



COLLABORATIVE PROGRAMS BETWEEN CHILD WELFARE AND SUBSTANCE USE DISORDER SYSTEMS FOR SUBSTANCE-INVOLVED FAMILIES



PURPOSE

Purpose

This brief highlights innovative State programs for families impacted by substance use disorders (SUDs) involved in the child welfare system. It illustrates collaborative programming occurring with the courts and judicial systems, state child welfare and SUD agencies, services providers, and other partners. It is a product of the American Public Human Services Association (APHSA) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) workgroup. The workgroup consists of state leaders from state alcohol and drug agencies and child welfare agencies.

Addressing Equity

Ensuring equitable access to programs and services regardless of background or personal characteristics is essential to creating impactful and inclusive systems of support. In evaluating equity, states should examine the demographics and socio-economic status of their service populations to determine if specific populations are being over or underrepresented in the service system.



COURT-BASED PROGRAMS

Pima County, Arizona



Background

Pima County Family Drug Court (FDC) and Gila River Indian Community Family Treatment Court has spearheaded efforts to provide and sustain a comprehensive family-centered approach for children, parents and families affected by parental SUDs, child abuse, and neglect. The Pima County FDC has adopted an early-reunification model, providing services such as:

- Child-parent psychotherapy (parents and children ages 0-6)
- Parent-child relationship therapy (children ages 0-8)
- [Incredible Years parenting program](#) (FDC families with children ages 0-12)
- [Incredible Years Dinosaur School](#) (children ages 4-8)
 - SUD prevention program for school-aged children
- SUD Treatment Services as part of the [Arizona F.I.R.S.T. program](#)
- Trauma-Specific Services
- Recovery Support Services

As part of Pima County FDC's systems changes they underwent a philosophical shift from the goal of parental recovery to one of family recovery. In doing so, they implemented the Prevention and Family Recovery Program to advance the capacity of the FDC by providing and sustaining a comprehensive family-centered care approach.

Through the [Pima County Prevention and Family Recovery Program](#), families and PFR staff developed and implemented a Family Recovery Plan that coordinates the parents' substance use treatment with the children's developmental, medical, and mental health services to improve outcomes for children, parents, and families affected by SUD and child abuse and neglect. The PFR Program aims to reunify children with their parents within six months of FDC entry by requiring evidence-based parenting for all families enrolled in the FDC.

Pima County, Arizona

Implementation

The Prevention and Family Recovery Initiative is considered to have made broader, sustainable systems improvements for families in the child welfare system rather than a single intervention. Ultimately, they made efforts to transform the ways in which FDCs and their cross-system collaborative partners make decisions about policies, programs and resource allocations, and how to better serve, support and improve outcomes for families in the child welfare system that are affected by parental substance use disorders. Key partners included the Juvenile Court Presiding Judge, the Department of Child Safety (child welfare), the Regional Behavioral Health Authority (RBHA), contract attorneys and the Attorney General's office, and others. The active involvement of child welfare and the mental and SUD publicly funded services was essential.

Pima County is one of four grantees for the Prevention and Family Recovery program, the others being San Francisco County, CA, Tompkins County, NY, and Robeson County, NC. The program is funded by the Doris Duke Charitable Foundation and The Duke Endowment. Implementation for a program like this requires a significant level of collaboration and use of evidence-based interventions in the process of deciding cases for families affected by SUDs as well as involvement with the Department of Child Safety.

Timeline:

- Implemented January 1, 2015.
- Expanded to four additional states by January 2017.
- Currently in place in Pima County.

LINKS:

- [THE PREVENTION AND FAMILY RECOVERY INITIATIVE'S CASE STUDY ON PIMA COUNTY](#)
- [THE PREVENTION AND FAMILY RECOVERY PROGRAM IN PIMA COUNTY OVERVIEW](#)

The use of evidence-based strategies led to the implementation of trauma-focused therapy for parents and the strengthening of collaboration between adult and children's services providers to encourage coordinated recovery.



Jefferson County, Colorado

Background

Family Integrated Treatment (FIT) Court is a voluntary, family-based program within the Dependency and Neglect System. It is based on a National Drug Court model and implements Family Drug Court best practices. [Jefferson County Family Integrated Treatment Court](#) and the Colorado Judicial Department have implemented familial supports for substance misuse in child welfare cases. They have implemented a family-centered judicial approach that is a collaborative effort striving to empower families to look beyond compliance and abstinence and encourage them to make a commitment to a recovery lifestyle. Their family-centered approach includes SUD treatment, court reviews, support groups, parenting programs, family therapeutic services, mental health treatment, and domestic violence treatment. Families entering FIT Court must develop and implement a recovery plan with both the parents' and children's needs in mind. The FIT Court program consists of five phases, taking a minimum of 11 months to complete, though most families complete the program in 12-18 months.

