Community Child Protection Team Review Guide

A Guide for Local Community Child Protection Teams' Review of *Substance Affected Infants/Plan of Safe Care Cases*

The following guidance is presented to assist county departments and local Community Child Protection Teams through the review process, and to better understand and identify the factors associated with infants who are substance affected.

Brought to you by:
The North Carolina
Community Child Protection Team Advisory Board

BACKGROUND

Prenatal exposure to unhealthy substances is extensive in the United States. Of the 4.3 million infants born annually in the United States, at least 800,000 are exposed to drugs during pregnancy.[1] Drug use occurs with or separately from alcohol consumption. The extent of infants exposed to alcohol is high. Among pregnant women, one out of five report drinking alcohol during pregnancy, and nearly half of the women report binge drinking and over one-third report use of drugs.[2] No known amount of alcohol is considered safe during pregnancy.[3]

Depending on the type of substance or combination of substances, prenatal exposure may result in premature birth, low birth weight, slowed growth, and a variety of physical, emotional, behavioral, and cognitive problems, and/or fetal alcohol spectrum disorder (FASD).[4] This prenatal exposure may continue to have an impact on children throughout maturation, potentially resulting in poor cognitive, social, emotional development, and physical health issues.

The US Department of Health and Human Services [USDHHS] received reports from states of a total of 38,625 infants referred in 2019 to child protection services as infants with prenatal substance exposure.[5] Out of these referrals, 83% were screened in for an investigation or alternative response. The referrals were primarily for drug exposure (71%) and secondarily for drug and alcohol exposure (11%). Contributing to the greater identification of exposure to drugs than alcohol are difficulties in detecting alcohol exposure at birth[6] and workers' discounting alcohol consumption. Another factor is systemic racism:

[1] Joseph, R., Brady, E., Hudson, M. E., & Moran, M. M. (2020). Perinatal substance exposure and long-term outcomes in children: A literature review. *Pediatric Nursing, 46*(4), 163-173.

[2] England, L. J., Bennett, C., Denny, C. H., Honein, M. A., Gilboa, S. M., Kim, S. Y., Guy, G. P., Jr, Tran, E. L., Rose, C. E., Bohm, M. K., & Boyle, C. A. (2020). Alcohol use and co-use of other substances among pregnant females aged 12–44 years — United States, 2015–2018. *Morbidity and Mortality Weekly Report, 69*(31), 1009-1014. doi:10.15585/mmwr.mm6931a1

[3] Centers for Disease Control and Prevention. (2020). *Substance use during pregnancy.* Available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/substance-abuse/substance-abuse-during-pregnancy.htm#collapse_103555f1094700f100

[4] Mattson, S. N., Bernes, G. A., & Doyle, L. R. (2019). Fetal alcohol spectrum disorders: Neurobehavioral deficits associated with prenatal alcohol exposure. *Alcoholism Clinical and Experimental Research, 43*(6), 1046–1042. doi:10.1111/acer.14040; and Joseph, R., Brady, E., Hudson, M. E., & Moran, M. M. (2020). Perinatal substance exposure and long-term outcomes in children: A literature review. *Pediatric Nursing, 46*(4), 163-173;

[5] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau [USDHHS]. (2021). Child Maltreatment 2019. Available from https://www.acf.hhs.gov/cb/research-data-technology/ statistics-research/child-maltreatment

[6] Coles, C. D. (2011). Discriminating the effects of prenatal alcohol exposure from other behavioral and learning disorders. *Alcohol Research & Health, 34*(1), 42-50.

> Those children exposed to substances that may be more commonly used among minority communities—but that are not more harmful to the child (e.g., cocaine, amphetamines)—may have higher rates of removal than those children exposed to substances more prevalent in White communities (e.g., alcohol, opioids).[7]

USDHHS defines drug and alcohol abuse as "the compulsive use" of drugs and/or alcohol "that is not of a temporary nature" (p. 91). Accordingly, USDHHS frames substance abuse as an addiction, requiring treatment and support, not punishment, of parents. To prioritize treatment and support, states are revising child welfare policies so that pre-natal exposure to substances is not an automatic reason for making a finding of child maltreatment, and states are increasing their use of alternative responses for these families.[8] These changes are in line with recent federal legislation.

In 2016, the Comprehensive Addiction and Recovery Act (CARA) required communities to employ the use of Plans of Safe Care (POSC) to support the care of infants who are born identified as being affected by substance abuse or withdrawal symptoms, or FADS. The POSC is designed to support caregivers in accessing treatment and recovery services, while also ensuring child safety.

