MAVIS PROJECT
Maternal Anti-Violence Innovation & Sharing

A Kansas Department of Health and Environment Program

Pathways and Barriers

Understanding Perinatal Substance Use Disorder Systems in Kansas

Fall 2025

Contents

KU THE UNIVERSITY OF KANSAS | Center for Public Partnerships and Research

Funding

The Maternal Anti-Violence Innovation and Sharing (MAVIS) Project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) Office of Women's Health as part of an award totaling $3,500,000 with 100% funded by HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

Authors

Silke von Esenwein, PhD
Patricia Carrillo, MPH
Chris Tilden, PhD
Meghan Cizek, MA

Graphic Design

Eliza Mayo

Suggested Citation

von Esenwein, S., Carrillo, P., Tilden, C., & Cizek, M. (2025). *Pathways and barriers: Understanding perinatal substance use disorder systems in Kansas.* Prepared by the University of Kansas Center for Public Partnerships and Research for the Kansas Department of Health and Environment.

Language Disclaimer

While the quotes in this document may contain stigmatizing language, it is important to retain them for authenticity. These quotes provide genuine insight into the perspectives of Kansans about substance use disorders (SUDs), mental health, and intimate partner violence (IPV). Understanding their viewpoints and the language they use is crucial for comprehending the full scope of the issue and for developing effective, empathetic responses.

Executive Summary

Substance use disorder (SUD) during pregnancy and the postpartum period is an increasingly significant contributor to maternal and infant health challenges in Kansas. Between 2016 and 2022, the Kansas Maternal Mortality Review Committee (KMMRC) found that SUD contributed to more than one in four pregnancy-associated deaths, with all overdose deaths occurring in the postpartum period (Kansas Department of Health and Environment [KDHE], 2023). Accidental overdose was a leading cause, and substance use rarely occurred in isolation. Mental health conditions, including suicide and intimate partner violence (IPV), often overlapped, compounding the risks.

These deaths were not inevitable. **Many of these pregnancy-associated deaths could have been prevented through earlier identification, treatment engagement, and stronger continuities of care.** The underlying risk factors, such as untreated behavioral health conditions and fragmented postpartum services, were visible and, in many cases, addressable. Their persistence reflects missed opportunities across health, behavioral health, and child welfare systems.

Kansas has made meaningful progress in shifting toward family-centered, trauma-informed care. Medicaid Postpartum Extension, the introduction of integrated programs like Sobriety Treatment and Recovery Teams (START) and Family Strong, and the revision of child-welfare policies on substance-exposed infants all signal a move away from punitive responses and toward recovery-oriented systems. However, significant barriers remain. Gaps in rural access, workforce capacity, harm reduction, and culturally responsive care continue to limit consistent, high-quality outcomes for pregnant and parenting people affected by SUD.

Trauma-Informed Care

Trauma-informed care means understanding that many individuals have experienced difficult or harmful events in their lives, and delivering services in ways that feel safe, respectful, and empowering. It's based on six principles developed by the Substance Abuse and Mental Health Services Administration (SAMHSA; 2023): creating safety, building trust, offering peer support, promoting shared decision making, empowering people with voice and choice, and recognizing cultural and historical factors.

Strategic Priorities

This report outlines five strategic priorities, each grounded in statewide data, lived experience, and practice-based insights:

PRIORITY 1: Upstream Identification and Prevention

Expand non-punitive universal screening, early identification, and behavioral health promotion in preconception (e.g., primary care) and prenatal care settings. Include evidence-based interventions in early and middle adolescence that reduce the likelihood of later substance use and/or IPV perpetration or victimization.

PRIORITY 2: Expand Flexible, Evidence-Based Care Across the Perinatal Continuum

Substance use care for pregnant and parenting people and their families should be available wherever they receive medical care, before, during, and after pregnancy. These services must follow proven best practices and be delivered in ways that support whole families, reduce stigma, and adapt to each person's unique situation. Treatment should include access to medication for opioid use disorder (MOUD), mental health support, and help from peers or case managers who understand the challenges of parenting in recovery.

What is MOUD?

Medications such as methadone, buprenorphine, and naltrexone used to treat opioid use disorder. Some older guidance uses the term medication-assisted treatment (MAT); in this report we use MOUD to emphasize that medication is treatment in its own right.

Association of State and Territorial Health Officials [ASTHO], 2019.

PRIORITY 3: Harm Reduction and Postpartum Continuity

Preventing overdose-related maternal deaths requires intentional support during the postpartum period, when risks are highest. Harm reduction strategies, such as access to naloxone, fentanyl test strips, syringe services, and safer-use education, should be integrated into maternity and postpartum care. Every birthing hospital can play a role by ensuring mothers with a history of substance use, and their support networks, leave with overdose prevention tools and practical education. Medicaid and managed care incentives can further strengthen continuity of care, ensuring consistent follow-up visits and reducing relapse risk during this vulnerable window.

PRIORITY 4: Family-Centered Child Welfare and Court Partnerships

Strengthen alignment across child welfare, courts, and community-based programs to keep families safely together whenever possible. This includes expanding Family First–funded prevention services for families at risk of entering the child welfare system and enhancing Family Preservation services for those already under investigation or supervision. By coordinating trauma-informed care, timely assessments, peer mentorship, and court-based diversion strategies, Kansas can reduce unnecessary child removals while supporting parental recovery and safe, stable homes.

PRIORITY 5: Data-Driven Quality and Sustainable Financing

Invest in care coordination infrastructure, shared metrics, and Medicaid-supported service innovations that sustain impact statewide.

Building a Stronger Perinatal System for Kansas Families

This report is designed for policymakers, health care professionals, community leaders, and advocates who influence perinatal and behavioral health systems in Kansas. It distills complex data and evidence into actionable insights, showing where early intervention, family-centered support, and cross-system coordination can make the greatest impact. Readers will find practical examples of promising practices, gaps that demand attention, and policy opportunities that can reduce preventable deaths, improve maternal and infant health, and strengthen families. **Investing in high-quality perinatal care not only protects mothers and babies today, it also helps prevent childhood adversity, fosters positive early life experiences, and creates healthier, more resilient communities for generations of Kansans to come.**

Introduction

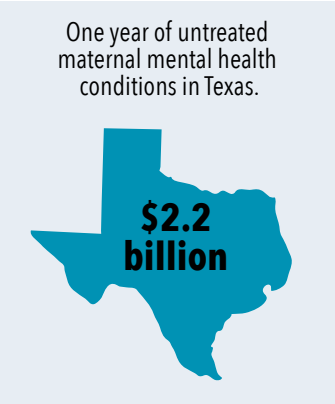
Kansas faces a growing public health challenge at the intersection of substance use, maternal health, and child welfare. SUD among pregnant and postpartum individuals has become a major contributor to maternal complications and death, with wide-ranging effects on families and communities. According to KMMRC data, substance use contributed to nearly one in four pregnancy-associated deaths from 2016 to 2022 (KDHE, 2023). Most of these deaths occurred after delivery and often involved other serious risks such as depression, suicide, or IPV. The consequences of SUD during pregnancy extend to infant health and family stability. Babies exposed to substances in utero are at increased risk for preterm birth, low birth weight, and neonatal opioid withdrawal syndrome. These families are also more likely to come into contact with the child welfare system. Many face barriers such as stigma, fragmented services, or punitive responses that make it harder to engage in care and sustain recovery.

The perinatal period, from pregnancy through the first year after birth, offers a critical opportunity to change this trajectory. During this time, people often engage with a variety of services including prenatal care, behavioral health treatment, and community supports. When those systems are well-coordinated, they can identify needs early and provide meaningful support that improves outcomes for both parents and infants. This report examines how Kansas can better leverage that window of opportunity to build a stronger, more connected safety net for families affected by substance use.

Strong Starts, Strong Returns: The Fiscal Case for Comprehensive Perinatal Behavioral Health and Safety Services

Perinatal mental health carries very large, avoidable costs. A national modeling study estimated $14.2 billion in societal costs for births in 2017, about $32,000 per untreated mother–infant pair through five years postpartum; **preventing and treating perinatal mood and anxiety**

disorders (PMADs) can therefore yield sizable savings to families, payers, and state budgets (Mathematica et al., 2019). While data from Kansas is not available, analyses from other states reflect national patterns. For example, in Texas, one year of untreated maternal mental health conditions cost ~$2.2 billion, including healthcare, productivity losses, and child impacts (Mathematica, 2022). Economic evaluations consistently find screening and treatment for perinatal depression to be cost effective, especially when paired with timely access to evidence-based therapies (Camacho & Shields, 2018; Wang et al., 2024). Family-support models also return value: recent syntheses of home visiting show positive benefit-cost ratios (e.g., Nurse-Family Partnership yields >$1 returned per $1 invested) and improved maternal mental health over time (Georgetown University Center for Child and Human Development, Infant & Early Childhood Mental Health TA Center, 2023). For relationship-safety work, the Confidentiality, Universal Education, Empowerment, and Support (CUES) approach offers a practical, low-cost clinical model with implementation resources and infographics can be used in clinical settings (Futures Without Violence, 2024).



Methodology

This report draws upon a comprehensive mixed-methods approach to examine SUD and perinatal health outcomes in Kansas. The goal was to assess the prevalence and impact of perinatal SUD while also understanding how systemic conditions, including policy, geography, stigma, and service infrastructure, shape access to care and health outcomes for pregnant and parenting individuals.

Quantitative data were drawn from multiple state and national sources. These included the Kansas Department of Health and Environment (KDHE), the Kansas Department for Children and Families (DCF), and Kansas Medicaid claims, as well as surveillance and epidemiological systems such as the Maternal Vulnerability Index (MVI), Kansas Pregnancy Risk Assessment Monitoring System (PRAMS), and Kansas Vital Statistics covering the years 2019 through 2025. In addition, data from the University of Kansas Center for Public Partnerships and Research (KU-CPPR) informed the analysis. These sources included findings from the United to Transform statewide substance use needs assessment, the Kansas Connecting Communities (KCC) Program, and the 2025 Title V Needs Assessment. Together, these datasets informed analyses of SUD prevalence, maternal and infant health outcomes, service utilization trends, and regional disparities across the state.

Qualitative data were integrated through several channels. KU-CPPR conducted interviews and focus groups with individuals who have direct experience navigating substance use during

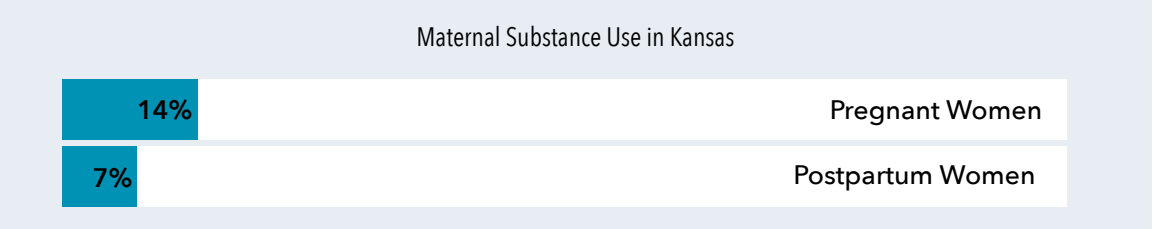
pregnancy and parenting, often referred to as "lived experience." These participants provided invaluable insight into how systems function in practice and where gaps in care, stigma, and system complexity pose barriers to treatment and recovery. Additional interviews and discussions were held with service providers, clinical professionals, and community-based organizations to further contextualize the delivery of services and system-level challenges.

To synthesize this learning into actionable insights, KU-CPPR developed composite patient journey narratives. These narratives, based on themes emerging from qualitative interviews, program data, and community engagement, were constructed to reflect common experiences in the perinatal SUD landscape. They illustrate real-world obstacles to accessing timely care, sustaining recovery, and keeping families together while navigating multiple overlapping systems.

Contextual analysis was further enriched by policy documents, provider interviews, and peer-reviewed literature related to Kansas-based programs such as KCC (Kansas Maternal & Child Health, n.d.), START (DCF, 2020; Casey Family Programs, 2022), and the state's Designated Women's SUD Treatment Programs (Kansas Department for Aging and Disability Services [KDADS], n.d.). This triangulated, mixed-methods approach allowed for a nuanced understanding of how individual experiences intersect with broader system structures, and how those intersections shape outcomes for families across Kansas.

The Scope of Perinatal Substance Use in Kansas

Substance use during pregnancy and the postpartum period is a growing concern in Kansas, with far-reaching impacts on maternal health, infant outcomes, and family well-being. According to KDHE, 14% of pregnant women report substance use during pregnancy and 7% in the postpartum period (KDHE, personal communication, February 5, 2025).



Medicaid claims data reinforce these trends: the rate of diagnosed SUD among pregnant enrollees rose from 9% in 2019 to 12% in 2021 (KDHE, personal communication, February 5, 2025).

