



National Association of State Alcohol and Drug Abuse Directors, Inc.

Therapeutic Services for Children Whose Parents Receive Substance Use Disorder (SUD) Treatment

Prepared by:

The National Association of State Alcohol and Drug Abuse Directors
(NASADAD)

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Table of Contents

Executive Summary.....	5
Introduction	7
Background	8
Federally Funded Programs and Policies.....	10
SAPT Block Grant Women’s Set-Aside	10
Title IV-B, Subpart 1—Child Welfare Services	10
Title IV-B, Subpart 2—Promoting Safe and Stable Families	10
Title IV-E—Foster Care.....	11
Part C of IDEA.....	11
CAPTA.....	11
Home Visiting Block Grant	12
Methodology.....	12
Therapeutic Services Across All States	13
Table 1: Therapeutic Services and Cross-Agency Collaborations	15
Case Studies	21
Table 2: How Therapeutic Services Are Defined and Who Provides These Services	22
Table 3: Prevention, Early Intervention, and Therapeutic Services Provided.....	25
Table 4: Screening and Assessment Requirements and Recommendations.....	29
Table 5: Case Management, System Linkages, and Memorandums of Understanding.....	31
Table 6: Funding of Therapeutic Services for Children.....	34
Table 7: Training and Technical Assistance Required and/or Offered	36
Table 8: Tracking and Monitoring.....	38
Table 9: Other Services, Initiatives, and Collaborations.....	40
Barriers to Services	43
Conclusions	44
Bibliography	46

Executive Summary

The Substance Abuse Prevention and Treatment Block Grant (SAPTBG), as described in the SAPTBG Interim Final Rule, Title 42 U.S.C., requirement for maintenance of effort in providing services to pregnant and parenting women includes a reference that services must include “therapeutic interventions for children in custody of women in treatment which may among other things address their developmental needs and their issues of sexual abuse, physical abuse, and neglect.” However, the phrase “therapeutic interventions” is not further defined. To learn more about these services for children, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) staff conducted a review of States’ practices. The staff reviewed States’ responses to this requirement and interviewed Women’s Services Network contacts in nine case study States—Colorado, Georgia, Massachusetts, Nevada, New Jersey, Oregon, Texas, Virginia, and Washington.

The goal of this study was to identify policies and practices that States have implemented to offer high-quality services for children whose parents enter treatment for substance use disorders (SUDs). This study also describes the ways that Single State Agencies (SSAs) for Alcohol and Drugs and SUD treatment providers are able to collaborate with other agencies to provide cost-effective services to children whose parents enter SUD treatment. Toward this goal, this report reviews (1) how States have defined therapeutic services for children; (2) what services States offer for children under this requirement; (3) how a State determines whether and what type of therapeutic services a child should get; and (4) how States ensure that children have access to such services.

The following summary presents the findings of the assessment of these States:

1. These States define therapeutic services to children through contract language, administrative rules, licensing regulations, and therapeutic child care guidelines. Because these mechanisms vary from State to State, providers may be required and/or encouraged to improve their outcomes. Through these mechanisms, providers are directed to screen children for physical, developmental, social-emotional and behavioral concerns and to deliver a variety of prevention/early intervention services to children whose parents enroll in SUD treatment. Providers are generally encouraged to create and maintain formal and informal linkages with a comprehensive resource network, including, but not limited to, Child Welfare Agencies, child care providers, and pediatricians and other primary care providers.
2. Care coordination and case management are critical to providing cost-effective, age, and developmentally appropriate services for children whose parents enroll in SUD treatment. Information sharing reduces duplication of services and helps to ensure that children receive appropriate services. In these nine States, there are efforts to coordinate with other agencies and providers to expand the range of therapeutic services available to children and families beyond those funded by the Block Grant. These coordination efforts have increased treatment providers’ ability to provide services needed by children of parents in treatment, either on site by program or partner agency staff or through referrals to community services. Referrals to outside services are closely monitored to ensure that children actually receive services.
3. Establishing which agency has primary responsibility for ensuring that children receive appropriate services while their parents receive SUD treatment is often challenging. This determination is often challenging because wait lists increase, services are subject to funding reductions, and eligibility standards are raised in ways that exclude some children from receiving services.