In response to the opiate crisis and extensive research about the long-term effect of alcohol use during pregnancy, CARA removed the qualifier "illegal" from describing substances. In addition, the use of "substance abuse or withdrawal symptoms" was intentional. A newborn may have withdrawal symptoms from medication that was prescribed to the mother during pregnancy. POSC are not specific to substance misuse or abuse situations or all substance exposed infants. Instead POSC are focused on substance use that has an impact on the infant.

POSC are not specific to child welfare-involved families. Prenatal substance use does not require child welfare involvement. POSC are necessary when the newborn is affected by substance use as determined by a healthcare provider. An infant identified as a "substance affected infant" (SAI) is defined by:

- An infant has a positive urine, meconium or cord segment drug screen with confirmatory testing in the context of other clinical concerns as identified by current evaluation and management standard.
- The infant's mother has had a medical evaluation, including history and physical, or behavioral health assessment indicative of an active substance use disorder, during the pregnancy or at time of birth.
- An infant that manifests clinically relevant drug or alcohol withdrawal.
- An infant affected by FASD with a diagnosis of Fetal Alcohol Syndrome (FAS), Partial FAS (PFAS), Neurobehavioral Disorder associated with Prenatal Alcohol Exposure (NDPAE), Alcohol-Related Birth Defects (ARBD), or Alcohol-Related Neurodevelopmental Disorder (ARND)

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[7] Page 13, Ingoldsby, E., Richards, T., Usher, K., Wang, K., Morehouse, E., Masters, L., & Kopiec, K. (2021). *Prenatal alcohol and other drug exposures in child welfare study: Final report*. Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. Available at https://www.acf.hhs.gov/sites/default/files/documents/cb/paode-in-cw-final-report-rev.pdf

[8] Ingoldsby, E., Richards, T., Usher, K., Wang, K., Morehouse, E., Masters, L., & Kopiec, K. (2021). *Prenatal alcohol and other drug exposures in child welfare study: Final report*. Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. Available at https://www.acf.hhs.gov/sites/default/files/documents/cb/paode-in-cw-final-report-rev.pdf

- An infant has known prenatal alcohol exposure when there are clinical concerns for the infant per current evaluation and management standards.

In an effort to measure the implementation of POSC and to specify recommendations for improving the response to infants identified as SAI, the North Carolina Community Child Protection Team Advisory Board is providing this guide to local Community Child Protection Teams (CCPTs) to support the gathering of information and development of recommendations on how to improve county department and community response to this vulnerable population.

PURPOSE

The following guidance is presented to assist county departments and local CCPTs through the review process, and to better understand and identify the factors associated with situations of infants affected by substances. Child welfare may identify the families as "in need of services" or make a finding of child maltreatment.

This guide is intended to be a resource, it is not a mandate, and may evolve as we continue to learn how to best review and analyze this type of situation. The purpose of a CCPT Review is multifaceted. Before embarking on organizing, preparing for, and scheduling a review of a SAI/POSC case, it is important to consider the purpose of this review and gather relevant information. It is important to identify what factors may have led to the parent's substance use, what services did the family receive, what contacts did the county and other service provider have with the family prior to the birth of an infant affected by substances.

This document offers guidance on the following:

- The purpose of a CCPT Review;
- Preparation for a CCPT Review of a Substance Affected Infant; and
- Tools that can be used to help achieve an effective and thorough review.

I. COMMUNITY CHILD PROTECTION TEAM

The CCPT is a group of community representatives who promote a community-wide approach to preventing and responding to child abuse and neglect. Local teams identify and respond to process gaps and promote maximizing the use of community resources. CCPTs are charged with reviewing active cases in which abuse, neglect, or dependency are found and that are:

- Selected from categories defined by the team;
- Brought for review at the specific request of a team member; or
- Brought for review at the initiative of the director of the county department.

When reviewing active cases, CCPT should:

- Assess the interventions made by the county department;
- Evaluate the case plan;
- Identify areas of strengths and/or weaknesses in the county department's engagement of the family;

- Analyze any systemic issues that may have led to delays or oversights;
- Evaluate the role played by other community agencies and the overall case coordination; and
- Develop recommendations for staff training and/or changes in the system that would address assessed concerns.

