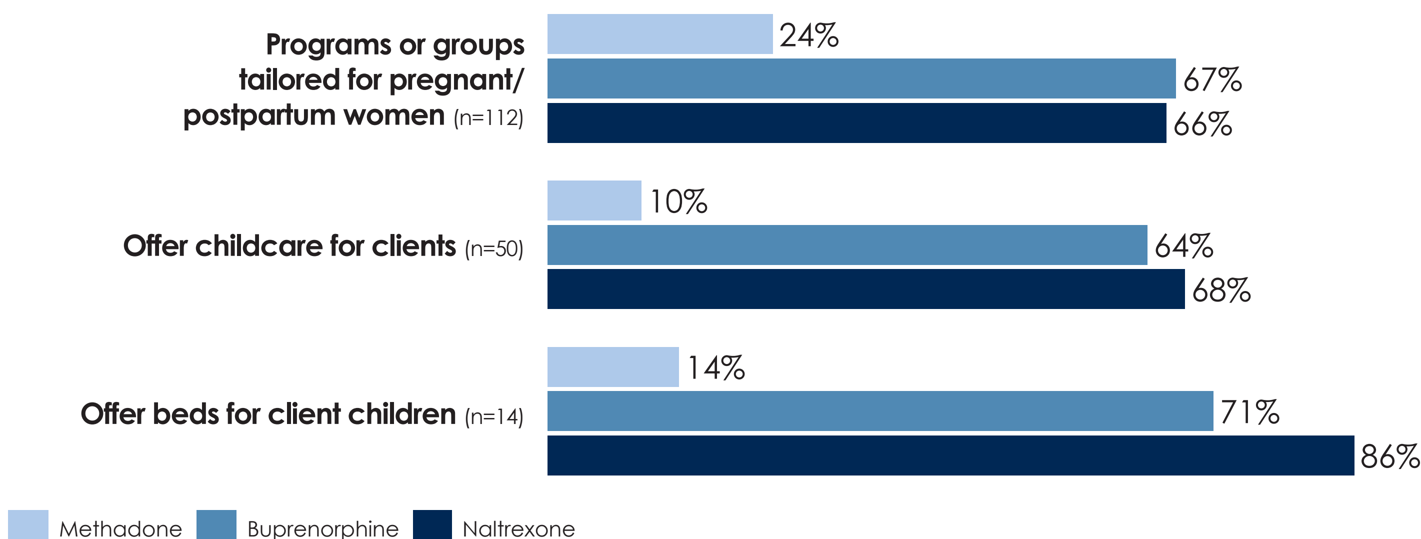
Research evidence indicates that MAT is a cost-effective treatment for opioid use disorder,[79] and methadone and buprenorphine, along with behavioral counseling, are recommended for pregnant women with opioid use disorder.[80] There is currently insufficient evidence about the safety of naltrexone (a third form of opioid use disorder MAT) for pregnant women. Many, but not all, Ohio facilities with treatment services for pregnant women and parents offer MAT (see figure 18). For example, 67% of facilities that offer programs tailored for pregnant/postpartum women offer buprenorphine. (See **Ohio Addiction Policy Scorecard: Prevention, Treatment and Recovery** for more information about MAT.)

Figure 17. **Percent of Ohio treatment facilities that provide services tailored to pregnant/postpartum women and parents, 2019** (n=554)



Source: HPIO analysis of 2019 N-SSATS data (SAMHSA)

Figure 18 . **Percent of relevant treatment facilities that offer MAT, Ohio, 2019**



Source: HPIO analysis of 2019 N-SSATS data (SAMHSA)

Part 6. Evaluating the impact of Ohio's policies and programs

Evaluation research assesses how a policy or program was implemented and whether it was effective in achieving desired outcomes.

Of the 133 policies reviewed in this inventory, 28 (21%) included clear reference to an evaluation requirement or some other provision related to outcome monitoring or data tracking. This is a higher proportion than found for the first three phases of the Addiction Evidence Project, indicating that evaluation is more common for policies and programs focused on child welfare, compared to other addiction-related topics.

The inventory analysis found three common types of evaluation and data reporting activities:

- **Federal evaluation and reporting requirements**, such as fidelity monitoring for Family First programs and HRSA Title V Maternal and Child Health Block Grant performance measures
- **State outcome reporting mandates**, such as legislation requiring quarterly infant mortality scorecards by ODM and annual Help Me Grow reports from ODH
- **Comprehensive program evaluation** designed to document implementation and assess progress toward intended outcomes, such as the Ohio START and MOMS evaluations described in figure 16

Transparency of evaluation results

Of the 28 policy changes with an evaluation or data monitoring component identified, 12 had evaluation results or other data posted online. Figure 19 lists the most comprehensive and recent evaluation results available as of Oct. 2020.