4. Some of these States and their providers are using an increasing number of evidence-based practices that have been assessed in depth regarding their effectiveness with children and families. There is not, however, widespread evaluation of the impact of therapeutic services to children of parents in treatment, or of the specific assessment tools used in determining which children need which services.
5. Family treatment—meaning treatment that treats the whole family as a unit and responds to an assessment of the whole family’s needs—is available in some of these States through a range of treatment providers. But it is not yet a standard response to the needs of children and families in treatment. States are moving toward family-centered treatment, but with limited resources, they must make strategic decisions to prioritize spending. Services for children can be more costly than models that largely ignore children, and providing these services requires specialized skills and a mechanism for paying for them. For these reasons, SSAs have been able to increase services to children through linkages to other available services and leverage funding from other State agencies. Specifically, Medicaid is an important additional source of funding for therapeutic services for children. In addition to Medicaid, SSAs have been able to collaborate across agencies, particularly with their child welfare counterparts, and have leveraged existing services and areas of expertise. Links to the expanded home visiting services are an important new direction in this area.
6. State efforts focus on children whose parents are in treatment and, to a lesser degree, on children who were themselves prenatally exposed to alcohol, tobacco, and illicit drugs. These substance-exposed infants are a special target of policy and practice efforts in some of these States, but comprehensive approaches to the full range of their therapeutic needs are not yet in place.

It should be noted that this review looked primarily at those therapeutic services funded under the Block Grant requirement, not the full range of children’s services that may be funded in the States. The other funding sources mentioned in this document may be supporting children’s therapeutic services above and beyond what the Block Grant provides. In fact, it is the growing collaboration between SSA Block Grant-funded activities in children’s services and these wider sources of funding and service delivery that was one of the lessons of this review. No single agency can provide the full range of services needed to respond to the needs of the children affected by parental substance use disorders. It takes an integrated services effort, and the efforts under way in these States represent important progress toward that goal.

These nine case studies review States that have taken quite different and innovative approaches to defining what therapeutic services for children will be provided. The States have worked creatively with providers to ensure that children whose parents enter SUD treatment receive appropriate, timely, and cost-effective services. These States have used available resources, both their own and those from Federal grants, to develop new therapeutic services for children. Though the scale of these efforts remains small in most States, the effort to respond to the set aside requirement has been genuine and has attracted significant resources in a time of considerable fiscal strain for these States. Model programs exist in all States, although replicating them has been difficult.

Whether these efforts can now be sustained remains to be seen, but many have already been able to demonstrate their success in improving child and family outcomes.

Introduction

The Substance Abuse Prevention and Treatment (SAPT) Block Grant Interim Final Rule, Title 42 U.S.C., requires that States “maintain expenditures for services for pregnant women and women with dependent children at a level that is not less than the FY 1994 expenditures” (Public Health and Welfare, 2010) to fund services for pregnant women and women with dependent children. These services must include “therapeutic interventions for children in custody of women in treatment which may among other things address their developmental needs and their issues of sexual abuse, physical abuse, and neglect” (Public Welfare, 1993). All States report that they comply with these requirements in Goal 3 and Attachment B of the SAPT Block Grant Application. “Therapeutic services” are not further defined in SAPT Block Grant statute or regulation. Though States must fund such services, the Block Grant statutes and regulations do not describe which children should receive such services, or when they should be delivered. These services can be provided either directly by the program staff or by referral to another agency. As States move toward family-centered models of substance use disorder (SUD) treatment, many States have begun to better define what service providers should offer to children whose parents enter SUD treatment, and which children should receive those services.

To learn more about how States define and deliver therapeutic services to children as part of their parent’s SUD treatment program, National Association of State Alcohol and Drug Abuse Directors staff, with funding from the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment, conducted a three-phase review of States’ practices:

1. A review of States’ responses to Goal 3 and Attachment B of the 2009 SAPT Block Grant Application;
2. Follow-up questions sent to the Women’s Services Network listserv requesting additional information based on common themes identified in no. 1; and
3. Telephone interviews with nine case study States—Colorado, Georgia, Massachusetts, Nevada, New Jersey, Oregon, Texas, Virginia, and Washington.

Specifically, this report examines (1) how States have defined therapeutic services for children; (2) what services States offer for children; (3) how a State determines whether and what type of therapeutic services a child should get; and (4) how States ensure that children have access to such services.