It is important that each local team commit to an approach that helps create a space to have respectful and sensitive conversations with county departments about their practices and lessons learned, while keeping the child(ren) and families at the center of the review.

Approaches to case reviews, which aim to focus on where something went wrong, may elicit a sense of fear and blame among professionals and organizations. While it is important to evaluate our work, it is equally important to understand the complex nature of human behavior and look at families with a larger system lens (i.e., public health approach). In the next section of this guide, we offer a framework to help guide you through a CCPT review of a case with an infant who has been affected by prenatal substance use.

II. PREPARATION

Selecting the Case

When an infant is born substance affected and in need of a POSC, it is important for county departments to reflect upon service delivery and analyze the factors that may have led to this adverse outcome. It is recommended that county departments select active cases to review when community provider and county department engagement is successful to learn how those approaches can be replicated. It is equally important to select and review active cases with challenges in service delivery to be able to explore what improvements are needed. The experience of the review team may be helpful in addressing systemic concerns (e.g., punitive response, surveillance of minoritized families),[9] community resources (e.g., availability of clean and sober housing, child care, and substance treatment services),[10] partnership model of service,[11]and any factors causing or associated with specific "stuck" cases.

[9] Atkins, D. N., & Durrance, C. P. (2020). State policies that treat prenatal substance use as child abuse or neglect fail to achieve their intended goals. *Health Affairs*, *39*(5), 756-763. doi:10.1377/hlthaff.2019.00785

[10] Hildebrandt, U. C., Graham, J. C., & Grant, T. M. (2020). Predictors and moderators of improved social- emotional functioning in mothers with substance use disorders and their young children enrolled in a relationship-based case management program. *Infant Mental Health Journal, 41*(5), 677-696. doi:10.1002/imhj.21872

[11] Singh, R., Rothstein, R., Ricci, K., Visintainer, P., Shenberger, J., Attwood, E. & Friedmann, P. (2020). Partnering with parents to improve outcomes for substance exposed newborns-a pilot program. *Journal of Perinatology, 40*(7), 1041-1049. doi:10.1038/s41372-020-0662-9

The Social-Ecological Model: A Framework for Prevention[12]

Once a case is selected, the county department may employ the Social-Ecological Model to organize the presentation of the case to the CCPT.

Many factors contribute to why families struggle to create safe and nurturing home, and it is important to consider the totality and influence of these factors to better understand why such situations may occur and how to prevent them. The social-ecological framework is broadly used in the context of child maltreatment prevention. The following information is presented by the National Center for Injury Prevention and Control.

The ultimate goal is to prevent child maltreatment before it begins. Prevention requires understanding the factors that influence child maltreatment. The CDC uses a four-level social-ecological model to better understand child maltreatment and the effect of potential prevention strategies. This model considers the complex interplay between individual, relationship, community, and societal factors. It allows us to understand the range of factors that put people at risk for child maltreatment or protect them from experiencing or committing harms in their family. The overlapping rings in the model illustrate how factors at one level influence factors at another level. The model, as originally developed, moves the focus away from seeing these harms as parental neglect to collective neglect of children.[13]

Besides helping to clarify these factors, the model also suggests that to prevent child maltreatment, it is necessary to act across multiple levels of the model at the same time. Given the role of CCPT in the community, utilizing this approach in the review process best aligns with the desired outcome of preventing future child maltreatment. In preparing to present a case, review and categorize the available information into these four levels. Similarly, recommendations may also be categorized into these levels.

Individual

The first level identifies biological and personal history factors that increase the likelihood of an infant being impacted by a parent/caregiver use of substances and an infant's recovery from this impact.. The primary individuals are the infant, mother, and father. Some factors concerning the infant are general health, impact of the mix of substances to which exposed, and early identification of these substances. Some parental factors are age, education, income, substance use, incarceration, and history of family violence. Prevention strategies at this level are early diagnosis of exposure to specific substances so that parents can understand the infant's responses and so that appropriate interventions can be instituted. Especially problematic has been the failure to diagnose accurately exposure to alcohol.

Information presented should include both protective and risk factors. Consider specific areas to be aware of, including what is known from research and what is known from the county department's specific experience with the family being presented to the CCPT.

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[12] Jointly published by: Dahlberg LL, Krug EG. Violence: A global public health problem. (2002). In E. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano (Eds.), World report on violence and health (pp. 1-21). Geneva, Switzerland: World Health Organization.