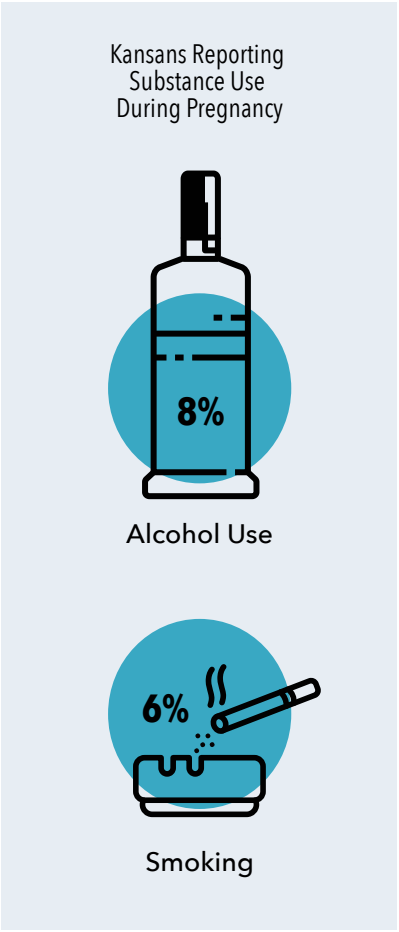
The scope of perinatal substance use is also visible in child welfare. Kansas received more than 1,400 reports of infants positive for substances (IPS) in a single year. For state fiscal year 2025, reports were more frequent in the Kansas City metropolitan area than in Wichita (DCF, 2024; DCF, personal communication, February 5, 2025). This challenges assumptions that perinatal

substance use is primarily rural and suggests reporting practices vary by region. Between July 2024 and June 2025, over 16% of Family in Need of Assessment (FINA) reports involved substance use. Caregiver substance use was the most common issue, cited in 12% of cases statewide, with regional highs in Southeast Kansas (14%) and lows in Wichita (10%). In 3% of cases, children themselves were identified as using substances, and in 2%, infants tested positive at birth, most frequently in the Northeast Region (3%) (DCF, 2025d).

1,400

reports of infants positive for substances in one year in Kansas.

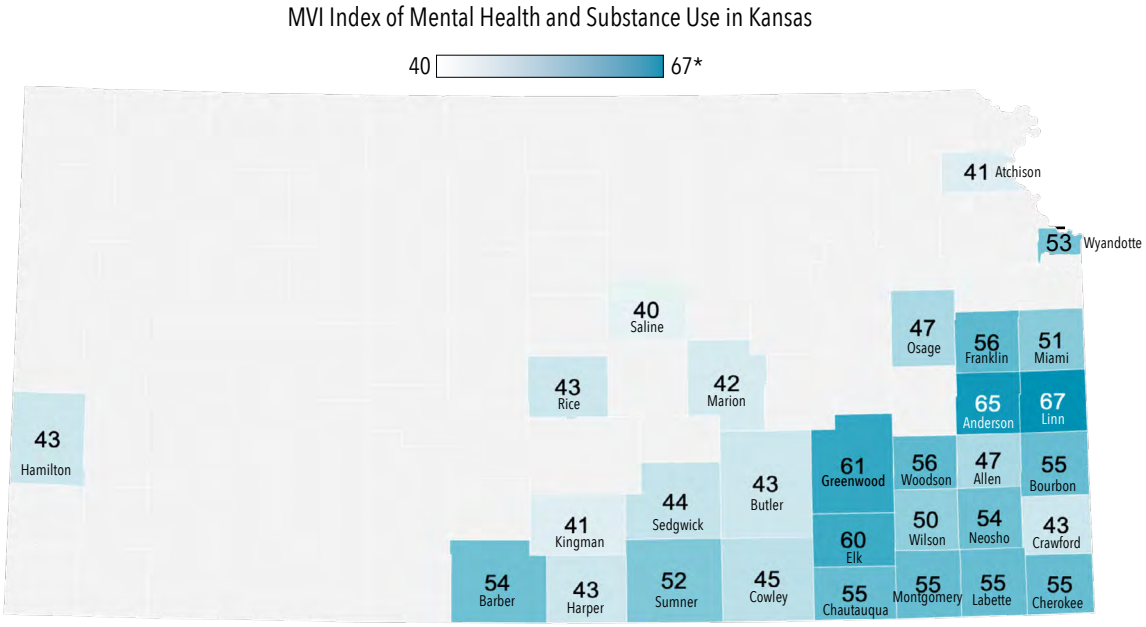
Disparities cut across insurance status, geography, and race. Medicaid-insured populations experience higher rates of perinatal SUD diagnoses and related outcomes such as NAS and preterm delivery. Rural communities face persistent barriers to treatment, including shortages of MOUD providers, behavioral health services, and women-specific SUD programs. Surveillance data also highlight inequities: Black women are more likely to face surveillance, child welfare involvement, and severe maternal outcomes even when substance use levels are comparable to other groups.



Substance use spans the reproductive years. Roughly one in five Kansas adults ages 26 to 35 meets criteria for an SUD, mirroring the statewide adult prevalence of 20% (KU-CPPR, 2025). During pregnancy, about 8% of Kansans report alcohol use (Health Resources and Services Administration Maternal and Child Health, n.d.), and close to 6% report cigarette smoking (Kansas Health Matters, n.d.). Nationally, about 8% of births involve prenatal exposure to illicit drugs and 11% to alcohol (Casey Family Programs, 2023). Together with rising overdose rates among young Kansans, these figures underscore that **substance use remains a serious and often silent threat across adolescence through the mid-thirties.**

The consequences extend into early life. Nationally, NAS has increased dramatically since 2000, with Medicaid-covered infants seven times more likely to be diagnosed than those with private insurance (Winkelman et al., 2018; Kim & Stabler, n.d.). In Kansas, despite statutes prioritizing pregnant women for treatment (Kansas Statutes Annotated, 2021), access remains inconsistent. Fragmented services and limited trauma-informed care often result in infants being removed from mothers shortly after birth, with lasting developmental and relational consequences (Trivedi, 2019). **The federal Children and Family Services Review has called on Kansas to improve in-home supports to reduce preventable removals** (Administration for Children and Families, 2023).

Geographic disparities further shape outcomes. The Maternal Vulnerability Index identifies counties such as Greenwood, Anderson, and Linn as high-risk in the mental health and substance use domain (Valerio, V. C., et al. ,2023). These scores reflect behavioral health workforce shortages, lack of integrated treatment models, and limited culturally responsive services. Addressing these challenges will require expanded perinatal mental health screening (American College of Obstetricians and Gynecologists [ACOG], 2023), integrated care models (Silverman & Benyo, 2024), and investment in trauma-informed systems that support maternal health and family stability (Task Force on Maternal Mental Health, 2024)).



**Darker colors denote higher risk.*

Access to medication for opioid use disorder (MOUD) when combined with mental health and wraparound services is a cornerstone of effective treatment, but availability remains low and uneven across the state (KU-CPPR, 2025). Rural areas in particular face significant shortages of providers certified to offer buprenorphine or methadone, making it difficult for many individuals to receive timely, evidence-based care. Geographic barriers also limit access to designated women's treatment programs, which are especially scarce outside major metro areas. The Kansas Fights Addiction Act prioritizes expanding MOUD access, particularly in underserved counties, acknowledging its critical importance in improving both maternal and neonatal outcomes (KU-CPPR, 2025).

Risks and Barriers

Women experience substance use and its impacts in ways that are often distinct from men, shaped by biological, psychological, and social differences. While women typically begin using substances later in life, they often escalate more quickly from initial use to dependence—a phenomenon known as the "telescoping effect" (Towers et al., 2023). This leads to more rapid development of physical consequences even at lower levels of use. For example, women are more likely than men to experience liver disease (Kezer et al., 2021) and alcohol-related cognitive impairment (Sullivan et al., 2002) despite consuming less on average. Telescoping effects have been observed with substances like alcohol, tobacco, opioids, and methamphetamine (Towers et al., 2023).

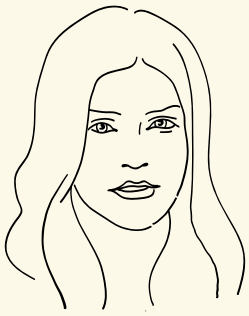
Beyond the biological risks, women who use substances are more likely to experience co-occurring mental health conditions such as depression, anxiety, or post-traumatic stress disorder (National Institute on Drug Abuse [NIDA], 2020). One study found that more than 85% of women with alcohol dependence also met the criteria for at least one mental health condition (NIDA, 2020). Childhood trauma is also disproportionately common among women with SUD. Women with current substance use frequently report a history of childhood physical or sexual abuse at rates far exceeding rates the general population. In a recent study, almost three-quarters (73%) of women engaged in MOUD treatment had experienced of childhood sexual abuse (Rodriguez et al., 2025). In many cases, substance use becomes a way to manage unresolved trauma, reinforcing a cycle of emotional pain and dependency (Werner et al., 2023).

Stigma is another major barrier. Women, especially mothers, often face heightened judgment and shame around substance use, which deters them from seeking help. These fears are especially intense during pregnancy and postpartum, when the consequences of disclosure may include involvement with child protective services or even loss of custody. Research confirms that women are significantly less likely to enter treatment if they believe it might result in being labeled "unfit" or trigger child welfare investigations (Meinhofer et al., 2022).

Following is a story about Emma (a fictitional case built from common patterns and prevalent factors identified across the data) whose experience highlights how alcohol use during pregnancy is often minimized or overlooked in suburban settings, where assumptions about low risk can lead to missed interventions.

PATIENT JOURNEY

Meet Emma



Emma represents a demographic often overlooked in discussions of substance use: a suburban, White, privately insured mother whose alcohol use is shaped by cultural norms and social acceptability. Often referred to as a "wine mom," Emma's experience highlights how substance use can be normalized in certain social circles, making it less likely to be recognized as a concern, either by those around her or by Emma herself. Her story demonstrates how **factors like stable housing, insurance coverage, and social status can contribute to delayed recognition and engagement with support services.** This journey calls for greater attention to how substance use presents across different populations and settings.

Discovery

Emma, an elementary school teacher, discovered her pregnancy during a routine primary care visit. Despite being well-connected and privately insured, she felt uncertain and overwhelmed by conflicting messages online about alcohol use during pregnancy. Social norms in her friend group, where alcohol use was often joked about as "mommy juice," added pressure and downplayed her growing concerns.

Engagement

When Emma brought up her alcohol use with her OB-GYN, she encountered vague reassurances rather than meaningful dialogue. The provider suggested occasional wine might be fine, which left Emma without the clarity or support she needed. She attempted to find mental health care but ran into difficulties: her insurance directory was outdated, and there were few clinicians trained in perinatal behavioral health. Emma's early signs of emotional distress, including irritability, insomnia, and sadness, went largely unrecognized.

Challenges

Emma hesitated to share her full story due to fear of stigma and possible professional consequences. Without structured behavioral health screening or clear pathways to care, her alcohol use remained unaddressed, heightening risks for her and for her baby. She worried silently about potential effects to developmental such as low birth weight or neurodevelopmental delays.

Intervention

Eventually, a colleague recommended a therapist with perinatal experience. Through evidence-based outpatient counseling, Emma received support in managing stress, reducing alcohol use, and developing healthy coping strategies. Therapy incorporated elements of motivational interviewing and cognitive-behavioral therapy.

Family Involvement

Emma's partner joined select therapy sessions, learning supportive communication strategies and helping reduce stress at home. This increased Emma's sense of safety and accountability.

Outcome

With targeted behavioral health care and family engagement, Emma reduced her alcohol use, carried a healthy pregnancy, and entered postpartum with greater emotional stability. Without early intervention, she faced risk of postpartum depression, continued substance use, and impaired mother-infant bonding.

Provider Action Plan

Normalize Screening and Conversations About Alcohol Use

Offer routine, nonjudgmental screening during prenatal visits, and provide specific feedback about risks—even for moderate or "social" drinking.

Strengthen Behavioral Health Referral Pathways

Maintain updated referral directories and build collaborative relationships with therapists trained in perinatal mental health and substance use.

Reframe Mental Health and SUD Services as Preventive and Empowering

Communicate that early counseling is a strength—not a sign of failure—and a critical tool for preventing long-term maternal and child health risks.