Figure 19. **Publicly-available evaluation results for addiction-related programs implemented in 2013-2019 focused on children, youth and families**

Program or policy	Evaluation results posted online (or available upon request)
Ohio START	• Ohio START is currently being evaluated by The Ohio State University College of Social Work, and an initial report is anticipated to be available by the end of 2020. • A Dashboard with basic program information is posted here.
MOMS	• The MOMS pilot project (4 sites) was evaluated by the Ohio Colleges of Medicine Government Resource Center, ODM, OMHAS and ODJFS. A July 2019 article in the *Journal of Substance Abuse Treatment* described outcomes of the pilot project, including increased use of and retention in behavioral health treatment for pregnant and postpartum women. Notably, the study found "marginally lower" likelihood of out-of-home placements for infants born to MOMS participants relative to the comparison group. • Subsequent phases are currently being evaluated.
Ohio Family Drug Court Statewide System Improvement Program (SSIP)	• The Ohio Colleges of Medicine Government Resource Center, Supreme Court of Ohio, ODJFS and ODM conducted an evaluation of an initiative to improve family stability and recovery outcomes in Family Drug Courts in 11 counties. • A Sept. 2020 evaluation report (available from the Supreme Court upon request) concluded that SSIP may have improved family stability outcomes, such as reduced rates of out-of-home placements and increased family reunification.
Racial and Ethnic Disparities Assessment (RED Tool used by specialized dockets)	• The American University Justice Programs Office, in partnership with the Supreme Court of Ohio, prepared an aggregate report describing results of the RED Tool assessments completed by 30 courts. • The Sept. 2020 report is available from the Supreme Court of Ohio upon request. The aggregate assessment found that treatment court graduation rates were higher for white participants (65%) than for Black (29%) or Hispanic (24%) participants. Notably, 81% of courts reported that they had never previously evaluated their outcomes to assess racial or ethnic disparities.

Appendix

Inventory process

In order to compile the detailed policy inventory, HPIO researchers searched the Ohio Revised Code (ORC), Ohio Administrative Code (OAC), state agency websites and policy summaries from other organizations. See figure 20 for examples of the types of policy changes reviewed.

Figure 20. **Types of policy changes reviewed**

Type of policy change	Examples
Legislative changes	• Senate Bill 332 strengthened home visiting services under the Help Me Grow program and allocated resources to increase smoking cessation services, including for pregnant women. • The 2013-2014 state operating budget, House Bill 59, expanded Medicaid eligibility to previously optional groups, including children in foster care; identified priority populations for state agency services, particularly addiction-related services; and expanded mental health service access to those under age 21 in the child welfare system.
Rules or regulations	Reporting on birth defects, including FASDs and NAS, is required of maternal and infant health providers under OAC 3701-57-02 and ORC 3711.30.
New or expanded state agency initiatives	• Bridges, an ODJFS program launched in 2018, supports foster youth between the ages of 18 and 21. • OMHAS and Ohio Family and Children First launched ENGAGE in 2013 to expand Wraparound services to youth, ages 14-21, with behavioral health needs and at-risk for becoming a multi-system youth.

HPIO researchers used the following search terms when reviewing the ORC and OAC:

- Adolescent
- Child health
- Child protect* (Including "child protection" and "child protective services")
- Child safety
- Child trauma
- Child welfare
- Children services
- Comprehensive Addiction and Recovery Act
- Crossover youth
- Custody
- Delinquency
- Dependency court
- Dyad
- Family First Prevention Services Act
- Family treatment drug courts
- Foster care
- Grandfamilies
- Infant
- Inpatient addiction treatment
- Juvenile
- Kinship care
- Multi-system youth
- Neonatal Abstinence Syndrome
- Permanency
- Plan of safe care
- Postpartum
- Pregnant
- Prenatal drug exposure
- Prenatal substance exposure
- Recovery housing
- Relative care
- Sibling
- Youth

Scorecard process

Step 1: Rating for specific policies and programs in detailed scorecard. HPIO researchers rated the specific policies, programs and services in the **detailed policy scorecard** based on five rating levels: strong, moderate, mixed, weak and unknown/more information needed. Each policy was given two ratings, one for alignment with evidence and another for extent of implementation reach. Figure 21 defines each of these ratings, as well as the score assigned to each rating.