Implementation

Funding for the program was initially awarded in 2018 in the amount of \$861,290 by the Office of Juvenile Justice and Delinquency Prevention (OJJDP).

Colorado FIT Court recommends that all participants enroll in Medicaid and other supportive programs to afford the cost of medical, dental, and SUD treatments. The program does not cover the costs for families.

Timeline:

- FIT Court began in 2008 and has evolved over time to better serve families.
- In 2011 the program was restructured to include a family-centered approach and create other employment positions to benefit participants
- In 2015 as part of the family-centered approach, FIT expanded to include a reunification process.

Ultimately, implementation of a program such as this requires a significant amount of funding, often through grant awards, as well as reevaluation of program services according to goals on a yearly basis. The program requires cross-agency collaborations

LINKS:

- [PRESENTATION: EVALUATING FIT COURT OUTCOMES AND COST](#)

between health and human services organizations, the court system, community treatment and required judicial officers checking in with families regularly on engagement in treatment. The program utilized data to make decisions focused on principles of continuous quality improvement.

COMMUNITY-BASED PROGRAMS

Kansas



Background

The [Kansas Strong for Children and Families](#) project is a five-year cooperative agreement between the University of Kansas School of Social Welfare and the U.S. Department of Health and Human Services' Administration for Children and Families (ACF). The program is administered by the Kansas Department for Children and Families (DCF) and aims to improve outcomes for DCF-involved families by changing practices in both courts and agency settings that allow families to overcome system barriers to accessing services. The project's parent and youth facilitation process are designed to reduce the number of out-of-home placements by connecting families with effective community resources. [Kansas Strong](#) also includes a coaching program, "KanCoach," which focuses on developing and strengthening supervisory capacity. KanCoach priority topics include safety, risk assessment, case planning, engagement, relative/kin connections, and secondary traumatic stress.

Implementation

Kansas Strong is led by a cross-programmatic board of key leaders and stakeholders called the [Interagency Advisory Board](#), who also oversees the states

implementation of the Family First Prevention Services Act (FFPSA). The board is intentionally inclusive of those with lived experience and draws on the expertise of communities and how best to serve diverse populations. [The Parent/Youth facilitation](#) model is a two-pronged approach led by Kansas-Approved Parent-Adolescent Mediators who have training and experience working with families and adolescents. Through the facilitation process, families are also connected to additional community-based services.

Timeline:

- Kansas Strong started in October of 2018 and is currently funded to operate through September of 2023.

LINKS:

- [INFORMATION ABOUT THE INTERAGENCY AND COMMUNITY ADVISORY BOARD \(ICAB\)](#)
- [GENERAL OVERVIEW OF KANSAS STRONG FOR CHILDREN AND FAMILIES](#)
- [YOUTH VOICES FROM FOSTER CARE](#)

Kansas Strong at its core is a public-private partnership that is inclusive of private providers and faith-based organizations that serve and provide supportive services to Kansas families. This partnership model brings whole communities and stakeholders together to streamline access to all supportive services.

Michigan

Background

In Michigan, the state SUD agency and child welfare agency collaborated to implement the [Screening and Assessment for Family Engagement, Retention and Recovery \(SAFERR\) framework](#) that was originally developed by the National Center on Substance Abuse and Child Welfare (NCSACW) in 2006. The framework includes general substance use/child welfare principles, Family Treatment Court (FTC) practice principles, screening/assessment instruments, and engagement/retention strategies. Michigan's child welfare and SUD agencies have also worked together to develop the [Substance Use Disorder Family Support Program \(SUDFSP\)](#), which provides intensive services for substance-affected families at risk of child welfare system involvement. The state has two contracts with ten counties through SUDFSP, which provides skill-based, in-home interventions and support to parents with SUDs and co-occurring disorders. Facilitators focus on family challenges and require a minimum of two hours face-to-face with clients in the first month with one hour per week thereafter.

Implementation

To implement the SAFERR program, Michigan developed a series of principles that encouraged effective collaboration amongst the family court, child protection system, and SUD service providers. The framework was tailored to fit the state's unique population. SUDFSP effectively serves families by assigning each family a dedicated Family Support Specialist that focuses the intervention on the family's specific issues that are driving SUDs. Family Support Specialists create treatment plans for each family and document progress in monthly reports. After completing the program, parents are expected engaged in services to aide in their treatment and recover long term.

Timeline:

- The SAFERR program began in April of 2008 in Michigan courts. The program is still running.