The goal of this study was to identify policies and practices that States have implemented to offer high-quality services for children whose parents enter SUD treatment. This study also sought to understand the ways that Single State Agencies (SSAs) and SUD treatment providers are able to collaborate with other agencies to provide cost-effective services to children whose parents enter SUD treatment. This study did not examine the effectiveness of individual interventions or services provided by SUD treatment programs or through referral to other agencies.

Background

Over 8.3 million children in the United States under the age of 18 live with a parent who suffered from alcohol and/or illicit abuse or dependency during the past year, representing 11.9% of children nationwide (Substance Abuse and Mental Health Services Administration, Office of Applied Studies,

2009). In 2005, an estimated 10 to 11% of the 4.1 million live births involved prenatal exposure to alcohol or illegal drugs (Young et al., 2009). Children exposed, either prenatally or environmentally, to parental substance abuse are more likely to be affected by child abuse or neglect. A study from Chapin Hall in 2011 reported that almost 61% of infants and about 41% of older children in out-of-home care had a primary and/or secondary caregiver who reported active alcohol and/or drug abuse (Wulczyn, Ernst, & Fisher, 2011).

The incidence of children affected by parental substance abuse creates urgency to provide services to the impacted children and families. Research has indicated that children whose parents have substance use disorders (SUDs) are at an increased risk of having a range of developmental, behavioral, and emotional difficulties (Conners, Bokony, Whiteside-Mansell, Bradley, & Liu, 2004; Carlson, 2006; Schulman, Sigal, Shapira, & Hirschfield, 2000;). Children with substance-abusing mothers are in need of long-term supportive services that address their intermediate, transitional, and long-term needs (Conners et al., 2004). However, these children are often not assessed, are misdiagnosed, and are not offered services to address their own needs (Caprara, Nash, Greenbaum, Rovet, & Koren, 2007; Premji, Benzie, Serrett, & Hayden, 2007).

Research has shown that services provided to children of substance-abusing parents lead to improved outcomes for parents as well. Programs that offer services to children (both childcare and therapeutic services) have been shown to increase parents' retention in care and to improve outcomes for women (Uziel, Miller, & Lyons, 2001). When children's therapeutic services are provided in conjunction with family residential substance abuse treatment, women have been found to have longer stays in treatment and higher treatment completion rates (Clark, 2001; Conners et al., 2006; Metsch et al., 2001; McComish et al., 2003; Porowski, Burgdorf, & Herrell, 2004). Retention and completion of treatment have been found to be the strongest predictors of reunification with children for substance-abusing parents (Green, Rockhill, & Furrer, 2007; Marsh, Smith, & Bruni, 2010). Therefore, substance abuse treatment services that include children in treatment can lead to improved outcomes for the parent, which can also improve outcomes for the child. Grella, Hser, & Yang (2006) found that women who participated in programs that included a "high" level of family and children's services and employment/education services were twice as likely to reunify with their children as those who participated in programs with a "low" level of these services. Higher reunification rates for families involved in the child welfare system because of substance abuse are another benefit to providing services to children affected by parental substance abuse, with direct impact on expenditures for out-of-home care.

There are many interventions for at-risk children and for those determined to have problems due to their parents' SUD. Several programs, such as *Incredible Years*, *All's Pals*, *Strengthening Families*, *Celebrating Families*, *Too Good for Drugs/Violence*, and *Nurturing Parenting*, have been found to decrease children's behavior problems and support appropriate child development. Information on the models and effectiveness of these programs can be found at SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP), an online registry of evidence-based interventions. While not all of these interventions were specifically developed for children whose parents enroll in SUD treatment, these programs have been shown to be effective with high-risk populations, such as families affected by substance abuse and child maltreatment. *Strengthening Families* is an example of one program specifically designed for children of substance-abusing parents. This family skills training program works to reduce risk factors for behavioral, emotional, academic, and social problems in children 3 to 16 years old (NREPP, 2011).

The Center for Substance Abuse Treatment's "Comprehensive Substance Abuse Treatment Model for Women and Their Children" (2004) identifies a range of clinical treatment and clinical support services

that are recommended for provision to children whose parents enter SUD treatment. These services include screening, intake, assessment, case management, case planning, medical care and services, substance abuse education and prevention, therapeutic child care and development, residential care (in residential settings), mental health and trauma services, onsite or nearby child care, recreational services, mental health and remediation, educational services, advocacy, prevention services, and recovery community support services. Therapeutic child care services should include developmental assessments, play therapy, behavioral modification, individual counseling, self-esteem building, and family intervention. These standards offer guidelines for the services that should be provided to children of substance-abusing women. However, the standards do not define specifically which approaches or manuals should be used for each of these services, or when children should receive each of these services during SUD treatment.