Centers for Disease Control and Prevention. (2002). The Social-Ecological Model: A Framework for Prevention. Atlanta, GA: Author. Available at https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html

[13] Blumenthal, A. (2021). Neglect as collective failure to provide for children: Toward a new theoretical approach. *Child Welfare, 99*(3), *31*-60.

Relationship

The second level examines close relationships that may decrease or increase the risk of experiencing or committing harms within the family. . A person's closest social circle-peers, partners, and family members-influences their behavior and contributes to their experience. Prevention strategies at this level may include parenting or family-focused prevention programs and mentoring and peer programs designed to strengthen problem-solving skills and promote healthy relationships. Prevention strategies at this level reduce parental sense of guilt and promote parental sense of competence.[14] Programs focusing on parenting skills with infants are less effective than programs focusing on parent-infant bonding.[15] Helpful strategies for enhancing bonding are infants rooming with their mothers at the hospital, breastfeeding, support from the father and other family, and nonjudgmental responses from service providers.[16]

Community

The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of child maltreatment. Prevention strategies at this level impact the social and physical environment. For example, by reducing social isolation, improving economic and housing opportunities in neighborhoods, as well as the processes, policies, and social environment within school and workplace settings. Mothers with substance use disorders and a history of physical abuse are more likely to recover with increases in community services (e.g., housing, public health), but no such effect is found for greater time spent in case-management services.[17] Policy and guidance for service providers are needed. For example, the American College of Obstetricians and Gynecologists states that their members have "an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use

[14] Short, V. L., Alexander, K., Gannon, M., Abatemarco, D. J., & Goyal, N. K. (2021). What aspects of their child's primary care do mothers value? A qualitative analysis of perspectives of women in treatment for opioid use disorder. *Child: Care, Health & Development, 47*(1), 40-46. doi:10.1111/cch.12811

[15] Lowell, A. F., Maupin, A. N., Landi, N., Potenza, M. N., Mayes, L. C., & Rutherford, H. J. V. (2020). Substance use and mothers' neural responses to infant cues. *Infant Mental Health Journal, 41*(2), 264-277. doi:10.1002/imhj.21835

[16] Partnering with parents to improve outcomes for substance exposed newborns-a pilot program. (2020). *Journal of Perinatology, 40*(7), 1041-1049. doi:10.1038/s41372-020-0662-9;

Rockefeller, K., Macken, L. C., & Craig, A. (2019). Trying to do what is best: A qualitative study of maternal-infant bonding and neonatal abstinence syndrome. *Advances in Neonatal Care: Official Journal of the National Association of Neonatal Nurses, 19*(5), E3-E15. doi:10.1097/ANC.0000000000000616;

Singh, R., Rothstein, R., Ricci, K., Visintainer, P., Shenberger, J., Attwood, E. & Friedmann, P. (2020). Partnering with parents to improve outcomes for substance exposed newborns-a pilot program. *Journal of Perinatology, 40*(7), 1041-1049. doi:10.1038/s41372-020-0662-9

[17] Hildebrandt, U. C., Graham, J. C., & Grant, T. M. (2020). Predictors and moderators of improved social- emotional functioning in mothers with substance use disorders and their young children enrolled in a relationship-based case management program. *Infant Mental Health Journal, 41*(5), 677-696. doi:10.1002/imhj.21872

disorder, either suspected or confirmed."[18]

Societal

The fourth level looks at the broad societal factors that help create a climate in which child maltreatment is encouraged or inhibited. These factors include social and cultural norms that support child maltreatment as an acceptable way to resolve familial conflicts (i.e., discipline). Other large societal factors include the health, economic, educational, and social policies that help to maintain economic or social inequalities between groups in society. Racist practices and policies impoverish minoritized families, and, even after taking poverty into account, racist bias leads to greater reporting, especially by medical personnel, of children of color with the same injuries as White children to child welfare.[19]

Content source: National Center for Injury Prevention and Control, Division of Violence Prevention

Who to Invite

Given the community's shared responsibility to ensure POSC are implemented when an infant is identified as substance affected, it is important to ensure key stakeholders are invited to the CCPT Review Meeting. County departments should lean on the expertise and experience of those participating in the meeting. Therefore, it is essential to promote participation from key stakeholders. In addition to the statutorily mandated participants, consider inviting local representation from:

- Case Management for At Rick Children (CMARC) [Formally Care Coordination for Children/CC4C]
- Hospitals and/or Medical Home/Pediatric Providers
- Lactation Consultants with Substance Use Specialty
- Prenatal care providers
- Substance Use Disorder Treatment Providers
- Local Management Entity-Managed Care Organization (LME-MCO)
- Medication Assisted Treatment Providers
- Family Violence Expert/Advocate
- Fatherhood Advocate
- Peer Support, Family Partner, and/or those with Lived Experience (Substance use, Family support and child protection, Infant involved with Child Welfare, Caregiver of substance affected infant, etc.)