In many states, these fears are legally grounded. Substance use during pregnancy can be interpreted as child abuse, and criminal charges have been brought against pregnant women for drug use (Association of State and Territorial Health Officials [ASTHO], 2019). These punitive policies create a chilling effect on care-seeking behavior and increase risks for both mother and baby by delaying access to both prenatal and behavioral health care (ASTHO, 2019). One Kansas nonprofit leader described the dilemma this way:

> *"DCF has some really awesome programs that would greatly benefit some of my people [but] my families won't touch it because it's connected to DCF. That's who took the kids away. I've got a mom with postpartum depression, and she is not going to say, 'Hey, I'm struggling with some really negative dark thoughts,' because she doesn't want her kid or her older kids put in foster care. Her mom had depression, and she was put in foster care…. How do we utilize these resources that are available without getting burned by them, without losing custody of my kids?"*

Even when stigma is not the primary concern, women encounter significant structural barriers. Childcare responsibilities are a frequent obstacle: many mothers cannot leave their children for lengthy residential treatment stays or travel long distances to outpatient appointments. The lack of transportation, flexible scheduling, or on-site childcare routinely prevents women from engaging in treatment (SAMHSA, 2024). One rural provider shared:

> *"We have got this challenge… of accessible daycare and time off—if they are employed—in order to travel to obtain those services… I think we have got to figure out a way that we have good childcare services available."*

Financial hardship compounds these challenges. In Kansas, around 34% of single-mother households live in poverty (Ginther et al., 2022). Without paid leave or health coverage, even low-cost treatment becomes out of reach. These pressures disproportionately affect those in rural areas, communities of color, and justice-involved populations.

Meanwhile, many treatment programs fail to address women's needs. Few facilities offer parenting support, trauma-informed services, or mental health care alongside substance use treatment. Residential centers that allow mothers to stay with their infants are rare. Mixed-gender group settings can feel unsafe or uncomfortable for women, particularly those with histories of sexual trauma (KU-CPPR, 2025). As one woman in recovery noted:

> *"There's no meetings here for me to go to… I've gone to a NA meeting. I don't want to go to NA meeting. It's a bunch of old guys talking around, smoking cigarettes, and I'm this young girl here, and they're just happy I'm there."*

Some Kansas providers are adapting. One rural physician described a low-barrier approach to screening for violence and trauma:

> *"We did have a little badge card… that had a list of red flags… just in general, things and signals to look out for when these patients were coming in the triage unit… and making sure that if there is a suspicious partner present, to try to get them alone. Tell them we need to do an ultrasound, just something which would allow us to have a one-on-one conversation if we're picking up on any red flags."*

Yet service adaptation remains inconsistent. According to 2025 Kansas's Title V Needs Assessment, many maternal and child health (MCH) agencies recognize substance use as a growing issue but remain unsure how to intervene effectively (von Esenwein et al., 2025). Referrals are common, but follow-up is often weak or siloed, and families remain without the coordinated care they need.

These challenges are not insurmountable, but they require systemic realignment. Programs must center on the realities of women's lives: trauma histories, caregiving responsibilities, and deep concerns about custody loss. Interventions that are trauma-informed, flexible, and culturally responsive can shift the landscape, helping women access care earlier and stay engaged longer.

Programs that provide wraparound support, including things like prenatal care, substance use treatment, mental health services, parenting support, childcare, and case management, have been shown to improve outcomes for both mothers and their babies (ASTHO, 2019).

Pregnancy and Postpartum Vulnerabilities

Pregnancy and the months after birth are medically complex and emotionally intense. For people who use substances, this period also brings heightened stigma, fear, and judgment. Public attention often centers solely on fetal risk, which can eclipse the parent's health needs and fuel narratives of being "unfit." These perceptions are reinforced by policy: as of 2019, 24 states and Washington, D.C. define prenatal substance use as child abuse, and many allow criminal prosecution during pregnancy (ASTHO, 2019).

Kansas data show how policy climate and access barriers interact. In FY23, 4,427 Kansans gave birth without any prenatal care, and 823 of these births involved a documented SUD diagnosis—clear missed opportunities for screening and early support (KDHE, personal communication, February 5, 2025). Treatment availability also remains uneven: only about 53% of outpatient programs that offer MOUD report accepting pregnant patients, even though clinical guidance identifies methadone and buprenorphine as standard treatments in pregnancy (ASTHO, 2019; ACOG, 2017). Fear of system involvement can further influence care-seeking. In FY2025 year-to-date (July 1, 2024 to June 30, 2025), 96% of Kansas child protective services (CPS) investigative findings were unsubstantiated (44,482 of 46,465), while 3% were substantiated (1,557) and 1% were "affirmed" (426; the affirmed category was sunset January 1, 2025) (DCF, 2025e). Over the same period, the state received 70,303 CPS reports (DCF, 2025c), and 48% were assigned for a response (DCF, 2025b). Taken together, these patterns point to opportunities for policies that strengthen screening, ensure consistent access to evidence-based treatment, and build supportive pathways into care that families can trust.

As one Kansas clinician put it,

> *"We are falling short in identifying women earlier in the [substance use] process and recommending as much as we can to get them into treatment, understanding that if they are pregnant or they have children, there is this fear of what happens with their child and law enforcement. Let us figure out how we address that and destigmatize that."*

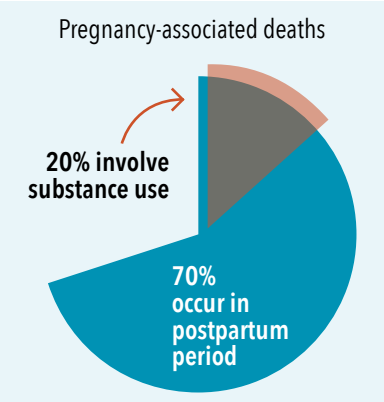
Pregnancy can also be a powerful catalyst for change. Many women reduce or stop substance use during pregnancy out of care for their developing baby. Research shows that between 70% and 90% of women who use drugs stop during pregnancy (Forray et al., 2015). But the risks do not end at birth. The postpartum period is an especially vulnerable time, filled with sleep deprivation, hormonal shifts, caregiving demands, and potential postpartum depression or anxiety. Without sustained support, this can lead to recurrence of use, often accompanied by guilt, fear of legal repercussions, and child welfare involvement (Forray et al., 2015; Hayes, 2020). In addition, as the unregulated drug supply continues to evolve, particularly with the increasing presence of fentanyl and other potent synthetics, individuals returning to use after a period of abstinence may encounter drugs that are dramatically stronger than what their bodies are prepared for, placing them at elevated risk of fatal overdose even at previously tolerated doses (Ware et al., 2025).

Postpartum substance use is not just common—it can be fatal. National data identify SUD as a leading cause of pregnancy-associated deaths, with most of these deaths occurring not during pregnancy, but in the year following delivery (Martin & Parlier-Ahmad, 2021). In Kansas, approximately 9.3% of postpartum maternal deaths between 2016 and 2022 were attributed to poisoning or overdose (KDHE, 2024). This reflects broader findings from the KMMRC, which show that SUD contributed to nearly one in four pregnancy-associated deaths in the state, most of which occurred after delivery. Part of the problem is structural. Health care systems often center care on the fetus during pregnancy and the infant after birth, unintentionally neglecting the mother's physical, emotional, and behavioral health. Many women report feeling that their own needs are overlooked in the postpartum period, even as they face compounding stressors and health risks. Experts have called for a redesign of perinatal care that actively includes and supports the birthing parent, not just the baby, extending well into the first year after birth (Martin & Parlier-Ahmad, 2021). Programs that offer wraparound services, combining prenatal care, SUD treatment, mental health support, parenting assistance, case management, and childcare, have been shown to improve outcomes for both mothers and their infants (ASTHO, 2019). Yet in Kansas, many of these supports remain siloed and underfunded. Continued investment in integrated, trauma-informed, and family-centered care is essential to protect maternal and infant health during this critical window.

Perinatal health should also include those who experience miscarriage or stillbirth, which are often excluded from standard definitions despite their emotional and physical impact. While substance use during pregnancy has been linked to an increased risk of stillbirth and other adverse outcomes (Ragsdale et al. 2024), many individuals also face heightened risk of substance use following a pregnancy loss, as they cope with grief, trauma, and limited access to support (Chen et al., 2024). Both pathways underscore the importance of compassionate, inclusive care throughout the perinatal period.

Differential Health Outcomes

Kansas, like many other states, is facing a maternal health crisis shaped by systemic barriers and inadequate support systems. Maternal mortality and severe maternal morbidity rates remain alarmingly high across the state, with significant gaps in health outcomes by race, geography, and socioeconomic status. These differences are further intensified by the impact of SUD, which contributes to a large and growing share of preventable maternal deaths.



According to the KMMRC, approximately 70% of pregnancy-associated deaths occurred in the postpartum period, with more than half taking place between 43 days and one year after delivery (KDHE, 2023). Of these deaths, SUD was a contributing factor in nearly one-fourth. Accidental overdose was a leading cause, particularly in the late post-partum period, and SUD rarely occurred alone—mental health conditions, suicide, and IPV were frequently co-occurring. Overall, nearly 80% of pregnancy-related deaths reviewed by the KMMRC were deemed preventable (KDHE, 2023).

The burden of these deaths is not evenly distributed. Black mothers in Kansas are nearly three times more likely to die from pregnancy-related causes than white mothers (KDHE, 2023). Indigenous women, Latina women, and low-income rural mothers also face elevated risks, often compounded by lack of local services, gaps in culturally responsive care, and higher rates of Medicaid coverage or uninsurance.

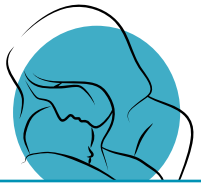
Infant outcomes mirror these maternal patterns. Kansas data show a troubling trend in the number of infants affected by substance use. Between July 2024 and May 2025, **approximately 1.6% of FINA child welfare case assignments involved infants testing positive for substances at birth**, with the highest rates reported in the Northeast region (excluding the Kansas City region) of the state (DCF, 2025d). Moreover, as far as current data indicate, Kansas substantiated or affirmed 40 infants as being substance-affected at birth in

Persistent gaps exist in service delivery for substance-affected infants at birth.

2024; however, only one of those families received a federally required Plan of Safe Care, highlighting persistent service delivery gaps (DCF, personal communication, February 5, 2025; Child Welfare League of America, 2024).

The systemic barriers extend to treatment access. Pregnant and parenting women covered by Medicaid are far more likely to be diagnosed with NAS or related conditions than those with private insurance. Nationally, Medicaid-covered infants are seven times more likely to be diagnosed with NAS (Winkelman et al., 2018). Despite Kansas law granting pregnant women priority access to publicly funded treatment (Kansas Statutes Annotated, 2021), access remains inconsistent, especially in rural areas and communities with high social vulnerability scores on the Maternal Vulnerability Index.

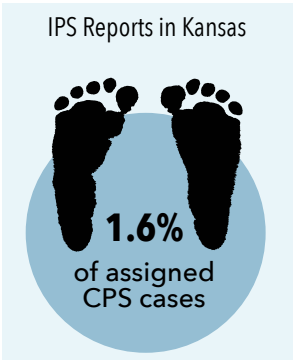
Counties such as Greenwood, Anderson, and Linn have been identified as particularly high-risk according to the MVI's mental health and substance use indicators. These elevated scores point to a lack of behavioral health providers, underfunded perinatal services, and limited integration of care across systems. The combination of these factors creates a dangerous environment for maternal and infant health, where individuals with SUD are more likely to fall through the cracks.



Families impacted by SUD struggle to receive support.

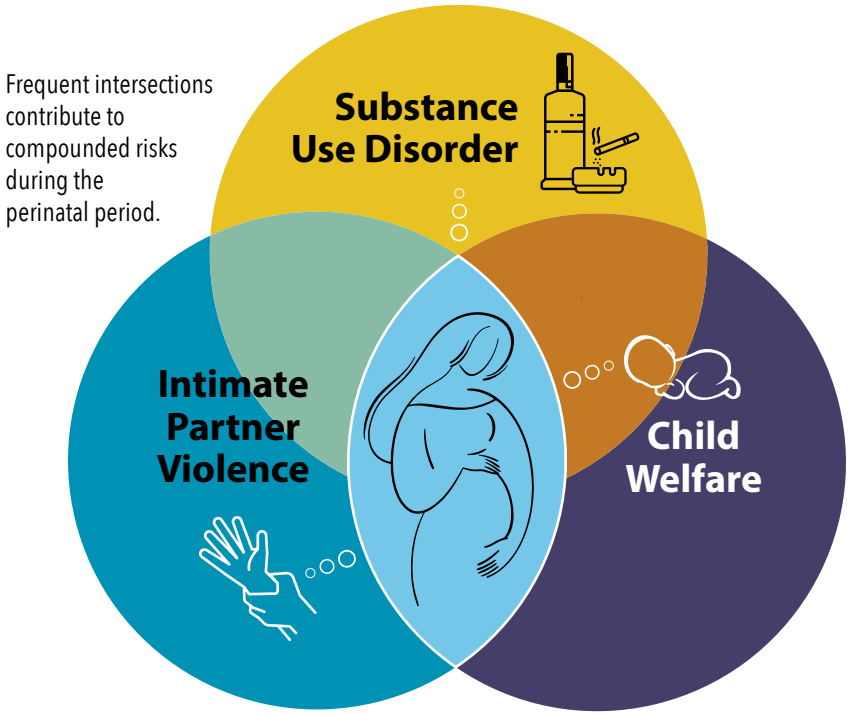
There is also a disconnect between referrals and follow-through. Many local maternal and child health agencies identify SUD as a top concern, but **limited infrastructure and unclear referral pathways result in inconsistent care delivery** (von Esenwein et al., 2025). Without robust systems for coordination and accountability, families impacted by SUD may struggle to receive even basic services, let alone the comprehensive supports needed for long-term recovery and family stability.