As per Subpart L, Section 96.124, of the Substance Abuse Prevention and Treatment Block Grant requirements, States must ensure that programs that receive funds set aside for pregnant women and women with dependent children provide or arrange for:

- Primary medical care, including prenatal care;
- Primary pediatric care for the women's children, including immunizations;
- Gender-specific substance abuse treatment;
- Other therapeutic interventions for women addressing issues such as relationships, sexual and physical abuse, and parenting;
- Therapeutic interventions for children in custody of women in treatment to address, among other things, developmental needs, sexual abuse, physical abuse, and neglect;
- Child care while the women are receiving services; and
- Sufficient case management and transportation to ensure that the women and their children have access to the above services.

States do not require, but are strongly encouraged to require, programs that receive these set-aside funds to provide or arrange for the following additional services:

- Case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments;
- Employment and training programs;
- Education and special education programs;
- Drug-free housing for women and their children; and
- Therapeutic day care, Head Start, and other early childhood programs for children.

The document "Guidance to States: Treatment Standards for Women with Substance Use Disorders" offers guidelines for the comprehensive services that could be provided for women entering SUD treatment who have children. These guidelines describe services to allow women to receive evidence-based SUD treatment that supports healthy development of children and families. *(The National Association of State Alcohol and Drug Abuse Directors [NASADAD] prepared this document, with support from the Substance Abuse and Mental Health Services Administration [SAMHSA], Center for Substance Abuse Treatment [CSAT], under the SAMHSA/CSAT contract #270-03-1000, task order #270-03-1002, to JBS International, Inc., and 2008.)*

Though there are challenges to providing services to children affected by parental substance abuse, treatment agencies have a unique opportunity to intervene with a highly vulnerable population of children and their families. The issues of prenatal exposure and therapeutic services for children do not "belong to" any one agency, because they demand comprehensive services provided along a continuum

of prevention, intervention, and treatment, and at different developmental stages in the life of the child and family. Agencies should strive to effectively collaborate with existing programs and funding streams to aid in providing comprehensive services that meet the needs of children. No single agency can deliver all of these services alone, or through a single funding source; an interagency, integrated services effort is critical to providing therapeutic children's services.

Federally Funded Programs and Policies

States are able to access a variety of Federal funding sources to provide therapeutic services to children whose parents receive substance use disorder (SUD) treatment. These funding sources include the Substance Abuse Prevention and Treatment (SAPT) Block Grant Women's Set-Aside, Part C of the Individuals with Disabilities Education Improvement Act (IDEA), Title X, State Early Learning Councils, the Keeping Children and Families Safe Act, Title IV-B and Title IV-E, Medicaid, and the Home Visiting Block Grant, which are administered by different Federal agencies and fund a variety of services for children. This list is not meant to be exhaustive of all sources of funding for therapeutic services to children. For a more comprehensive list of available funding, see *Funding Family-Centered Treatment for Women with Substance Use Disorders* (Dennis, Young, & Gardner, 2008). The SAPT Block Grant, IDEA: Part C, Title IV-B and Title IV-E, the Child Abuse Prevention and Treatment Act (CAPTA), and the Home Visiting Block Grant are described below as examples of funding opportunities that States can leverage to provide services for children.

SAPT Block Grant Women's Set-Aside

The SAPT Block Grant provides Federal funding to the Single State Agency (SSA) in every State to support substance abuse treatment and prevention programs and services. The SAPT Block Grant, which is managed by the Substance Abuse and Mental Health Services Administration (SAMHSA), requires that all States allocate a percentage of the Block Grant dollars to serve the specific needs of pregnant women, women with dependent children, and the children of women who enter SUD treatment. This set-aside, known as the Women's Set-Aside, is authorized by Title 42 U.S.C., which requires States to "maintain expenditures for services for pregnant women and women with dependent children at a level that is not less than the FY 1994 expenditures" (Public Health and Welfare, 2010). The expenditures may be any combination of SAPT Block Grant and State general revenue (including the State's contribution to Medicaid). Included are statutory requirements that funding for pregnant and parenting women must be used for primary medical care, including immunizations, for women and their children; gender-specific SUD treatment; therapeutic services for children; child care; case management; and transportation. Pregnant and parenting women also must be given priority admission to treatment. SAMHSA requires States to provide assurance in the annual Block Grant Application that these requirements have been met. The Application specifically asks States to describe how they have provided therapeutic services to dependent children whose parents enroll in SUD treatment.