LINKS:

- [GENERAL OVERVIEW OF SUDFSP](#)
- [MICHIGAN'S TITLE IV-E PREVENTION PLAN](#)
- [SAFERR FRAMEWORK](#)
- [MICHIGAN'S SUBSTANCE ABUSE/CHILD WELFARE PROTOCOL FOR SAFERR](#)

While the program itself is not rated on the IV-E Prevention Services Clearinghouse, part of the framework utilizes Motivational Interviewing (MI), a well-supported program, to help participants identify reasons to change behavior. If clearly defined in the states Prevention Plan, jurisdictions could receive partial federal reimbursement for all case management services done as part of this program.

Vermont

Background

The [Children and Recovering Mothers \(CHARM\)](#) Collaborative is a multi-disciplinary cross-agency team that includes child welfare and SUD agencies, along with Medicaid, criminal justice, and maternal and child health agencies. CHARM coordinates care for pregnant and postpartum mothers with a history of opioid use disorder, and their infants. The program was originally developed in Vermont. The collaborative has included child welfare and SUD professionals, as well as medical providers to provide interdisciplinary care for families struggling with opioid misuse. The CHARM Collaborative provides intervention opportunities beginning during the pre-natal stages of a pregnancy through the child's developmental milestones, including adolescence. Vermont's child welfare and SUD agencies worked together before the initiation of the CHARM Collaborative, but state funding facilitated CHARM's inception. Some of the offered services include SUD treatment, prenatal care, family-based residential services, parent and family support, child safety assessments, child welfare services, and home visiting referrals. The CHARM Collaboration model has been adopted and modified for use in many communities across the country.

The CHARM Collaborative had identified four goals for each family during pregnancy: 1) engage each woman in prenatal care as early in the pregnancy as possible, 2) reduce opioid cravings and withdrawal symptoms using medication for opioid use disorder (MOUD), 3) engage the woman (and her partner if possible) in substance abuse counseling, and 4) provide social support and meet basic needs for the family. The state also implemented the practice elements of the SAFERR framework.

CHARM services offered in Vermont included:

- SUD treatment
- MOUD (methadone maintenance therapy and buprenorphine treatment)
- Prenatal care
- Family-based residential services
- Parent and family support
- Child safety assessments
- Child welfare services
- Home visiting referrals



Vermont

Implementation

The American College of Obstetricians and Gynecologists (ACOG), District II has proposed a plan for the implementation of this program in New York State utilizing implementation guidance from Vermont:

- ACOG District II recommends **that at least \$1.5 million annually** is allocated in the state budget for:
 - A CHARM champion at each of the Regional Perinatal Centers (RPCs);
 - A division for CHARM-related activities that includes a state coordinator specifically for “hub & spoke” implementation components given the geographic expanse of New York; and,
 - Provider education that offers implementation tools to better assist women’s health care providers in caring for pregnant women with OUD.

To implement a program such as CHARM it is recommended that states:

1. Develop Regional “Hub and Spoke” Model similar to Vermont’s
2. Enhance Care Coordination and Linkage to Services Locally
3. Offer Multidisciplinary Provider Training

New York has only implemented a variation of CHARM, not the CHARM program specifically. Implementation of CHARM, or a similar program, will require many of these recommendations.

Other variations of the CHARM Program have been implemented in: Connecticut, Delaware, Kansas, Kentucky, Louisiana, Minnesota, New Hampshire,

New Jersey, New York, North Carolina, and Virginia. While CHARM is not rated by the IV-E Prevention Services Clearinghouse (Clearinghouse), if clearly defined in states Prevention Plan, jurisdictions could leverage Methadone Maintenance Therapy (MMT), rated

Timeline:

- CHARM was formally established in 2002. By 2014, the CHARM collaborative included 11 organizations that collectively provided comprehensive care coordination for pregnant women with SUD and OUD as well as consultation for child welfare, medical, and addiction professionals across Vermont.
- Variations of the CHARM Program have been implemented in: Connecticut, Delaware, Kansas, Kentucky, Louisiana, Minnesota, New Hampshire, New Jersey, New York, North Carolina, and Virginia.

LINKS:

- [CHARM IN BURLINGTON, VERMONT: A CASE STUDY](#)
- [NEW YORK IMPLEMENTATION GUIDANCE](#)
- [NY STATE LEGISLATION ENACTING CHARM](#)

promising on the Clearinghouse in order to get 50% federal reimbursement for MMT. If your state does not currently list CHARM or MMT in their Prevention Plans, amendments to the plan can be made at any time, subject to federal approval.

IV-E PREVENTION SERVICES CLEARINGHOUSE RATED PROGRAMS

*For all programs detailed in this section, if listed in a state's federally approved IV-E Prevention Plan, are eligible for 50% federal reimbursement.