Reducing maternal and infant mortality in Kansas will require more than clinical solutions. It demands investments in integrated care clinics; expanded access to perinatal SUD treatment; improved Medicaid coverage and care continuity; and better systems integration across behavioral health, public health, and child welfare. These changes are essential not only for improving health outcomes, but also for addressing the longstanding challenges that continue to shape who thrives and who struggles in the perinatal period.



The Overlap of Substance Use, Intimate Partner Violence, and Child Welfare

SUD, IPV, and child welfare involvement frequently intersect during the perinatal period, compounding risk and stress experienced by families. National studies have shown that **women who experience IPV around the time of childbirth are significantly more likely to also have SUD or other behavioral health conditions** such as depression and anxiety, placing both the parent and infant at heightened risk (Taillieu et al., 2021). These risks extend well beyond health alone. Infants born to mothers experiencing IPV during pregnancy are nearly nine times more likely to be referred to child protective services than infants whose mothers did not experience IPV (Taillieu et al., 2021).



Following is a story about Jasmine (a fictitional case built from common patterns and prevalent factors identified across the data). Jasmine's story powerfully demonstrates the intersection of substance use, intimate partner violence, and distrust of child welfare systems and how fear of DCF involvement, combined with IPV and fragmented services, can push families further from support when they need it most. She embodies the systemic failures that arise when care is not trauma-informed or culturally responsive. Her journey also validates the need for integrated IPV screening and peer-led engagement.

PATIENT JOURNEY

Meet Jasmine

Jasmine's story reflects the experiences of individuals facing multiple, overlapping challenges while seeking care. She is a Black woman living in an urban area, enrolled in Medicaid, who has experienced intimate partner violence (IPV) and uses both cannabis and alcohol. **Her journey shows how past trauma, personal safety concerns, and limited access to consistent resources can affect how and when someone connects with support.** It underscores the need for services that are sensitive to each person's life circumstances and history.

Discovery

Jasmine, a retail worker covered by Medicaid, disclosed occasional cannabis and alcohol use during a prenatal visit with a nurse-midwife. The intake questions made her uneasy, especially regarding potential Department for Children and Families (DCF) involvement, which her partner frequently used as a threat.

Engagement

Navigating healthcare for Jasmine meant contending with multiple layers of systemic and interpersonal barriers. These included lack of reliable transportation, limited availability of providers who accepted Medicaid, unclear communication about follow-up scheduling, and fear of being judged or reported. On top of these, Jasmine faced coercive IPV, including emotional manipulation, financial control, and social isolation—factors that discouraged her from seeking consistent care.

Challenges

Her partner's threats and misinformation about DCF fueled her silence and mistrust. She feared that any disclosure of substance use or her relationship issues would result in losing custody. These fears, coupled with logistical barriers, prevented her from fully engaging in significant care, despite concerns that stress and continued substance use could cause preterm birth or affect her baby's development.

Intervention

Over time, Jasmine's nurse-midwife used trauma-informed engagement strategies (e.g., building trust over multiple visits) to create a safe space for disclosure. Once Jasmine shared more about her IPV situation, the nurse connected her with wraparound community-based supports including behavioral health therapy with a licensed clinical social worker (LCSW), IPV-informed prenatal education, and transportation coordination. In addition to IPV-specific safety planning, the care team addressed healthcare navigation barriers by scheduling appointments directly, helping her apply for emergency transportation vouchers, and clarifying Medicaid-covered service options. This reduced missed visits and helped Jasmine remain in care while preparing to leave her relationship safely.

Family Involvement

Jasmine's mother and sister became vital emotional anchors, participating in prenatal support groups and helping implement her safety plan.

Outcome

Through consistent, coordinated care, Jasmine delivered a full-term baby and built a more stable postpartum environment. Without this support, she would have remained at risk for continued IPV, disrupted care, and poor maternal and infant outcomes.

Provider Action Plan

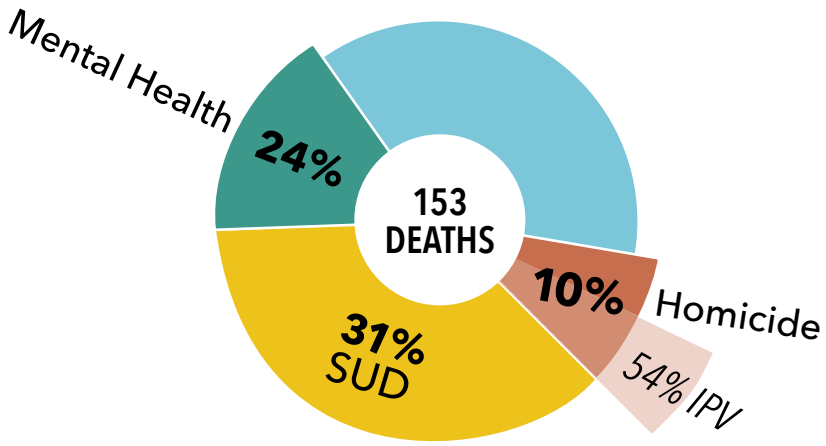
Recognize & respond to complex, overlapping barriers.	**Use trauma-informed engagement to build trust over time.**	**Clarify policies related to mandatory reporting.**
Offer support for transportation, Medicaid navigation, and appointment logistics alongside IPV and behavioral health referrals.	*Avoid rushed assessments. Instead, prioritize continuity and relationship-building to increase patient disclosure.*	*Reassure patients about what triggers DCF involvement to reduce fear and misinformation*

This complexity often plays out in silence. Many women do not disclose substance use or violence out of fear that it will result in child removal. This fear can lead them to avoid prenatal care, behavioral health services, or even disclosing critical safety concerns. These dynamics were confirmed in multiple interviews conducted as part of this project.

One maternal mental health specialist who shared:

> *"I feel like we need to figure out why people continue to die in our state, and not just women and birthing people but also their children. I guess that would be the most pressing thing. Why are people dying by suicide or overdose or intimate partner violence or just because of the stress of not being able to have the things that they need over time? And how do we provide support? I feel like the needs are great, and there are supports, but there are not enough supports, and there are not enough culturally grounded supports that employ people who look like and are from the communities that are mostly at risk."*

This intersection is further illustrated by the KMMRC case reviews, which found that 15 of 153 pregnancy-associated deaths between 2016 and 2022 were homicides, and that intimate partners were the perpetrators in over half (54%) of those cases. SUD was also identified as a contributing factor in nearly one-third of all reviewed deaths, underscoring the co-occurrence of substance use, mental health struggles, and violence.



System Gaps and Regional Inequities

Kansas continues to face significant challenges in delivering high-quality, timely, and consistent care for pregnant and postpartum individuals affected by SUD. While recent policy advancements have created momentum for improvement, persistent systemic barriers, such as provider shortages, fragmented care coordination, limited cultural responsiveness, and significant geographic disparities, continue to limit the state's effectiveness. Crucially, access challenges go beyond affordability; many families cannot reach or use services due to distance, lack of transportation, limited appointment availability, or provider hesitancy, especially in rural and frontier regions. These access gaps must be addressed alongside cost concerns to create a truly responsive perinatal SUD care system.

Barriers to Treatment Access and Service Availability

People who are pregnant or postpartum and living with SUD face numerous barriers to accessing care. These include pervasive stigma, limited availability of evidence-based treatment, provider hesitancy, and the daunting challenge of navigating fragmented healthcare and social service systems (KU-CPPR, 2025). In 2022, Kansas took a critical policy step forward by extending postpartum Medicaid coverage from 60 days to 12 months, acknowledging the perinatal period as a crucial opportunity to connect families with behavioral health and supportive services

(Centers for Medicare and Medicaid Services [CMS], 2022). However, coverage does not automatically translate into meaningful access. Utilization of services like MOUD, Designated Women's SUD Programs, and comprehensive wraparound supports for pregnant and parenting individuals remains low and uneven across the state.

Geographic disparities compound these challenges. Nearly half of Kansas counties are classified as maternity care deserts, lacking hospitals or providers that offer obstetric services. This forces many pregnant individuals to travel over 30 minutes, sometimes much farther, for prenatal and delivery care (March of Dimes, 2023; University of Kansas School of Nursing and United Methodist Health Ministry Fund, 2025). These access gaps are likely to worsen with looming Medicaid cuts and policies restricting full-spectrum reproductive care, which threaten provider retention and the financial viability of rural hospitals. Alarmingly, 87% of rural hospitals in Kansas currently operate at a financial loss, putting them at risk of closure if federal reimbursements decline (Manatt Health, 2025).

87%
of rural hospitals in Kansas are at risk of closure due to financial loss.

These systemic challenges exacerbate existing barriers for pregnant and postpartum individuals seeking SUD treatment. As of 2024, fewer than half of Kansas counties offer adequate SUD treatment services, and in some areas, the nearest detox or medical stabilization facility may be over 100 miles away (KU-CPPR, 2025). Without local access to maternity and behavioral health services, opportunities for early screening, timely intervention, and postpartum follow-up are often lost, placing vulnerable families at heightened risk of adverse outcomes.

As one northwest Kansas treatment provider described:

> *"We cover a nine-county service delivery area… it is the nine far northwest counties, and we are the only treatment facility inside those nine counties. The next closest one is in Hays, so it is 105 miles from the center of my service delivery area. If you go to my farther counties outside, it is more like almost 200 miles one way."*

A corrections officer highlighted the regional disparities:

> *"There is a large distinction… on the availability of services in more of that eastern part of the state versus the western, especially the northwestern, part of Kansas. Things like sobering centers or detox services, social detox, medical detox, MAT services, all of those things."*

Even in areas where services technically exist, access is often limited by additional barriers such as a lack of insurance coverage, providers who do not accept Medicaid (KanCare), long waitlists, or restrictive eligibility criteria. A statewide advocate observed:

> *"There is a plethora of data available to demonstrate that the states that expanded Medicaid in those states, there is increased access to mental health treatment and increased access to substance use disorder treatment. We know from a policy standpoint that that [Medicaid expansion] works [would increase access]…That is one of the vulnerable populations, the uninsured."*

A corrections officer added:

> *"I think sometimes they run into issues where the providers don't accept KanCare, so then they have to find someone who does or figure out if they can pay for it out of pocket."*

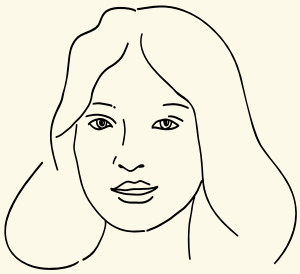
An SUD provider further reflected on systemic capacity issues:

> *"There's gaps in several places, honestly. I think there's gaps in funding allotted to existing treatment centers that want to expand. I think [we need] to meet more of the needs and not be having these six-to-eight week wait lists."*

Kayla's story below shows how geography and limited local options can delay care during critical windows of need—especially in rural areas with few or no SUD providers.

PATIENT JOURNEY

Meet Kayla



Kayla lives in a rural community, is White, and is eligible for Medicaid. Her experience involves the use of fentanyl and illustrates the challenges of accessing timely and appropriate care in areas with fewer treatment options and long travel distances. **Kayla's story highlights how geographic isolation limited local services, and financial constraints can delay care and complicate recovery efforts.** Her journey emphasizes the need for flexible, locally available supports that meet people where they are.

Discovery

During a routine visit to a rural public health department, Kayla, a young woman working in the food industry, disclosed her fentanyl use to a public health nurse. Anticipating judgment and fearing child welfare involvement, Kayla hesitated to engage in care. The nurse responded using harm reduction approaches, including motivational interviewing, affirming Kayla's autonomy and safety while building trust in a nonjudgmental setting.

Engagement

Kayla's engagement was shaped by multiple barriers: limited treatment options in rural areas, long waitlists, transportation challenges, and pervasive community stigma. Initially reluctant to engage with Medicaid or home visiting services, Kayla was gently guided by the nurse, who reframed these programs as supports rather than surveillance. The nurse emphasized that enrolling in Medicaid and home visiting could help Kayla avoid DCF involvement and keep her baby safe and at home.

Intervention

Recognizing the urgency of Kayla's situation, the nurse facilitated a rapid connection to MOUD via telehealth—a necessary strategy given the lack of local providers. She also offered harm reduction tools, including fentanyl test strips, and provided education on safer use strategies while working with Kayla toward stabilization. The nurse coordinated a referral to an intensive home visiting program, pairing Kayla with a nurse-social worker team, and enrolled her in the Becoming a Mom program for prenatal support.

Family Involvement

Kayla's mother became a key support, providing transportation to appointments and actively participating in home visits. This family engagement helped buffer stigma and reinforced Kayla's connection to care.