Title IV-B, Subpart 1—Child Welfare Services

The Child Welfare Services program aids States in establishing, extending, and strengthening coordinated child welfare services and provides funding for programs to prevent the abuse, neglect, and exploitation of children; to ensure that children are raised in safe, loving families; to develop alternative placements if children must be removed from the home; and to reunify children with their families when possible (Dennis, Young, & Gardner, 2008). Funds may be utilized for programs that provide support services to at-risk families, including substance abuse treatment for parents to resolve child welfare problems and services for children in out-of-home care.

Title IV-B, Subpart 2—Promoting Safe and Stable Families

The Promoting Safe and Stable Families program provides funding to aid States in stabilizing families, strengthening family functioning, preventing out-of-home care for children, enhancing child development, increasing parenting competency, facilitating timely reunification of children with their parents, and supporting appropriate adoptions when in the best interest of the children (Dennis et al., 2008). The Administration for Children and Families (ACF) allocates funds to the State agency responsible for providing child welfare services. Funding must be used for family preservation, family support services, time-limited family reunification services, and adoption promotion and services. Examples of such services may include substance abuse assessment and treatment, mental health services, child development training and education, parent-child interaction and parent-child bonding services, family counseling, and early developmental screening and assessment of children and linkage to developmental services.

Title IV-E—Foster Care

The Title IV-E Foster Care program of the Social Security Act was established in 1980 as a funding stream to help States provide child welfare services for eligible children who need temporary out-of-home placement (Dennis et al., 2008). Funds may be used to provide food, shelter, daily supervision, school supplies, and reasonable travel home for visitation. Such funds may also be used for administrative costs such as referral to services; placement of the child; case management, reviews, and supervision; and recruitment of foster and adoptive homes and facilities.

Part C of IDEA

In 2004, Congress reauthorized IDEA in 1986 to assist children with disabilities in receiving special services. IDEA provides Federal funding to help States develop and operate a statewide program of early intervention services for children from birth to age 2 through the Program for Infants and Toddlers with Disabilities (Part C). Allocations are determined by the population of children ages birth to 3 years in each State. Federal legislation requires that Part C provide early intervention to every eligible child and his or her family. States develop their own definitions of disabilities and establish guidelines to determine which children and families are eligible for Part C services. In addition, each State must designate a lead agency to receive the grant and administer the program and must appoint an Interagency Coordinating Council to advise and assist the lead agency. Under Part C, there are two mandated eligibility categories and one discretionary category. States must serve all children who have (1) a developmental delay (determined by developmental assessment), and (2) a diagnosed mental or medical condition that has a high probability of resulting in developmental delay (e.g., chromosomal abnormalities, genetic or congenital disorders, severe sensory impairments, and exposure to toxic substances). States have a choice about whether they serve at-risk children (discretionary category). In the great majority of U.S. States and territories, infants and toddlers are eligible to receive Part C services only if they are experiencing a developmental delay or have a diagnosed medical condition. Eight States and territories also choose to serve children who are at risk of developmental delay due to biomedical risks (e.g., low birth weight, failure to thrive, and chronic lung disease) and/or environmental risks (e.g., parental substance abuse, poverty, parental age, child abuse, and neglect).