III. TOOLS

Face Sheet (Attachment 1)
Utilizing a Face Sheet provides a quick reference tool to team members that organizes the case participants, the county department's history with the family, the current dates of involvement and allegations, professionals involved with the family, and any additional information. Keep information on

[18] American College of Obstetricians and Gynecologists. ACOG committee opinion no. 633. (2015). Alcohol abuse and other substance use disorders: Ethical issues in obstetric and gynecological practice. *Obstetrics and Gynecology, 125*(6), 1529–1537. doi:10.1097/01.AOG.0000466371.86393.9b

[19] Dettlaff, A. J., Boyd, R., Merritt, D., Plummer, J. A., & Simon, J. D. (2021). Racial bias, poverty, and the notion of evidence. *Child Welfare, 99*(3), 61-89.

the face sheet concise and fact-based.

Timelines
Timelines help illustrate relevant events, patterns, relationships, behaviors, risks, and protective factors associated with patterns of family harm. Plotting out a family's major life events (i.e., dates of marriage, childbirth, divorce, treatment, criminal charges) and dates of contact with relevant systems and/or providers, has shown to be an effective way of analyzing families' risks and contributing factors which may have led to prenatal substance exposure. Additionally, incorporating the social-ecological model above, timelines can provide a visual depiction to help understand the range of factors that put people at risk for harm in the family or protect them from experiencing or causing family harm. You can use a whiteboard, paper and pen, or utilize an online program to help complete your timeline.

Genograms (Attachment 2)
Genograms are another visual tool to help map out family relationships, households, and dynamics. They can also help illustrate key individuals and major life changes or events such as adoptions, marriages, divorce, incarcerations, etc.

Discussion Framework (Attachment 3)
The framework for the CCPT Review Meeting is intended to act as a guide and facilitation tool for discussing the case. The components of the framework incorporate the objectives and requirements of a CCPT Review, with a systems model approach. The framework can help the county department and CCPT engage in discussion that keeps the child and family at the forefront of the review, while evaluating systems level responses and service delivery. This tool should be completed by the team and during the CCPT Review Meeting.

SMART Format (Attachment 4)
Key to the CCPT Team process is developing recommendations for county departments, community providers, and the State to address systemic concerns that arose during the discussion of a case. Recommendations should include each layer of the system (i.e., local level – county department and community, state level – policy, training, legislation). Crafting a SMART recommendation is designed to identify what is to be. When utilizing the SMART format, use concise language while including relevant information.

IV. CONCLUSION AND ACKNOWLEDGEMENTS

It takes great courage to reflect on our work and engage in dialogue about children whose caregivers are unable to protect them from harm. . As professionals, helpers, social workers, and community members, we must seek to better understand why such patterns of family harm are occurring.

Many thanks to the dedicated, brilliant, and compassionate leaders who shared their time and expertise to create this guidance for CCPT Reviews. The following leaders were instrumental in this work:

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George Bryan, Advocate, Forsyth County
Melissa Godwin, Behavioral Health Springboard, UNC Chapel Hill School of Social Work
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Joan Pennell, Center for Family & Community Engagement, NCSU
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Meghan Shanahan, Gillings School of Global Public Health, UNC Chapel Hill
Barbara Young, Family Partner

If you have any questions about this document or would like support from the NCDHHS Child Welfare Division staff in implementing this guidance, please contact Jadie Baldwin-Hamm at jadie.baldwin@dhhs.nc.gov.