Outcome

Thanks to coordinated care, supportive services, and a strong harm reduction framework, Kayla delivered a healthy, full-term baby. She remained engaged in treatment, avoided Neonatal Abstinence Syndrome outcomes, and developed the stability needed for early parenting. Without these interventions, Kayla faced a high risk of continued fentanyl use, family separation, and long-term health challenges for her child.

Provider Action Plan

Lead with Harm Reduction and Trust-Building.

Use nonjudgmental, harm reduction-based approaches such as motivational interviewing, safer use education, and practical goal setting to establish trust. This can reduce fear of child welfare involvement and increase patient engagement in care.

Prioritize Rapid Connection to MOUD and Prenatal Support.

Establish protocols for same-day referrals to MOUD providers (including via telehealth) and integrate referrals to prenatal support programs like Becoming a Mom and home visiting services to stabilize care early in pregnancy.

Reframe Medicaid and Support Services as Empowerment Tools.

Help patients understand that enrolling in Medicaid and intensive home visiting can prevent system involvement, not trigger it. Present these services as resources for staying connected, healthy, and in control of their pregnancy and parenting journey.

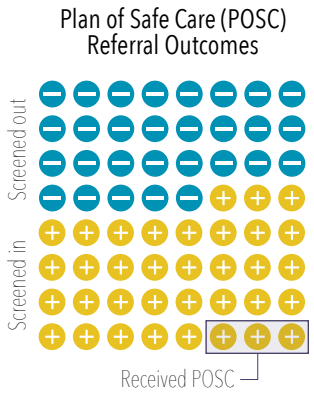
Workforce Shortages and Provider Hesitancy

Kansas has a limited behavioral health workforce, and this shortage is more severe in certain regions and specialty areas. Providers often report being reluctant to treat pregnant patients with SUD due to perceived complexity, liability concerns, or insufficient training in trauma-informed and family-centered approaches. Nationally, only about 53% of outpatient MOUD programs report accepting pregnant patients (ASTHO, 2019), and recent reports suggest Kansas falls short of that benchmark (KU-CPPR, 2025). The result is a patchwork of care that leaves many individuals falling through the cracks, especially during the critical postpartum year.

Care Coordination and Plans of Safe Care

Federal law requires that infants born affected by substances receive a Plan of Safe Care (POSC), which is a coordinated roadmap linking families to medical, behavioral, and social supports. In Kansas, compliance with this requirement has historically been limited, but recent policy reforms signal meaningful progress.

DCF has initiated a workgroup to improve implementation of the Comprehensive Addiction and Recovery Act (CARA; Administration for Children and Families, Children's Bureau, 2016) and expand the consistent use of POSCs. According to the most recent federal data, Kansas received 78 referrals in 2023 involving infants with prenatal substance exposure. Of these, 43 were screened in and 35 were screened out; only three of the screened-in cases, about 7%, resulted in a POSC (Children's Bureau, 2025). While this highlights ongoing challenges, it also underscores that **there is an opportunity for more effective coordination across health, early childhood, and family support systems**. Providers outside of child welfare, such as clinicians, case managers, and early learning professionals, are often well positioned to build trust with families and help connect them to needed services. Expanding awareness and training in these fields can strengthen the use of POSCs, reduce family separation, and promote prevention.



Kansas has also modernized its child welfare policies to reduce the criminalization of substance use during pregnancy. The state no longer categorizes Neonatal Opioid Withdrawal Syndrome (NOWS) as automatic evidence of child maltreatment, reflecting best practices that recognize SUD as a treatable health condition rather than a moral failure (NIDA, 2024; Peacock-Chambers, 2021). Effective July 1, 2025, new guidance under §1650 of the Prevention and Protection Services Policy and Procedure Manual specifies that reports involving substance-affected infants will not be automatically routed as abuse or neglect allegations. Instead, they are assessed using structured decision-making tools to determine whether a FINA or safety response is appropriate (DCF, 2025a; 2025f). In addition, "substance-affected infant" (SAI) has been removed from the department's definition of neglect, and all SAI cases are now assigned as FINA cases rather than placed on an investigative track.

Together, these changes represent a significant shift toward family-centered, prevention-focused practice. They reduce fear and stigma for families, align Kansas more closely with national best practices, and open the door for earlier and more supportive interventions that keep parents and infants together whenever safely possible. These reforms also create a strong foundation for building and scaling promising models and Kansas-grown innovations that demonstrate what effective, family-centered responses can look like in practice.

Promising Models and Kansas Innovations

Kansas has made significant strides in aligning with national best practices for treating substance use during pregnancy and postpartum. Through a combination of evidence-based care models, cross-system partnerships, and policy reforms, the state is working to create a

more supportive and recovery-oriented perinatal system. However, these innovations are not yet consistently available across settings or regions. This section highlights both national standards and how Kansas has begun to implement them.

Evidence-Based Practices and Kansas Implementation

National guidelines recommend supportive, non-punitive approaches to caring for pregnant individuals with SUD, emphasizing early screening, intervention, and access to person-centered treatment (ACOG, 2017; SAMHSA, 2018). Validated screening tools such as the 4Ps Plus, CRAFFT, and the 5 P's are recommended for universal use in prenatal care settings.

For opioid use disorder (OUD), medications like buprenorphine and methadone, along with counseling and support services, are the gold standard. These medications are linked to improved prenatal care utilization and better birth outcomes, while medically supervised withdrawal is discouraged due to its association with relapse and overdose risk (ACOG, 2017; SAMHSA, 2018).

For alcohol use, no safe threshold has been established during pregnancy. While some medications are approved for treating alcohol use disorder, behavioral interventions and brief counseling remain first-line treatments (American Society of Addiction Medicine, 2025). For stimulant use, treatment is based on behavioral therapies, as no medications are currently approved (Haile & Kosten, 2013; Smid et al., 2019). Tobacco use remains a leading modifiable risk factor for poor birth outcomes, and providers are encouraged to apply the "5 A's" (Ask, Advise, Assess, Assist, Arrange) along with nicotine replacement therapy when appropriate (Agency for Healthcare Research and Quality, 2012). Cannabis use during pregnancy and breastfeeding is also discouraged due to its impact on fetal brain development (Centers for Disease Control and Prevention [CDC], 2025).

Across all substances, trauma-informed, multidisciplinary care is the recommended standard, with strong guidance against punitive responses or criminalization of pregnant individuals (ACOG, 2017; SAMHSA, 2018).

In Kansas, the policy reforms outlined earlier are being reinforced by complementary initiatives. KDHE has developed perinatal behavioral health resources for providers, including a workflow for managing SUD in pregnancy (e.g., KDHE, n.d. a–d). Medicaid now covers MOUD and behavioral health supports during the postpartum year (CMS, 2019). Validated tools like the NIDA Quick Screen and Screening, Brief Intervention, and Referral for Treatment (SBIRT) evidence-based process is recommended by Kansas agencies, and state law prioritizes pregnant women for treatment access. Yet many pregnant people using opioids report not receiving counseling from providers (KU-CPPR, 2024), and rural service availability remains limited. SBIRT protocols, endorsed by ACOG and SAMHSA, emphasize early identification and connection to care (ACOG, 2017; SAMHSA, 2018), but implementation is often hindered

by modifiable barriers such as limited provider training, reimbursement challenges, lack of publicly available validated substance use screening tools for the perinatal population, and lack of integration into quality improvement systems. Policy strategies like Medicaid billing reform and SBIRT incentives could help address these gaps. Oregon's adoption of a prenatal SBIRT performance metric through Medicaid led to increased uptake increases in use of, and billing for, SBIRT in primary care settings (Winkle, 2016). Kansas could pursue similar reforms through the Kansas Perinatal Quality Collaborative and Medicaid to strengthen early SUD identification and treatment.

Emerging best practices in perinatal behavioral health also emphasize the importance of addressing the needs of partners and fathers, who are often overlooked in maternal and infant health programming. **Research shows that men may experience perinatal mental health conditions differently than women, with symptoms more commonly manifesting as irritability, anger, or withdrawal rather than sadness or anxiety** (Fisher & Garfield, 2016). These behavioral shifts can go undetected and untreated, despite being linked to poor outcomes for the entire family, including elevated risk for relationship stress, child developmental delays, and IPV (Maternal Mental Health Leadership Alliance, 2024). Promising innovations in Kansas and elsewhere suggest that integrating fathers and partners into perinatal screening and support, particularly through home-visiting, prenatal care, and behavioral health settings, may improve early detection and engagement in services. Future Kansas initiatives might consider piloting partner-inclusive screening and referral protocols as part of whole-family SUD and behavioral health models.

Men experiencing perinatal mental health conditions contributes to poor outcomes for the entire family.

Family-Oriented and Cross-System Programs

Kansas has expanded several initiatives aimed at keeping families safely together through trauma-informed, family-centered, and inter-generational services. Among them are Family Strong, funded through the federal Family First Prevention Services Act (FFPSA), and the University of Kansas School of Social Welfare's Family First programs, which weave parenting education, substance-use treatment, and behavioral-health supports into a single prevention framework (KU-CPPR, 2023; University of Kansas School of Social Welfare, 2023). Statewide FFPSA evaluation results show both promise and persistent gaps: from October 2019 to May 2025, roughly 7,300 Kansas families were referred for FFPSA services, yet only about 6%, approximately 444 cases, involved substance-use treatment. Even so, 84% of children in those substance-use cases remained safely at home one year after referral; however, just 49% of families completed treatment and 9% of children still entered foster care, nearly double the overall FFPSA foster-care entry rate of 5% (DCF & KU-CPPR, 2025). These data confirm that

family-centered prevention reduces removals but also reveal a need for stronger follow-through and coordinated supports for substance-affected families.

The START (Sobriety Treatment and Recovery Teams) model, now operating in fifteen Kansas counties, illustrates a promising cross-system response. START is a treatment-delivery framework, rather than a clinical treatment itself, that pairs a child-welfare case manager with a peer mentor who has lived experience of recovery. From the initial hotline report, the dyad rapidly completes assessments, initiates treatment, and stabilizes the family, often meeting key milestones within 38 days. As one provider noted,

> *"START is not a treatment model: it's a treatment delivery model. It has a very specific timeline… from day 1, when the hotline report comes into DCF, to day 38, we will have met with the family, obtained their drug-and-alcohol assessment, secured treatment recommendations, and they will have attended four treatment sessions."*

Another practitioner highlighted the dyad's value:

> *"My favorite part of the START model is that it's a dyad. The case manager works with the entire family, and the mentor, someone in recovery, helps the parent navigate assessments, set up treatment, and move from pre-contemplation to real engagement."*

Evaluations indicate that START increases parental engagement, lowers out-of-home placements, and improves reunification rates compared with standard practice (DCCCA, 2019; DCF, 2020; Casey Family Programs, 2022). Together with FFPSA-funded Family Strong and Family First efforts, START signals Kansas's shift toward whole-family healing, even as FFPSA outcome data make clear that reliable transportation, peer-mentor capacity, and sustained care coordination are still essential to help families complete treatment successfully.

However, there are limitations with the START model. To ensure START service delivery meets fidelity requirements, the family must have an open Family Preservation case. In an ideal service delivery system, START program services would be made available to all families identified as at-risk of child welfare system involvement opposed to already having child welfare system involvement. This upstream approach could help increase families' ability to get desired supports while also reducing their fear of child removal and other punitive actions.

Behavioral Health Infrastructure and Innovation

KCC and the Maternal Anti-Violence Innovation and Sharing (MAVIS) program, supported by $8.5 million in grant funding, are important components of Kansas's broader maternal behavioral health efforts, offering psychiatric consultation, care navigation, and workforce training for perinatal behavioral health providers. While MAVIS funding supports only a portion of the state's perinatal behavioral health work, it complements other initiatives. KDHE also plans to leverage an additional $17 million from the 2025 Transforming Maternal Health grant to strengthen and expand these activities (Kansas Office of the Governor, 2025). While these efforts represent significant progress, challenges persist in implementation. Barriers such as fragmented screening, inconsistent referral protocols, confusion around mandated reporting, and provider shortages continue to limit impact (KU-CPPR, 2025).

KDADS certifies nine Designated Women's SUD Programs across the state and supports them through broader funding mechanisms, including federal block grants and Medicaid. These programs are designed to be trauma-informed and gender-responsive, offering services such as prenatal care, case management, parenting support, childcare, and access to MOUD (KDADS, n.d.). These programs are required to prioritize pregnant clients and initiate treatment within 48 hours when clinically necessary. However, many of these services are concentrated in urban areas, and waitlists and capacity gaps are common in rural counties (KU-CPPR, 2025).