CAPTA

CAPTA was originally enacted in 1974 (P.L. 93-247). This Act was reauthorized on June 25, 2003, by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36) and on December 20, 2010. CAPTA provides Federal funding to the State Child Welfare Agencies through a Block Grant administered by the Federal ACF to States to fund programs and activities designed to strengthen and support families to prevent

child abuse and neglect. Specifically, this funding can be used to provide training to Child Welfare Agency staff, to improve case monitoring and case management, to develop safety assessment tools and protocols, to create or improve tracking systems to monitor cases, and to enhance interagency coordination with other agencies, including the SSA. CAPTA also requires that States develop procedures, including “appropriate referrals” to child protective services (CPS), to address needs of infants born “affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.” CAPTA requires that hospitals notify CPS of substance-exposed babies, with the caveat that notification does not establish a definition under Federal law of what constitutes child abuse, and that it does not require “prosecution for any illegal action.” CAPTA further requires development of a plan of “safe care” for the infant. The CAPTA provision at section 106(b)(2)(A)(xxi) requires that States have provisions and procedures for the referral of children under the age of 3 who are involved in substantiated cases of child abuse or neglect to early intervention services funded by Part C of IDEA. CAPTA does not specifically require that *every* child under the age of 3 who is involved in a substantiated case of child abuse or neglect *must* be referred to Part C services. Therefore, States have the discretion about whether to refer every such child under the age of 3 for early intervention services, or to first employ a screening process to determine whether a referral is needed. The most recent reauthorization in 2010 (P.L. 111-320) amended earlier language to include newborns diagnosed with fetal alcohol spectrum disorders (FASD) in the mandated identification, referral, and safe care plans requirement. States are also required to report the number of children referred under these provisions.

Home Visiting Block Grant

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act, which included an expansion of funding for home visitation programs. This legislation established the Maternal, Infant, and Early Childhood Home Visiting Program, a \$1.5 billion, 5-year Federal grant program. The program provides funding for States to establish or continue to fund early childhood home visiting programs for families who reside in at-risk communities, such as those affected by substance abuse and child maltreatment. The grants will enable States to provide evidence-based home visiting programs aimed at increasing school readiness, reducing the incidence of child maltreatment, improving parenting related to child development outcomes, reducing crime and domestic violence, improving family economic self-sufficiency, and improving referrals to community support and services. Families with a history of substance abuse or who are in need of substance abuse treatment, and families who use tobacco products in the home, are among the populations targeted through this grant.

Methodology

To identify States that have successfully prioritized the delivery of high-quality, appropriate therapeutic services to children, National Association of State Alcohol and Drug Abuse Directors staff compiled and reviewed States’ responses to Goal 3 and Attachment B of the 2009 Substance Abuse Prevention and Treatment (SAPT) Block Grant Application. Based upon common themes identified through this review process, staff sent an email to the NASADAD Women’s Services Network (WSN) listserv asking whether States:

- Require providers to ask clients whether they have dependent children at intake;
- Recommend specific screening and/or assessment tools that can be used to assess children whose parents enter substance abuse treatment;
- Require or recommend that providers offer specific evidence-based practices to children whose parents enter substance abuse treatment; or

- Participate in State networks that identify and coordinate services on behalf of children of substance abusers.

The email to the listserv also solicited voluntary participation in the creation of State profiles for those States in which WSN members felt their States are doing an excellent job of providing therapeutic services to children whose parents enroll in substance use disorder (SUD) treatment. On the basis of the Block Grant reports and responses to the listserv email, NASADAD chose nine States with which to conduct further case studies: Colorado, Georgia, Nevada, New Jersey, Massachusetts, Oregon, Texas, Virginia, and Washington.

The case studies were conducted via telephone interviews with State agency staff. NASADAD staff, with the assistance of the WSN and the NASADAD Research Committee, drafted a discussion guide. This guide used the National Center for Substance Abuse and Child Welfare's 10-element framework for cross-system collaboration between child welfare agencies, substance abuse treatment agencies, and the family court system.

The discussions focused on the following areas:

- How the State defines therapeutic services for children whose parents enter SUD treatment;
- What the State requires of counties or providers with respect to therapeutic services for children whose parents enter substance abuse treatment;
- How the State ensures that these requirements are met;
- The types of providers required to deliver therapeutic services to children;
- Whether the State has developed specific manuals or protocols that providers are required to use;
- How the Single State Agency(SSA) assists SUD treatment providers in accessing therapeutic services for children that are provided by other social services agencies (Head Start; Women, Infants and Children; home visiting services, etc.);
- Whether SSAs track the numbers of children who enter SUD treatment with their parents;
- The number of children who receive therapeutic services as part of their parent's treatment;
- How therapeutic services to children are funded; and
- Whether and how the SSA provides training or technical assistance to help providers deliver high- quality therapeutic services to children.