Figure 21. **Definition of detailed scorecard rating levels**

Rating and score	Ohio alignment with evidence	Extent of implementation reach in Ohio
Strong (4)	Services, programs and policies being implemented in Ohio are highly consistent with the most rigorously-evaluated and effective evidence-based approaches in this category.	Services and programs are being implemented throughout the entire state (statewide or > 80 counties), are reaching a majority of intended groups of Ohioans and are funded at the level needed to implement widespread, effective programming with fidelity to the evidence-based model. Policies are being monitored, implemented and enforced as intended.
Moderate (3)	Services, programs and policies being implemented in Ohio are mostly consistent with recommended evidence-based approaches in this category.	Services and programs are being implemented in at least 40-80 counties, are reaching large numbers of intended groups of Ohioans and/or are funded adequately to meet current capacity and demand. Policies are likely being implemented and enforced as intended, although rigorous monitoring information may not be available.
Mixed (2)	Ohio is implementing some services, programs or policies with "strong" or "moderate" alignment with evidence, but is also implementing significant number of services, programs or policies with "weak" alignment.	Within this category, Ohio is implementing some services or programs with "strong" or "moderate" implementation reach, but is also implementing a significant number of services or programs with "weak" implementation reach. Some policies are being implemented as intended and enforced, while others are not.
Weak (1)	Ohio is implementing services, programs and policies that are not consistent with recommended evidence-based approaches within this category.	Services and programs are being implemented in fewer than 40 counties, are only reaching a small proportion of intended groups of Ohioans, and/or funding is inadequate to meet demand. Policies are not being implemented as intended and/or are not being enforced.
Unknown/ More information needed (1)	Adequate information to determine evidence alignment is not currently available.*	Adequate information to determine implementation reach is not currently available.*

*Note that this information may be available within specific counties, but is not available for the state overall.

Step 2. Summary score for subtopics. To summarize the scorecard findings for this report, the scores for each policy and program in the detailed policy scorecard were averaged across subtopics. For example, policies on NAS, FASDs, maternal tobacco use and plans of safe care were averaged to calculate scores for the topic *"Prenatal drug exposure."* This method was replicated for each subtopic (see figure 22). The total score for a subtopic is a composite score of alignment with evidence and extent of implementation and reach. If the subtopic total score was 6.0 or higher, it received a strong rating. Subtopics with a score between 5.0 and 5.9 received a moderate rating, and subtopics with a score below 5.0 received a weak rating.

Figure 22. **Final summary score and rating for children, youth and family subtopics**

Subtopic	Alignment with evidence*	Extent of implementation reach*	Total summary score	Summary rating
Family-focused prevention	3	1	4	Weak
Addiction treatment and recovery for parents	3.1	2.4	5.5	Moderate
Prenatal drug exposure	3.5	2.9	6.4	Strong
Child protection services and the foster care system	2.4	2.6	5	Moderate
Kinship care	3	3.3	6.3	Strong
Multi-system youth	3.2	3.5	6.7	Strong

*Average score across specific policies/programs within subtopic
Note: Subtopics with a score of 6.0 or higher received a strong rating, subtopics with a score between 5.0 and 5.9 received a moderate rating and subtopics with a score below 5.0 received a weak rating.

Sources of evidence

To identify the evidence-based policies, programs and practices listed in the scorecard, HPIO relied upon the most credible sources of information available. Rather than citing individual studies, HPIO turned to expert consensus statements, best practice guidelines and evidence registries whenever possible; these sources involve rigorous review of available research evidence by a group of experts who synthesize the information and make a recommendation or statement about what approaches are most effective. The types of sources used to develop the scorecard are listed below, in order of preference. For some topics, gray literature reports were used if expert consensus statements or best practice guidelines were not available:

1. **Expert consensus statements or recommendations from independent expert panels** convened by organizations, such as the International Association of Chiefs of Police or the National Association of Drug Court Professionals. These reports are based on rigorous, systematic reviews of research evidence and typically rate the strength of recommendations based on quality of the evidence base. Example: National Association of Drug Court Professionals, *Family Treatment Court Best Practice Standards*.
2. **Best practice guidelines from professional/ medical associations**, sometimes published in peer-reviewed journals. Example: U.S. Substance Abuse and Mental Health Services Administration, *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants*
3. **Evidence registries and clearinghouses.** Searchable databases or other user-friendly compilations of evidence-based policies and programs. These registries use specific screening criteria to identify effective strategies and/or rate strategies on the strength of their available evidence

of effectiveness. Examples: California Evidence-Based Clearinghouse for Child Welfare (Chadwick Center for Children and Families), Blueprints for Healthy Youth Development (University of Colorado Boulder) and What Works for Health (University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation). (Note: Only programs with high ratings of evidence of effectiveness were included.)