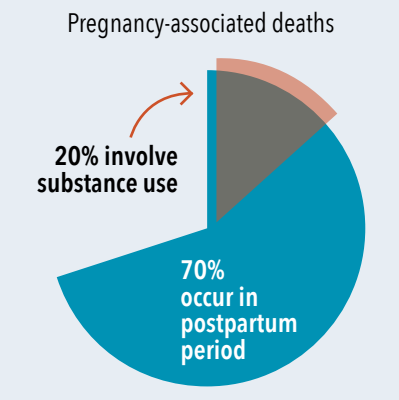
Kansas has also piloted important models in the carceral setting. The Topeka Women's Prison Project provides behavioral health services, MOUD, and reentry support to incarcerated women with co-occurring disorders. The model emphasizes continuity of care after release and addresses barriers such as Medicaid reinstatement. However, its reach remains limited—only 48 beds are available, and services are not provided evenings or weekends. One official noted:

> *"A large majority of the residents that we do get are here for drug crimes. And we do our best here, but we certainly don't reach everybody that we wish we could… We have so many people that don't get the treatment that they need. And also, as far as resources go, when they leave here [many don't] have access to treatment without having Medicaid."*

Strategic Priorities and Policy Recommendations

SUD is now implicated in nearly every adverse perinatal outcome in Kansas. One in five adults in the state meets diagnostic criteria for SUD, and an estimated 8% of births involve prenatal substance exposure (KU-CPPR, 2024, 2025). Neonatal abstinence syndrome (NAS) continues to rise, with Medicaid-covered infants being diagnosed at 11 times the rate of their privately

insured peers (Kim & Stabler, n.d.). Additionally, the KMMRC reports that nearly 70% of pregnancy-associated deaths occur during the postpartum period, with one in four involving substance use (KDHE, 2023). This growing crisis calls for a bold, coordinated response grounded in five strategic priorities that align clinical best practices, family preservation goals, and sustainable financing mechanisms.



PRIORITY 1: Upstream Identification and Prevention

Expanding early identification and prevention of perinatal substance use requires embedding trauma-informed, non-punitive screening and brief interventions across all maternal health settings, including prenatal care, WIC visits, emergency departments, and home-visiting programs. Universal screening with validated tools such as the 4Ps, CRAFFT, and the NIDA Quick Screen should be standard practice. Processes like SBIRT (Screening, Brief Intervention, and Referral to Treatment) illustrate how screening can be paired with timely intervention, but screening alone is not enough. Real-time support from peer behavioral-health navigators is essential to make referrals meaningful, including offering transportation coordination, motivational coaching, and warm handoffs to care.

Low utilization of SBIRT reflects a range of barriers, including limited provider awareness and training, challenges in selecting among numerous universal education tools, and the burdens of competing clinical demands, documentation requirements, and staffing shortages (National Council for Mental Wellbeing, 2023). In Kansas, additional constraints stem from Medicaid coverage policies that limit reimbursement for validated screening tools in perinatal populations to once annually, restricting providers' ability to screen when clinically appropriate. Low reimbursement rates across payor sources further reduce financial incentives for providers to prioritize SBIRT over other billable services. Underutilization is also perpetuated when SBIRT is not embedded within performance measure indicators that drive provider practice.

These barriers are modifiable and present key opportunities for policy solutions—such as payment reform, expanded screening coverage and frequency under Medicaid, enhanced training supports, and integration into quality improvement initiatives that streamline screening workflows. Additionally, Kansas should explore the underlying reasons for the low volume of SBIRT claims submitted to Medicaid, which may reflect systemic gaps in billing practices, provider knowledge, or administrative barriers. Oregon's integration of SBIRT into Medicaid performance metrics offers a promising model, demonstrating significant increases in SBIRT utilization within primary care settings (Winkle, 2016).

Upstream prevention should also begin well before pregnancy. Evidence-based interventions delivered in early and middle adolescence, such as school-based life skills training, healthy relationship programs, and family-centered prevention models, can significantly reduce the likelihood of later SUDs and IPV. The Youth Screening, Brief Intervention, and Referral to Treatment (YSBIRT) model is an evidence-based framework designed to help providers identify risky substance use early, deliver brief motivational interventions, and connect youth to needed resources (National Council for Mental Wellbeing, 2023). In Kansas, YSBIRT could be integrated into school-based health centers, adolescent primary care, juvenile justice diversion programs, and community-based youth services. It also offers an opportunity to extend screening and early intervention into populations currently underserved by the system, such as youth connected to Community Developmental Disability Organizations (CDDOs), who at present often do not receive coordinated behavioral health prevention services until the adult transition phase. Embedding YSBIRT alongside other adolescent prevention strategies would create a continuum of care that links early risk reduction to healthier perinatal outcomes later in life.

ACTIONS: Upstream Identification and Prevention

Short-term Actions *1 to 2 years*	Medium-term Actions *3 to 5 years*	Long-term Actions *5+ years*
Expand Medicaid reimbursement frequency for validated screenings *(Kansas Medicaid-KanCare, Kansas Legislature).*	Integrate SBIRT and YSBIRT into performance metrics for perinatal and adolescent health *(Bureau of Family Health (BFH), Bureau of Health Promotion, BHP, DCF, Division of Health Care Finance (Medicaid/KanCare), Kansas Medicaid, MCOs).*	Sustain universal, non-punitive screening across all maternal and adolescent health touchpoints *(KDHE, KDADS, provider networks).*
Initiate statewide training for perinatal and youth-serving providers on SBIRT/YSBIRT *(KDHE Bureau of Family Health, National Council for Mental Wellbeing, professional associations)*	Expand school- and community-based prevention programming *(Kansas State Department of Education (KSDE), local school districts, youth-serving nonprofits).*	Link screening data to statewide quality improvement efforts *(Kansas Perinatal Quality Collaborative (KPQC), BFH).*
Deploy peer navigators in high-need counties *(KDADS, local CMHCs, regional health departments).*		

PRIORITY 2: Expand Flexible, Evidence-Based Care Across the Perinatal Continuum

Access to treatment must not depend on geography or income. To ensure timely access to evidence-based treatment, Kansas should guarantee same-day access to MOUD in every county. This includes leveraging the existing Kansas perinatal behavioral health consultation line to support providers in initiating or managing MOUD, particularly in complex perinatal cases. Waiver-free buprenorphine prescribing, backed by a state-funded salary stipend, and pharmacist-led maintenance under collaborative practice agreements would further strengthen access, especially in rural and frontier areas. Kansas should also double its Designated Women's SUD programs from 9 to 18, targeting counties with high Maternal Vulnerability Index scores or overdose rates. This expansion would help meet statutory obligations to prioritize pregnant women and address widespread capacity and access gaps. These programs must provide trauma-responsive, child-friendly residential options tailored to perinatal needs. Additionally, the State should pilot expansion of Designated Women's SUD programs to include outpatient services that include the same quality service provision. Nationally, SAMHSA-funded MOUD programs that combine medication with wraparound care have shown improved maternal outcomes (SAMHSA, 2024), and Kansas can build on this model through Project ECHO-style training. In Minnesota, ECHO-trained primary care clinicians were significantly more likely to prescribe buprenorphine and treat more patients with OUD (Solmeyer et al., 2022).

The State should establish an integrated care clinic specifically designed to address perinatal substance use by providing coordinated, comprehensive services that meet the complex medical, behavioral health, and social needs of pregnant and postpartum individuals. The clinic should co-locate or closely coordinate obstetric care, substance use treatment, mental health services, peer support, and case management with close connections to pediatric care. This model would reduce barriers to access, improve continuity of care, and support better outcomes for both parent and infant. It is further recommended that the clinic be developed with input from individuals with lived experience and that it includes evaluation measures to assess effectiveness and inform ongoing improvement.

ACTIONS: Access to Evidence-Based Treatment

Short-term Actions *1 to 2 years*	Medium-term Actions *3 to 5 years*	Long-term Actions *5+ years*
Provide state-funded salary stipends for MOUD prescribers *(Medicaid/ KanCare; KDADS, Kansas Legislature, Professional Licensing Boards)*.	Open first integrated perinatal SUD clinic with lived-experience-informed design *(KDHE, hospital systems, community-based providers)*.	Ensure every county has same-day MOUD access *(KDHE, KDADS, provider networks)*.
Fully fund the perinatal behavioral health consultation line to support complex cases *(KDHE, KU Medical Center)*.	Pilot outpatient models under Designated Women's SUD program *(KDADS, local treatment providers)*.	Scale integrated care clinics statewide *(KDHE, large health systems)*.
Map counties for targeted expansion of Designated Women's SUD programs *(KDADS, BFH, Bureau of Epidemiology & Public Health Informatics (BEPHI), Governor's Office / SUD Task Force)*.	Sustain the training of rural providers through Project ECHO *(KU Medical Center, KDHE)*.	Embed MOUD with wraparound supports as the standard of care *(Kansas Legislature, KDHE)*.

PRIORITY 3: Harm Reduction and Postpartum Continuity

Reducing overdose-related maternal deaths requires intentional postpartum harm-reduction strategies. **Harm reduction** refers to a set of practical strategies and public health policies aimed at reducing the negative consequences of drug use without necessarily requiring abstinence. These strategies include access to naloxone, syringe service programs, fentanyl test strips, and safer-use education, and are grounded in principles of dignity, choice, and respect for people who use drugs (National Harm Reduction Coalition, n.d.). Every birthing hospital should provide mothers with a history of SUD, and their support persons, with naloxone, fentanyl test strips, and practical education before discharge. Kansas Medicaid should adopt and operationalize the HEDIS (Healthcare Effectiveness Data and Information Set) for Postpartum Care as part of the Prenatal and Postpartum Care measure. This visit ensures women receive necessary follow-up care, including screenings and discussions about their well-being, between 7 and 84 days after delivery. Managed Care Organizations (MCOs) would receive financial incentives for increased postpartum visit rates for their members. This continuum of support is designed to reduce relapse risk and prevent fatal overdoses during the vulnerable postpartum window.

ACTIONS: Harm Reduction and Postpartum Continuity

Short-term Actions *1 to 2 years*	Medium-term Actions *3 to 5 years*	Long-term Actions *5+ years*
Implement hospital-based naloxone and fentanyl test strip distribution protocols *(Birthing hospitals, BFH).*	Embed harm-reduction supply distribution into postpartum home-visiting programs *(KDHE, Healthy Families programs, local health departments).*	Normalize harm-reduction resources as part of standard postpartum care *(KDHE, hospital systems).*
Develop postpartum care pathways tied to Medicaid incentives *(Kansas Medicaid, MCOs).*	Track postpartum visit rates through Medicaid claims *(Kansas Medicaid, MCOs).*	Maintain statewide tracking of postpartum overdose rates *(KDHE, KPQC).*
Provide harm-reduction education in maternity wards *(Hospital systems, KDHE).*	Evaluate MCO incentive impact *(Kansas Medicaid, KDHE).*	Integrate harm reduction into perinatal care quality measures *(KPQC, KDHE).*

PRIORITY 4: Family-Centered Child Welfare and Court Partnerships

A trauma-informed, family-centered response must replace punitive approaches to perinatal SUD. Scaling the START model statewide will ensure that every infant identified as substance-affected triggers a rapid, coordinated response within 48 hours. Each case would involve a dyad of a trained caseworker and a peer mentor with lived experience, who together support the parent's treatment engagement, safety planning, and recovery. This model has been shown to increase family reunification and reduce foster care reentry in other jurisdictions and aligns with Kansas's shift away from automatic infant removals in cases of neonatal opioid withdrawal. All perinatal SUD programs should also include universal education for IPV and provide on-site advocacy. The Kansas Perinatal Quality Collaborative (KPQC), supported by KDHE's Bureau of Family Health, could lead development of standardized protocols and training, ensuring consistent implementation across designated programs. KDADS and contracted providers would then integrate these requirements into practice, in partnership with IPV advocacy organizations. The interrelationship between SUD and IPV is well documented, with research showing their combined impact on parental mental health, caregiving capacity, and child safety (Ogbonnaya, 2019). This priority supports both immediate family stabilization and long-term healing.

The State should identify and secure funding to support development and implementation of the START model beyond the child welfare system. The pilot should include clear evaluation components to assess feasibility, effectiveness, and impact. Findings from the evaluation can inform future scalability and contribute to determining whether the model demonstrates the potential to become evidence based.

ACTIONS: Family Preservation Through Trauma-Informed Systems

Short-term Actions *1 to 2 years*	Medium-term Actions *3 to 5 years*	Long-term Actions *5+ years*
Pilot START in high maternal vulnerability counties *(Kansas DCF, KDHE, KDADS)*.	Evaluate START pilot outcomes *(Kansas DCF, independent evaluators)*.	Scale START statewide *(Kansas DCF, KDHE)*.
Train caseworker–peer dyads *(Kansas DCF, provider agencies)*.	Expand START to additional counties *(Kansas DCF, KDHE)*.	Make family-centered dyad models a permanent part of perinatal SUD response *(Kansas Legislature, KDHE, KDADS)*.
Integrate universal IPV education in perinatal SUD programs *(KDHE, local treatment providers)*.	Secure braided funding from child welfare, Medicaid, and settlement dollars for START and universal IPV education *(Governor's Office, KDHE, Kansas Legislature)*.	Align with state family preservation policy reforms *(Kansas DCF, Kansas Legislature)*.