The goal of this study was to identify policies and practices that States have implemented to offer high-quality services for children whose parents enter SUD treatment. This study also sought to understand the ways that SSAs and SUD treatment providers are able to collaborate with other agencies to provide cost-effective services to children whose parents enter SUD treatment. This study did not examine the efficacy of individual interventions or services provided by SUD treatment programs or through referral to other agencies. Several case study participants noted that the discussion guide and interview process addressed a focused, useful set of topics, and might be useful as a self-assessment for other States.

Therapeutic Services Across All States

NASADAD staff sent an email to the Women's Services Network (WSN) listserv of the National Association of State Alcohol and Drug Abuse Directors, asking whether States provide guidance to substance use disorder treatment providers on a variety of facets of therapeutic services to children. The email also asked which cross-agency councils, networks, and task forces WSNs across the States participate in. The specific guidance areas were identified based on common responses to the Substance

Abuse Prevention and Treatment Block Grant. Twenty-four States responded to the email. All of the responses are detailed in “Table 1: Therapeutic Services and Cross-Agency Collaborations,” below. Nearly all of the responding States (22 out of 24 States) require their providers to ask clients whether they have dependent children at intake. Four States require or recommend specific screening or assessment tools for children. Fifteen States recommend that providers use specific evidence-based interventions with children, including Strengthening Families (eight States), Celebrating Families (four States), and SAMHSA’s Children’s Program Kit (three States). WSNs are also involved in various State networks, including the Fetal Alcohol Spectrum Disorders(FASD)Task Force (13 States); statewide maternal and child health networks emphasizing prenatal screening (nine States); statewide early learning councils created by Federal stimulus funding (two States); Part C agencies (two States); and prenatal screening (eight States). Eleven WSNs reported participating in other networks that coordinate services on behalf of children of substance abusers.

Table 1: Therapeutic Services and Cross-Agency Collaborations

Table 1: Therapeutic Services and Cross-Agency Collaborations

State	Ask clients whether they have dependent children at intake	Required/recommended screening and/or assessment tools for children	Required/recommended evidence-based practices (from NREPP)* for children	WSN Participation in Cross-Agency Collaborations					
				FASD Task Force	Regional Centers, Part C	Prenatal screening councils	Early learning councils created by Federal stimulus funding	Maternal and child health networks emphasizing prenatal screening	Others
AL	Yes	No	No	No	No	No	No	Yes	Alabama Alliance for Drug Endangered Children
AR	Yes	No	No	Yes	No	No	No	No	No
IA	Yes	No	No	No	No	No	No	Yes	No
ID	Yes; Management Services Contractor asks at screening to determine financial eligibility	No	Celebrating Families	No	No	No	No	No	No
IL	Yes; implicit, not explicit, in our system; required of providers receiving 10% Block Grant funds	No	Recommended/across age groups: Celebrating Families, Strengthening Families, and Brief Strategic Family Therapy	No	No	No	No	No	Statewide Perinatal Addiction Task Force
IN	No	No	No; encourage evidence-based practices but do not require them in provider contracts	No	No	No	No	No	No

Table 1: Therapeutic Services and Cross-Agency Collaborations

State	Ask clients whether they have dependent children at intake	Required/ recommended screening and/or assessment tools for children	Required/recommended evidence-based practices (from NREPP)* for children	WSN Participation in Cross-Agency Collaborations					
				FASD Task Force	Regional Centers, Part C	Prenatal screening councils	Early learning councils created by Federal stimulus funding	Maternal and child health networks emphasizing prenatal screening	Others
KS	Yes	Recommended: Healthy Babies screening, Rainbow, Kansas Children’s Service League, Community Mental Health Center, and Child Development programs	Strengthening Families and Children’s Program Kit	Yes	Yes	Yes	No	Yes	Kansas Alliance for Drug Endangered Children
MI	Yes; also about child welfare involvement	No	No; specific programs are not required but may be provided or contracted for in some SUD programs	Yes	No	Yes	No	No	No
MS	Yes	No	No	No	No	No	No	No	FASD Advisory Council
NC	Yes; monitored through the annual Substance Abuse Prevention and Treatment Block Grant monitoring process	Recommended: PEDS	Recommended: All Stars, Celebrating Families, Strengthening Families, Incredible Years, and Nurturing Parenting	No	No	Yes; with Division of Public Health (DPH)	No	Yes; DPH	No
ND	Yes	No	No	No	No	No	No	No	No
NE	Yes	No	No	No	No	No	No	No	No