WELL-SUPPORTED: GUIDING GOOD CHOICES PROGRAM

Summary

Guiding Good Choices® (GGC), formerly known as Preparing for the Drug Free Years (PDFY), aims to prevent teen substance use and risky behaviors by training parents to develop positive parenting and family management skills.

GGC includes five sessions that cover:

1. How to promote health and wellbeing during the teen years,
2. Setting clear guidelines,
3. Managing conflict,
4. Helping children avoid trouble, and
5. Strengthening family bonds.

The program has been reestablished for the inclusion of virtual use. When administered virtually, the program includes an additional introductory session focused on fostering community online.

Target Population

Families with children aged 9-14.

LINK:

- [GGC OVERVIEW AND SESSION DESCRIPTIONS](#)

Implementation

Workshop leaders deliver GGC over a five-week period, with one session per week in a group setting. The sessions can be in-person or virtual, but the virtual session contains an introductory session before the five other sessions begin. The sessions are approximately 2 to 2.5 hours long and are intended for parent use, however, session four is for both parents and children.

During its observation, GGC was administered in a school setting, but it is not required for proper implementation of the program. It is intended for the program to be implemented by two co-leaders, one of whom is a parent. Both co-leaders must go through a form of training that is typically 18-19 hours over 3-5 days. During the training, participants review the curriculum, practice leading sessions, and learn about the logistics for implementing the program. The program is available in English and Spanish, and it can be beneficial for at least one of the co-leaders to have Spanish proficiency.

SUPPORTED: SOBRIETY TREATMENT AND RECOVERY TEAMS

Summary

Sobriety Treatment and Recovery Teams (START) were designed to serve families involved in the child welfare system with a child that is at least five years old and at least one parent diagnosed with a substance use disorder (SUD). To prevent out-of-home placements for children, START was developed in order to promote treatment for parents while keeping children safe and secure.

The goals of START include:

1. Prevent out-of-home placements,
2. Promote child safety and well-being,
3. Increase permanency for children,
4. Encourage parental SUD recovery, and
5. Improve family stability and self-sufficiency.

LINKS:

- [START MODEL IMPLEMENTATION MANUAL](#)
- [START MODEL OVERVIEW](#)

Target Population

Families involved in the child welfare system with at least one child under the age of five and a parent with a diagnosed substance use disorder.

Implementation

Within 30-45 days of a Child Protective Services (CPS) report being filed, CPS will initiate a referral to START. The first activity in the program is a shared decision-making team meeting to discuss case and treatment planning. Afterwards, parents will complete an SUD assessment and at least four intensive treatment sessions. The START model is intended to place families at the center of treatment and involve them in decision-making during treatment and case planning.

The intervention activities include:

1. Intensive SUD recovery services,
2. Coaching to help with parenting and life skills,
3. Intensive CPS case management, and
4. Individual, group, and/or family counseling for parents, children, and other family members.

START teams are responsible for managing families' progress and coordinating cross-agency care. Family mentors also provide peer support to families and families will receive weekly home visits from their CPS caseworker for the first 60 days and weekly visits from their family mentor for the first 90 days.

Parents must have six months of documented sobriety before their case can be closed and families can be reunited. Typically, the program lasts for an average of 14 months.

PROMISING: METHADONE MAINTENANCE THERAPY

Summary

Methadone Maintenance Therapy (MMT) is a medication-assisted treatment with the purpose of reducing opioid use in those suffering from opioid use disorder (OUD). Methadone is an opioid agonist prescribed and administered at levels calibrated to prevent the onset of painful withdrawal symptoms and reduced over time to prevent dependence.

Requirements

MMT must be administered by clinicians in federally certified and licensed treatment programs and includes counseling and social support services. Dosage and treatment duration vary depending on individual needs.

To meet federal requirements, MMT programs must be certified through the Substance Abuse and Mental Health Services Administration (SAMHSA) Division of Pharmacologic Therapies (DPT). SAMHSA DPT also offers training courses, webinars, workshops, and reference publications to MMT clinicians.

Target Population

MMT is designed for individuals with an OUD. Those receiving treatment must be at least 18 years old. Individuals under 18 may receive MMT if they have had two previously unsuccessful treatments and have parental consent.

Implementation

MMT can be administered by trained clinicians, substance use disorder counselors, physicians, and nurses. Clinicians must have the appropriate licenses, certifications, training, and experience for their role. SAMHSA DPT offers training courses, webinars, workshops, and reference publications to MMT clinicians.

Some individuals who have progressed further into their treatment may be allowed to take MMT at home. However, this option is only available when deemed fit by a trained clinician according to individual stability for adherence to prescribed dosage.

LINKS:

- [MMT IN THE CLEARINGHOUSE](#)
- [OVERVIEW OF MMT](#)