PRIORITY 5: Data-Driven Quality and Sustainable Financing

Finally, Kansas must build the infrastructure to sustain improvements through data transparency and financial alignment. The Alliance for Innovation on Maternal Health (AIM) SUD patient safety bundle should be adopted across all birthing hospitals, with process measures such as screening rates and MOUD-at-discharge tracked through the Kansas Perinatal Quality Collaborative. At the county level, quarterly NAS dashboards, generated from linked hospital and Medicaid data, will allow state agencies to detect rising trends and offer technical assistance quickly. A braided-funding hub housed within the Governor's Office would coordinate opioid settlement funds, Medicaid investments, and Family First IV-E dollars to maximize impact and reduce duplication. Kansas should also pursue a Section 1115 Medicaid waiver to pilot contingency management, housing stabilization, and doula support services for pregnant and parenting Medicaid members. These mechanisms are critical to ensuring that funding supports the full continuum of care rather than isolated services.

ACTIONS: Data-Driven Quality and Sustainable Financing

Short-term Actions *1 to 2 years*	Medium-term Actions *3 to 5 years*	Long-term Actions *5+ years*
Launch quarterly NAS dashboards *(KDHE, Kansas Medicaid).*	Implement AIM SUD bundle statewide *(KPQC, KDHE, hospital systems).*	Maintain ongoing funding for the full continuum of perinatal SUD services *(Governor's Office, Kansas Legislature).*
Adopt AIM SUD bundle in early-adopter hospitals *(KPQC, hospital systems).*	Apply for Section 1115 waiver *(Kansas Medicaid).*	Institutionalize linked data reporting *(KDHE, KPQC).*
Establish braided-funding hub *(Governor's Office).*	Track linked outcome data for maternal and infant health indicators *(KDHE, KPQC).*	Align financing with long-term performance metrics *(Kansas Medicaid, KDHE).*

Conclusion

Kansas has the policy tools, state momentum, and community partnerships needed to transform its perinatal SUD response. Implementing the five strategic priorities identified in this report—early identification, high-quality treatment, postpartum continuity, trauma-informed family support, and sustainable financing—will reduce disparities, prevent avoidable deaths, and create stronger, healthier families statewide.

References

Administration for Children and Families, Children's Bureau. (2016). *Comprehensive Addiction and Recovery Act of 2016 (CARA). U.S. Department of Health and Human Services*. https://www.acf.hhs.gov/cb/law-regulation/comprehensive-addiction-and-recovery-act-2016-cara

Administration for Children and Families. (2023). *Child and Family Services Reviews, Kansas final report.* https://www.dcf.ks.gov/services/PPS/Documents/CFSR/KS_FinalReport_7%2018%202023.pdf

Agency for Healthcare Research and Quality. (2012). *Five major steps to intervention (The "5 A's").* https://www.ahrq.gov/prevention/guidelines/tobacco/5steps.html

American Academy of Pediatrics. (2022). *CUES: Confidentiality, Universal Education + Empowerment, Support (practice resource page).* https://www.aap.org/en/patient-care/intimate-partner-violence/cues-confidentiality-universal-education--empowerment-support/

American College of Obstetricians and Gynecologists (ACOG). (2017). *Opioid use and opioid use disorder in pregnancy* (Committee Opinion No. 711). https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

American College of Obstetricians and Gynecologists (ACOG). (2023). *Screening and diagnosis of mental health conditions during pregnancy and postpartum (Clinical Practice Guideline No. 4).* https://www.acog.org/clinical/clinical-guidance/clinical-practice-guideline/articles/2023/06/screening-and-diagnosis-of-mental-health-conditions-during-pregnancy-and-postpartum

American Society of Addiction Medicine. (2025). *About the ASAM criteria*. https://www.asam.org/asam-criteria/about-the-asam-criteria

Association of State and Territorial Health Officials (ASTHO). (2019). Stigma reinforces barriers to care for pregnant and postpartum women with substance use disorder. https://www.astho.org/topic/brief/stigma-reinforces-barriers-to-care-for-pregnant-and-postpartum-women-with-substance-use-disorder

Bateman, B. T., Cole, N. M., Maeda, A., Burns, S. M., Houle, T. T., Huybrechts, K. F., Clancy, C. R., & Leffert, L. R. (2016). Persistent opioid use following cesarean delivery: Patterns and predictors among opioid-naïve women. American Journal of Obstetrics and Gynecology, 215(3), 353.e1–353.e18. https://doi.org/10.1016/j.ajog.2016.03.016

Camacho, E. M., & Shields, G. E. (2018). Cost-effectiveness of interventions for perinatal anxiety and/or depression: A systematic review. BMJ Open, 8(8), e022022. https://bmjopen.bmj.com/content/bmjopen/8/8/e022022.full.pdf

Casey Family Programs. (2022). Strong Families strategy brief: What is the National START (Sobriety Treatment and Recovery Teams) model? https://www.casey.org/media/22.07-QFF-SF-Start.pdf

Casey Family Programs. (2023, October 19). What are some evidence-based interventions to prevent and mitigate the effects of prenatal substance exposure? Casey Family Programs. https://www.casey.org/prenatal-substance-exposure-prevention/

Centers for Disease Control and Prevention (CDC). (2021). Rates of NAS per 1,000 births in newborns whose deliveries were covered by Medicaid or CHIP, 2017-2019 [dataset]. https://data.medicaid.gov/dataset/0563d88c-8fe5-42a8-9d69-f67fd21c0e91/data

Centers for Disease Control and Prevention (CDC). (2022, February 23). Maternal mortality rates in the United States, 2020 (NCHS Health E-Stat). National Center for Health Statistics. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/E-stat-Maternal-Mortality-Rates-2022.pdf

Centers for Disease Control and Prevention (CDC). (2023). Let's talk: Communicating about alcohol and pregnancy. https://www.cdc.gov/alcohol-pregnancy/media/pdfs/LetsTalkCommunicationGuide-508.pdf

Centers for Disease Control and Prevention (CDC). (2024, May 18). Pregnancy-related deaths: Data from Maternal Mortality Review Committees in 36 U.S. states, 2017–2019. CDC Division of Reproductive Health. https://www.cdc.gov/maternal-mortality/php/data-research/mmrc-2017-2019.html

Centers for Disease Control and Prevention (CDC). (2025, January 31). Cannabis and pregnancy. https://www.cdc.gov/cannabis/health-effects/pregnancy.html

Centers for Medicare and Medicaid Services (CMS). (2019). Letter regarding Kansas SUD implementation protocol. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-cms-appvl-sud-implementation-plan-20190807.pdf

Centers for Medicare and Medicaid Services (CMS). (2022, July 26). HHS approves 12-month extension of postpartum coverage in Connecticut, Massachusetts, and Kansas. CMS Press Release. https://www.cms.gov/newsroom/press-releases/hhs-approves-12-month-extension-postpartum-coverage-connecticut-massachusetts-and-kansas

Chen, X., Li, W., Zhang, Y., Liu, Z., & Wang, J. (2024). Associations between pregnancy loss and common mental disorders: Evidence from a longitudinal UK Biobank cohort. *Frontiers in Psychiatry, 15*, Article 1326894. https://doi.org/10.3389/fpsyt.2024.1326894

Child Welfare Information Gateway. (2019). Plans of Safe Care for infants with prenatal substance exposure and their families. https://www.childwelfare.gov/resources/plans-safe-care-infants-prenatal-substance-exposure-and-their-families/

Child Welfare League of America. (2024). *Kansas' children*. https://www.cwla.org/wp-content/uploads/2024/04/Kansas-2024.pdf

DCCCA. (2019). DCCCA family preservation. https://kscourts.gov/KSCourts/media/KsCourts/Trial%20court%20programs/DCCCA-Family-Preservation-Overview-2019.pdf

Department for Children and Families and the University of Kansas Center for Public Partnerships and Research. (2025). Family First Prevention Services Act, report dates: 10/1/2019 – 05/31/2025.

Fisher, S. D., & Garfield, C. F. (2016). Opportunities to detect and manage perinatal depression in men. American Family Physician, 93(10), 824–825. https://www.aafp.org/pubs/afp/issues/2016/0515/p824.html

Forray, A., Merry, B., Lin, H., Ruger, J. P., & Yonkers, K. A. (2015). Perinatal substance use: A prospective evaluation of abstinence and relapse. Drug and Alcohol Dependence, 150, 147–155. https://doi.org/10.1016/j.drugalcdep.2015.02.027

Futures Without Violence. (2024). The evidence behind CUES [PDF]. https://ipvhealth.org/wp-content/uploads/2024/04/Evidence-behind-CUES_2024.pdf

Georgetown University Center for Child and Human Development, Infant & Early Childhood Mental Health TA Center. (2023). Cost-effectiveness of prevention approaches to support infant and early childhood mental health [Brief]. https://gucchd.georgetown.edu/Docs/iecmh/IECHM-TA_Cost%20Effectiveness%20Brief_FNL-508.pdf

Ginther, D. K., Hurd, G., Wedel, X., Becker, T., & Oslund, P. (2022). The status of women in Kansas. https://ipsr.unit.ku.edu/publicat/StatusofWomeninKansas2021.pdf

Haile, C. N., & Kosten, T. R. (2013). Pharmacotherapy for stimulant-related disorders. Current Psychiatry Reports, 15(11), 415. https://doi.org/10.1007/s11920-013-0415-y

Hayes, L. (2020). Postpartum relapse prevention: The family physician's role. American Family Physician, 101(8), 452 –453.

Hazelden Betty Ford Foundation. (2021). The role of grief in addiction: Research update. https://www.hazeldenbettyford.org/content/dam/hbff/images/sitecore/files/bcrupdates/griefandaddictionnov21.pdf

HRSA Maternal & Child Health. (n.d.). National outcome measures. https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalOutcomeMeasures

Institute for Research, Education, & Trainings in Addiction (IRETA). (2016). How Oregon dramatically increased SBIRT in primary care. https://ireta.org/resources/how-oregon-dramatically-increased-sbirt-in-primary-care/

Kansas Department for Aging and Disability Services (KDADS). (n.d.). *Designated women's substance abuse treatment programs*. https://www.kdads.ks.gov/services-programs/behavioral-health/services-and-programs/kansas-designated-women-s-substance-use-disorder-treatment

Kansas Department for Children and Families (DCF). (2020). New tiers for Family Preservation Begin. Prevention in Kansas, Issue 3,1. https://www.dcf.ks.gov/services/PPS/Documents/FF-newsletters/January%202020_Prevention%20Newsletter.pdf

Kansas Department for Children and Families (DCF). (2024). *Substance-affected infant and IPS [Dataset]*.

Kansas Department for Children and Families (DCF). (2025a, July 1). Prevention and Protection Services policy and procedure manual (Rev. ed.). https://www.dcf.ks.gov/services/PPS/Documents/PPM_Forms/PDF%20Manuals/Policy_and_Procedure_Manual_July2025.pdf

Kansas Department for Children and Families (DCF). (2025b, August 12). Child Protective Services (CPS) intake reports FY 2025: Assignment rate for CPS reports (July 2024–June 2025) [Data tables]. Prevention and Protection Services. https://www.dcf.ks.gov/services/PPS/Documents/FY2025%20DataReports/CPS/CPSintakereports_AssignedFY2025.pdf

Kansas Department for Children and Families (DCF). (2025c, August 12). Child Protective Services (CPS) intake reports FY 2025: CPS reports received (July 2024–June 2025) [Data tables]. Prevention and Protection Services.