4. **Gray literature reports** from private sector organizations with recommendations based on review of evidence (although typically not a systematic review). Example: Child Welfare Information Gateway, *Parental Substance Use and the Child Welfare System*

For a complete list of credible sources of evidence on effective addiction practices in the sectors that impact children, youth and families, visit the HPIO Addiction Evidence Project **Evidence Resource Page: Children, Youth and Families.**

Limitations

The inventory begins in 2013, and therefore does not include policies that were implemented earlier in the addiction crisis, such as the establishment of the Ohio Tobacco Quit Line in 2003. (Major policies implemented prior to 2013 are however mentioned in the detailed scorecard when relevant to evidence alignment.)

Although this inventory is the most comprehensive review of addiction-related policy changes regarding the well-being of children, youth and families in Ohio completed to date, it is likely that some policies may have been missed, such as:

- Legislation or rules/regulations that did not include any of the search terms used by HPIO researchers (listed on page 37) when reviewing legislation and the OAC
- Rules/regulations that were revised between 2013 and 2019 but have prior effective dates outside of that date range. Due to the way rules are recorded, HPIO researchers were unable to discern which language was newly added and which language existed prior to 2013.

There were several challenges to rating the extent of implementation reach for the scorecard. First, information about the number of Ohioans or number of counties reached by a program or service was not always available. Second, information about the extent to which policies were being implemented as intended was not always available. Finally, service penetration rates and per-capita spending information from other states would provide useful context for assessing the adequacy of Ohio’s efforts, but this information would be time consuming and costly to collect.

Advisory Group

HPIO convenes an Addiction Evidence Project Advisory Group made up of over 30 representatives from state and local, public and private organizations with expertise in child health and well-being, children services, addiction prevention, behavioral health treatment and recovery (listed below). This group provides guidance to HPIO on Addiction Evidence Project products, including this report.

First Name	Last Name	Organization
Anita	Armstrong	Ohio Department of Education
Carol	Baden	RecoveryOhio
Gayle	Channing Tenenbaum	The Center for Community Solutions
Dave	Ciccone	Nationwide Children's Hospital
Elizabeth	Conrey	Formerly with the Ohio Department of Health
Chelsea	Cordonnier	Governor's Office of Children's Initiatives
Jolene	Defiore-Hyrmer	Ohio Department of Health
Courtney	Ebersole	Ohio Association of County Behavioral Health Authorities
Fawn	Gadel	Public Children Services Association of Ohio
Kristin	Gilbert	Ohio Court Appointed Special Advocates/ Guardian ad litem Association
Lynanne	Gutierrez	Groundwork Ohio
Deanna	Herold	Ohio Department of Job and Family Services
Monica	Kagey	Supreme Court of Ohio
Kim	Kehl	Ohio Department of Mental Health and Addiction Services
Teresa	Lampl	The Ohio Council of Behavioral Health & Family Services Providers
Teresa	Long	Ohio State University College of Public Health
Rick	Massatti	Ohio Department of Mental Health and Addiction Services
Shelley	Marsh	Ohio Domestic Violence Network
Rob	Moore	Scioto Analysis
Sara	Morman	Ohio Department of Health
Reena	Oza-Frank	Ohio Department of Health
Matthew	Parrish	City of Columbus, Division of Fire
Holli	Ritzenthaler	OhioGuidestone
Kate	Rossman	Ohio's Children Alliance
Jim	Ryan	Alcohol and Drug Abuse Prevention Association of Ohio
Bob	Shapiro	Cincinnati Children's Hospital Medical Center
Reina	Sims	Ohio Commission on Minority Health
Kelly	Smith	Mental Health & Addiction Advocacy Coalition
Ann	Spicer	Ohio Academy of Family Physicians
Stephanie	Starks-Lovelady	Ohio Department of Mental Health and Addiction Services
John	Tharp	Sheriff, Lucas County
Cherrelle	Turner	ODJFS Office of Children Services Transformation and the Governor’s Office of Children’s Initiatives
Kelly	Vyzral	Children's Defense Fund-Ohio
Angela	Weaver	Ohio Association of Health Plans
Jonathan	Westendorf	Fire Chief, City of Franklin

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