CCPT REVIEW GUIDE OF SUBSTANCE AFFECTED INFANT/PLAN OF SAFE CARE CASE

FACE SHEET

County Name:		**CCPT Review Date:**	
Date of Current Report:			
Allegations:			
Family's Prior Involvement with Child Welfare:			

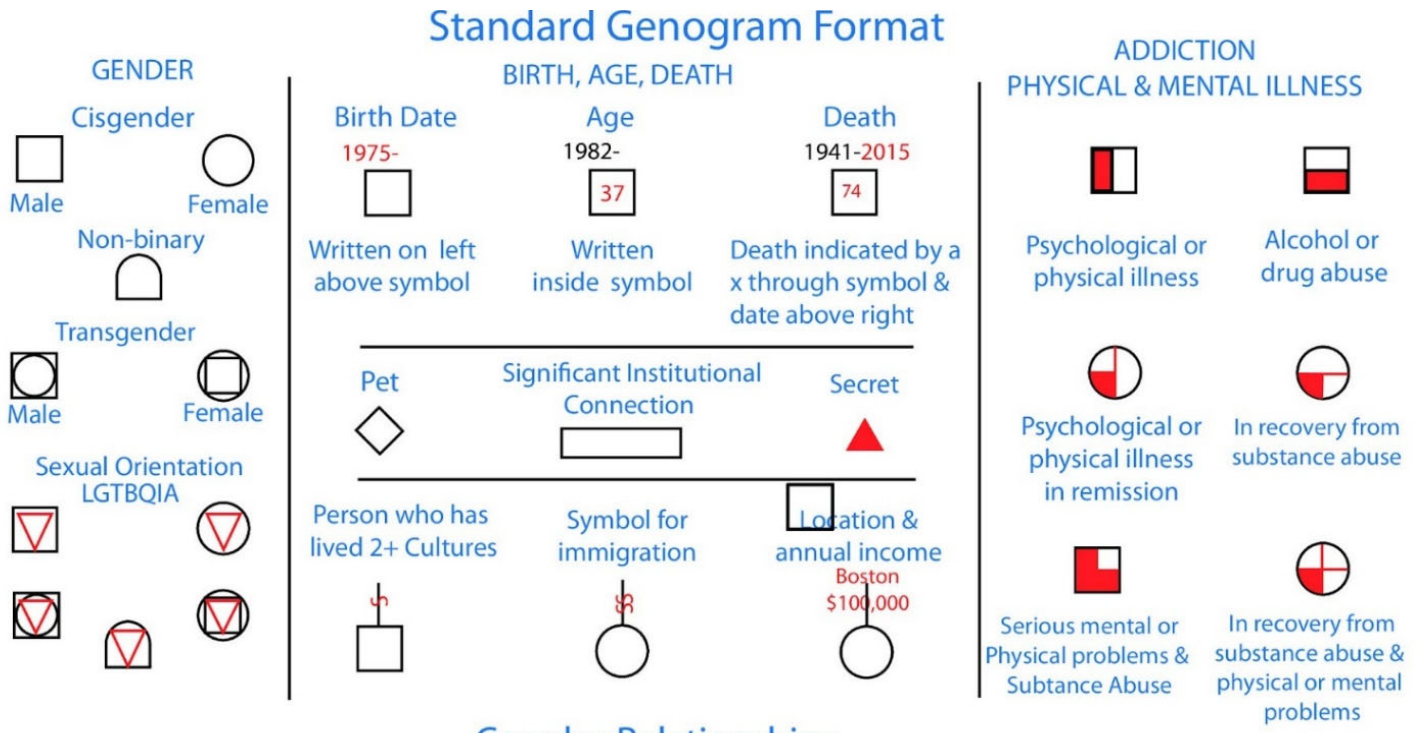
Family Demographics:					
Infant's Name:		**DOB:**		**Age:**	
Mother's Name:		**DOB:**		**Age:**	
Father's Name:		**DOB:**		**Age:**	
Other Children in the Home:					
Child's Name:		**DOB:**		**Age:**	
Child's Name:		**DOB:**		**Age:**	
Child's Name:		**DOB:**		**Age:**	
Child's Name:		**DOB:**		**Age:**	
Other Family/Household Members Involved:					
Name & Relationship to Infant:		**DOB:**		**Age:**	
Name & Relationship to Infant:		**DOB:**		**Age:**	
Name & Relationship to Infant:		**DOB:**		**Age:**	