Kansas Department for Children and Families (DCF). (2025d, August 13). FINA presenting situations for assigned CPS reports FY2025 (July 2024 – May 2025) [Data report]. FACTS. https://www.dcf.ks.gov/services/PPS/Documents/FY2025%20DataReports/CPS/Rprttypes_FINArsnFY2025.pdf

Kansas Department for Children and Families (DCF). (2025e, August 12). Investigative findings FY 2025 (July 1, 2024–June 30, 2025) [Data table]. Prevention and Protection Services. https://www.dcf.ks.gov/services/PPS/Documents/FY2025%20DataReports/CPS/Investigative%20Findings_FY2025.pdf

Kansas Department for Children and Families (DCF). (2025f). Kansas intake guidance policy and procedures manual. https://www.dcf.ks.gov/services/PPS/Documents/PPM_Forms/Appendices/Appendix_1A.pdf

Kansas Department of Health and Environment (KDHE). (n.d.a). Perinatal substance use [Web page]. https://www.kdhe.ks.gov/600/Perinatal-Substance-Use

Kansas Department of Health and Environment (KDHE). (n.d.b). Perinatal provider workflow: Pregnant women using substances [PDF]. https://www.kdhe.ks.gov/DocumentCenter/View/27296/Perinatal-Provider-Workflow-PDF

Kansas Department of Health and Environment (KDHE). (n.d.c). Perinatal mental health [Web page]. https://www.kdhe.ks.gov/520/Perinatal-Mental-Health

Kansas Department of Health and Environment (KDHE). (n.d.d). Perinatal substance use: Resource and reference guide for providers [PDF]. https://www.kdhe.ks.gov/DocumentCenter/View/5137/Resource-and-Reference-Guide-for-Providers-PDF

Kansas Department of Health and Environment (KDHE). (2023). Kansas Maternal Mortality Report 2016-2020. https://kmmrc.kdhe.ks.gov/wp-content/uploads/2024/10/KS-Maternal-Morbidity-Mortality-Report-2016-2020-202312-Final.pdf

Kansas Department of Health and Environment (KDHE). (2024). *Kansas severe maternal morbidity and maternal mortality, 2016–2022*. Kansas Health Statistics Report, Issue 99. https://www.kdhe.ks.gov

Kansas Department of Health and Environment (KDHE). (2025). Kansas Pregnancy Risk Assessment Monitoring System, 2022 surveillance report. https://www.kdhe.ks.gov/DocumentCenter/View/47094/Kansas-PRAMS-Report-2022-PDF

Kansas Department of Health and Environment (KDHE). (n.d.). Perinatal substance use. https://www.kdhe.ks.gov/600/Perinatal-Substance-Use

Kansas Health Matters. (2025). Percent of births where mother smoked during pregnancy. https://www.kansashealthmatters.org/indicators/index/view?indicatorId=1369&localeId=19

Kansas Maternal & Child Health. (n.d.). KCC: Working together to improve perinatal behavioral health. https://www.kansasmch.org/kcc-about.aspx

Kansas Office of the Governor. (2025, January 8). Governor Kelly announces $17M to transform maternal health. https://www.governor.ks.gov/Home/Components/News/News/479/

Kansas Statutes Annotated. (2021). K.S.A. 65-1,165. Same, referred pregnant woman first priority user of treatment through the Kansas department for aging and disability services. https://www.ksrevisor.gov/statutes/chapters/ch65/065_001_0165.html

Kezer, C. A., Simonetto, D. A., & Shah, V. H. (2021). Sex differences in alcohol consumption and alcohol-associated liver disease. Mayo Clinic Proceedings, 96(4), 1006–1016.

Kim, J. S., & Stabler, M. (n.d.). Neonatal abstinence syndrome: what do we know about Kansas? https://kansasmch.org/documents/nas/Kim%20Stabler%20NAS%20Poster.pdf

Manatt Health. (2025). Potential impacts of federal Medicaid cuts on rural maternity access in Kansas. United Methodist Health Ministry Fund. https://healthfund.org/a/wp-content/uploads/Manatt-Medicaid-Cuts-Potential-Impacts-April-2025-FINAL-3.pdf

Maternal Mental Health Leadership Alliance. (2024, November 19). Supporting new fathers: An overview of paternal mental health statistics, insights, and resources. https://www.mmhla.org/articles/supporting-new-fathers-an-overview-of-paternal-mental-health-statistics-insights-and-resources

March of Dimes. (2023). Where you live matters: Maternity care deserts and the crisis of access and equity – Kansas data summary. https://www.marchofdimes.org/peristats/reports/kansas

Martin, C. E., & Parlier-Ahmad, A. B. (2021). Addiction treatment in the postpartum period: An opportunity for evidence-based personalized medicine. *International Review of Psychiatry, 33*(6), 579–590. https://doi.org/10.1080/09540261.2021.1898349

Mathematica. (2022). The economic impact of untreated maternal mental health conditions in Texas [Report]. https://www.mathematica.org/publications/the-economic-impact-of-untreated-maternal-mental-health-conditions-in-texas

Mathematica, California Health Care Foundation, Perigee Fund, & Zoma Foundation. (2019). Societal costs of untreated perinatal mood and anxiety disorders in the United States [Issue brief]. https://www.chcf.org/resource/new-study-uncovers-heavy-financial-toll-untreated-maternal-mental-health-conditions/

Meinhofer, A., Witman, A., Maclean, J. C., & Bao, Y. (2022). Prenatal substance use policies and newborn health. Health Economics, 31(7), 1452–1467. https://doi.org/10.1002/hec.4518

National Center on Substance Abuse and Child Welfare. (n.d.). Interactive statistics series. https://ncsacw.acf.hhs.gov/research/child-welfare-statistics/interactive-statistics-series/

National Council for Mental Wellbeing. (2023). Youth Screening, Brief Intervention, and Referral to Treatment (YSBIRT). https://www.thenationalcouncil.org/program/ysbirt/

National Harm Reduction Coalition. (n.d.). Principles of harm reduction. Retrieved July 25, 2025, from https://harmreduction.org/about-us/principles-of-harm-reduction/

National Institute of Child Health and Human Development. (2013, December). Tobacco, drug use in pregnancy can double risk of stillbirth. https://www.nichd.nih.gov/newsroom/releases/121113-stillbirth-drug-use

National Institute on Drug Abuse (NIDA). (2020). *Substance use in women: Research report*. National Institutes of Health. https://nida.nih.gov/publications/research-reports/substance-use-in-women

National Institute on Drug Abuse (NIDA). (2024). Pregnancy and early childhood. https://nida.nih.gov/research-topics/pregnancy-early-childhood

Ogbonnaya, I. N., Keeney, A. J., & Villodas, M. T. (2019). The role of co-occurring intimate partner violence, alcohol use, drug use, and depressive symptoms on disciplinary practices of mothers involved with child welfare. Child Abuse & Neglect, 90, 76–87. https://doi.org/10.1016/j.chiabu.2019.02.002

Peacock-Chambers, E., Schiff, D. M., & Zuckerman, B. (2021). Caring for Families with Young Children Affected by Substance Use Disorder: Needed Changes. Journal of Developmental and Behavioral Pediatrics, 42(5), 408–410. https://doi.org/10.1097/DBP.0000000000000942

Ragsdale, A. S., Al-Hammadi, N., Loux, T. M., Bass, S., Keller, J. M., & Chavan, N. R. (2024). Perinatal substance use disorder: Examining the impact on adverse pregnancy outcomes. European Journal of Obstetrics & Gynecology and Reproductive Biology: X, 22, 100308.

Rodríguez, M. N., Colgan, D. D., Leyde, S., Pike, K., Merrill, J. O., & Price, C. J. (2024). Trauma exposure across the lifespan among individuals engaged in treatment with medication for opioid use disorder: differences by gender, PTSD status, and chronic pain. Substance Abuse Treatment, Prevention and Policy, 19(1), 25. https://doi.org/10.1186/s13011-024-00608-8

Silverman, K., & Benyo, A. (2024). Building healthy future: Addressing mental health and substance use disorders during pregnancy and postpartum. Center for Health Care Strategies. https://www.chcs.org/media/Executive-Summary_Building-Healthy-Futures_Addressing-Mental-Health-and-Substance-Use-Disorders.pdf

Smid, M. C., Metz, T. D., & Gordon, A. J. (2019). Stimulant use in pregnancy: An under-recognized epidemic among pregnant women. Clinical Obstetrics and Gynecology, 62(1), 168–184. https://doi.org/10.1097/GRF.0000000000000418

Solmeyer, A. R., Berger, A. T., Barton, S. L., Nguyen, B., Bart, G. B., Grahan, B., Bell, H. J., DeVine, K. M., & Merrick, W. (2022). Association of Project ECHO training with buprenorphine prescribing by primary care clinicians in Minnesota for treating opioid use disorder. JAMA Health Forum, 3(11), e224149. https://doi.org/10.1001/jamahealthforum.2022.4149

Substance Abuse and Mental Health Services Administration (SAMHSA). (2018). *Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants* (HHS Publication No. SMA 18-5054). U.S. Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/sma18-5054.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2023). Practical guide for implementing a trauma-informed approach (PEP23-06-05-005). U.S. Department of Health and Human Services. https://www.samhsa.gov/mental-health/trauma-violence/trauma-informed-approaches-programs

Substance Abuse and Mental Health Services Administration (SAMHSA). (2024). Issue brief: Innovative and holistic programs that offer medications for opioid use disorder to pregnant and parenting women (PEP2402009). https://library.samhsa.gov/sites/default/files/innovative-holistic-programs-pep24-02-009.pdf

Sullivan, E. V., Fama, R., Rosenbloom, M. J., & Pfefferbaum, A. (2002). A profile of neuropsychological deficits in alcoholic women. Neuropsychology, 16(1), 74–83. https://doi.org/10.1037/0894-4105.16.1.74

Taillieu, T. L., Brownridge, D. A., Tyler, K. A., Tiwari, A., & Santos, M. C. (2021). Intimate partner violence and child protective services contact during the perinatal period. *Child Abuse & Neglect, 117*, 105073. https://doi.org/10.1016/j.chiabu.2021.105073

Task Force on Maternal Mental Health. (2024). National strategy to improve maternal mental health care. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/mmh-strategy.pdf

Towers, E. B., Williams, I. L., Qillawala, E. I., Rissman, E., & Lynch, W. J. (2023). Sex/gender differences in the time-course for the development of substance use disorder: A focus on the telescoping effect. Pharmacological Reviews, 75(2), 217–249. https://doi.org/10.1124/pharmrev.121.000361

Trivedi, S. (2019). The harm of child removal. New York University Review of Law & Social Change. https://scholarworks.law.ubalt.edu/all_fac/1085

University of Kansas Center for Public Partnerships and Research. (2023). *Kansas Family First Prevention's three-year evaluation shows prevention services and supports protect family integrity.* https://cppr.ku.edu/news/article/2023/06/29/impact-kansas-family-first-prevention

University of Kansas Center for Public Partnerships and Research. (2024). *Kansas Connecting Communities (KCC) supplemental funding report: Final submission* [Unpublished internal report].

University of Kansas Center for Public Partnerships and Research. (2025). United to transform: A comprehensive statewide needs assessment of substance use disorder (SUD) systems and related work in Kansas. Reported to the Kansas Fights Addiction Grant Review Board on behalf of Sunflower Foundation. https://unitedtotransform.com/comprehensive-statewide-needs-assessment/

University of Kansas School of Nursing & United Methodist Health Ministry Fund. (2025, May). Access to obstetrical care in Kansas: 2025 analysis and recommendations. United Methodist Health Ministry Fund. https://healthfund.org/a/wp-content/uploads/2025-KU-SON-Access-to-Care-Report-FINAL.pdf

University of Kansas School of Social Welfare. (2023). Kansas families are benefiting from Family First initiative. https://medium.com/@KUSocialWelfare/kansas-families-are-benefiting-from-family-first-initiative-612b1c33c965

Valerio, M. A., Pasha, S., Smith, A., & Sturke, R. (2023). The Maternal Vulnerability Index: A tool for identifying maternal health risk at the county level. Surgo Ventures. https://maternalvulnerabilityindex.org/

von Esenwein, S. A., Zhao, H, & Tilden, C. D. (2025). Kansas 2025 Title V MCH needs assessment. Prepared by the University of Kansas Center for Public Partnerships and Research for the Kansas Department of Health and Environment. https://kansasmch.org/documents/objectives-2025/Title%20V%20NA%202025.pdf

von Esenwein, S. (2025, May 6). *Kansas Connecting Communities: Supporting perinatal mental health across Kansas* [Poster presentation]. NatCon 2025, Kansas City, KS. https://natcon2025.ipostersessions.com/?s=B4-7E-17-5A-C0-61-93-9C-EC-29-99-45-B9-1B-9D-C5

Wang, T., et al. (2024). Cost-effectiveness of perinatal depression screening: A systematic review. PharmacoEconomics. *https://link.springer.com/article/10.1007/s40258-024-00922-z*

Ware, O. D., Geiger, G. R., Rivas, V. D., Burgos, M. A. M., Nehme-Kotocavage, L., & Bautista, T. G. (2025). Risk of relapse following discharge from non-hospital residential opioid use disorder treatment: A systematic review of studies published from 2018 to 2022. Substance Abuse and Rehabilitation, 16, 105–118. *https://doi.org/10.2147/SAR.S440214*

Washington State Institute for Public Policy. (2024). Benefit-cost results: Nurse-Family Partnership. *https://www.wsipp.wa.gov/BenefitCost*

Werner, D., Pitonyak, J. S., Yonaitis, S. L., & Kunkel, S. (2023). Trauma and substance use disorder: Breaking the cycle in women. *The Journal for Nurse Practitioners, 19*(10), 108546. *https://doi.org/10.1016/j.nurpra.2023.108546*

Winkle, J. (2016). The story behind Oregon's SBIRT incentive measure and its impact on implementation. *https://my.ireta.org/sites/ireta.org/files/Winkle%20webinar%20handouts.pdf*

Winkleman, T. N. A., Villapiano, N. Kozhimannil, K. B., Davis, M. M, and Patrick, S. W. (2018). Incidence and costs of neonatal abstinence syndrome among infants with Medicaid: 2004-2014. Pediatrics, 141(4), E20173520. *https://doi.org/10.1542/peds.2017-3520*