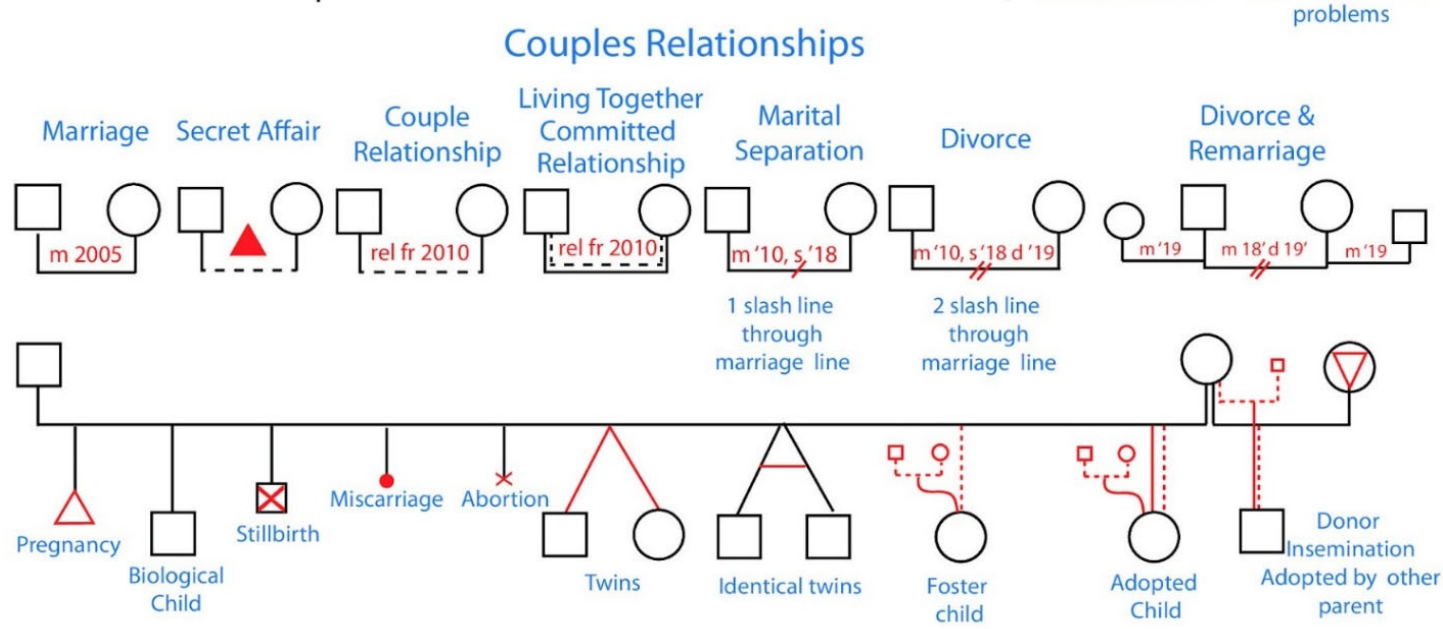
Professionals Involved with the Family:			
Provider Name:		**Date of Services:**	
Services Provided:			
Provider Name:		**Date of Services:**	
Services Provided:			
Provider Name:		**Date of Services:**	
Services Provided:			
Provider Name:		**Date of Services:**	
Services Provided:			

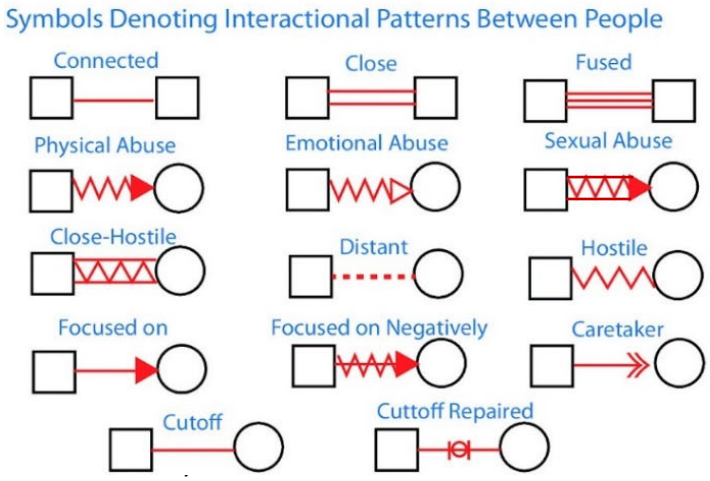
Additional Information:

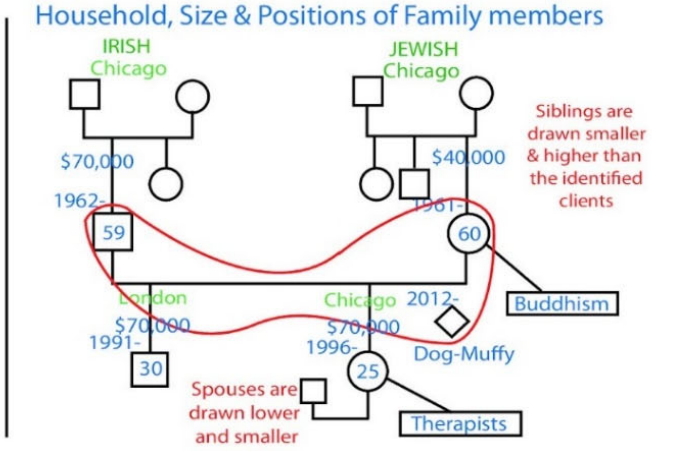
CCPT REVIEW GUIDE OF SUBSTANCE AFFECTED INFANT/PLAN OF SAFE CARE CASE

GENOGRAMS









Attachment 2

DISCUSSION FRAMEWORK

Contributing/Risk Factors Individual/Relationship/Community/Societal Levels	Service Delivery	Lessons Learned & Recommendations Individual/Relationship/Community/Societal Levels
Contributing/Risk factors identified: *Mother's substance use and impact on infant, sleeping environment, mental health, domestic violence, poverty, other vulnerable children in the home, age of parent, relationships, absence of support system, lack of acknowledgement of need for comprehensive substance and/or medication assisted treatment, etc.* *Protective Factors:* *Safe sleep practices, parenting plan (care, supervision, transportation, etc.) when utilizing substances, parental resilience, familial/peer supports, concrete supports, knowledge of parenting and child development, prior or current engagement in comprehensive substance and/or medication assisted treatment, etc.* *Systemic factors or influences that either support practice or create unsafe conditions in which poor practice is more likely to occur* *Consider the community, CMARC engagement and feedback, access to resources pre- and post-natal, accessibility to comprehensive substance and/or medication assisted treatment, etc. What aspects of the work make it easier for the mother and infant to receive needed services and supports? What barriers and challenges contribute to the infant being in an unsafe environment?*	*Strengths and Gaps:* • *Service delivery to the mother/infant/family* *Were there notable strengths or deficiencies in the prior or current service delivery to the mother/infant/family? Consider all systems that had contact and/or provided services to the family. What services were incorporated into the Plan of Safe Care?* • *Quality and sufficiency of coordination/ collaboration between local and state agencies* *Consider communication, coordination, and collaboration of agencies in response to family harm, and in any relevant longer-term work.* *Key practice episodes or turning points in service delivery from any servicesproviders who provided services to the family:* *Consider any provider or professional that had contact with the family (OB, medical, therapeutic, school staff, prevention specialist, etc.) Was there a professional that noticed something that others did not?* *Look at why decisions were made. Was there a particular service or intervention that had a positive or negative impact/outcome?* *Was there a particular event in this family's life that we should learn from?*	*Lessons Learned: What did the county department and CCPT learn from the review of this situation?* *How did this case review act as a "window" into the system? What was the actual experience of, or impact to, the staff/agency involved and the community service providers?* *Recommendations for Prevention:* *Is this recommendation focused on mitigating future prenatal substance use?* *All other recommendations will go into a parking lot.* *Is this recommendation county-specific or systemic?* *Consider the players in the recommendation and utilize a SMART format.* *Is this recommendation to change policy or practice?* *Consider the players in the recommendation and utilize a SMART format.*

Summary of review findings and recommendations to submit to the State: [*This section can summarize any themes, risk factors, patterns of behavior over time, services provided, community information, or understanding, and individual/relationship/community/societal recommendations that emerged through the completion of the framework.]*

SMART RECOMMENDATIONS

INITIAL RECOMMENDATION	Write the initial recommendation expressed by the Team
S **SPECIFIC**	What do you want to accomplish? Who needs to be included? When do you want it completed?
M **MEASURABLE**	How can you measure progress and know when the recommendation has been successfully implemented?
A **ACHIEVABLE**	Does the County, State, or System possess the skills and resources to achieve the recommendation? If not, can they be obtained or incorporated into the recommendation? Is the amount of effort required on par with what the recommendation will achieve?
R **RELEVANT**	Is the recommendation aligned with overall objectives and system values?
T **TIME-BOUND**	What is the deadline and is it realistic?
SMART RECOMMENDATION	Review what was written, and craft a new recommendation based on the answers above