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State	Ask clients whether they have dependent children at intake	Required/ recommended screening and/or assessment tools for children	Required/recommended evidence-based practices (from NREPP)* for children	WSN Participation in Cross-Agency Collaborations					
				FASD Task Force	Regional Centers, Part C	Prenatal screening councils	Early learning councils created by Federal stimulus funding	Maternal and child health networks emphasizing prenatal screening	Others
NH	Yes; providers also ask the number of dependent (under age 18) children and living arrangements of those children	No	No	Don't know	Don't know	Don't know	Don't know	Don't know	No
NJ	Yes; captured through the New Jersey Substance Abuse Monitoring System	No	Required: Strengthening Families	Yes	No	No	No	No	Statewide Maternal Health and Child Health Consortia, State women and children's child welfare substance abuse programs, Steering Committee meetings, and Division of Youth and Family Services Child Welfare Substance Abuse Consortia monthly meetings
NV	No	No	Recommended: Children's Program Kit (Supportive Education for Children of Addicted Parents)	Yes	Yes	Yes	No	No	Board of Perinatal Substance Abuse Prevention

Table 1: Therapeutic Services and Cross-Agency Collaborations

State	Ask clients whether they have dependent children at intake	Required/ recommended screening and/or assessment tools for children	Required/recommended evidence-based practices (from NREPP)* for children	WSN Participation in Cross-Agency Collaborations					
				FASD Task Force	Regional Centers, Part C	Prenatal screening councils	Early learning councils created by Federal stimulus funding	Maternal and child health networks emphasizing prenatal screening	Others
OR	Yes	No	No; encouraged to use Collaborative Problem Solving, Parent/Child Interaction Therapy, and Circle of Security (Dyad model for moms and children) as therapeutic models for children; Prevention staff support use of Strengthening Families	Yes	No	Yes; Maternal Mental Health Advisory Group and Title V Advisory Group	No	No	Women's Commission on Alcohol and Drug Issues-Oregon; Family Early Advocacy and Training
PA	Yes	No	No	Yes	No	No	No	No	No
SC	Yes	Recommended: Denver Developmental Screening II, BRIGANCE Early Childhood Screen® or the Child Development Inventory	Prevention staff offer All Stars and Strengthening Families	Yes	No	No	No	No	No
TN	Yes	No	No; but some providers use Strengthening Families	No	No	No	No	No	Juvenile Justice Foster Care Review Board

Table 1: Therapeutic Services and Cross-Agency Collaborations

State	Ask clients whether they have dependent children at intake	Required/ recommended screening and/or assessment tools for children	Required/recommended evidence-based practices (from NREPP)* for children	WSN Participation in Cross-Agency Collaborations					
				FASD Task Force	Regional Centers, Part C	Prenatal screening councils	Early learning councils created by Federal stimulus funding	Maternal and child health networks emphasizing prenatal screening	Others
TX	Yes	No	Yes; recommended: Celebrating Families and Strengthening Families	Yes	No	Yes	No	Yes	Title V, Women, Infants and Children program; Department of Family and Protective Services; Newborn Screening program, etc.
UT	Yes	SASSI (for youth)	Recommended: Strengthening Families and Children’s Program Kit (Supportive Education for Children of Addicted Parents)	Yes	No	No	No	Yes	No
VA	Yes	No	No	Yes	No	Yes	Yes; Head Start and Early Head Start involved in the Home Visiting Consortium	Yes	VA’s Home Visiting Consortium, Child Welfare Advisory Committee, Systems of Care Advisory Team, and Children and Adolescents Needs and Strengths workgroup
VT	Yes	No	No	Yes	No	Yes	Yes	Yes	No

Table 1: Therapeutic Services and Cross-Agency Collaborations

State	Ask clients whether they have dependent children at intake	Required/recommended screening and/or assessment tools for children	Required/recommended evidence-based practices (from NREPP)* for children	WSN Participation in Cross-Agency Collaborations					
				FASD Task Force	Regional Centers, Part C	Prenatal screening councils	Early learning councils created by Federal stimulus funding	Maternal and child health networks emphasizing prenatal screening	Others
WA	Yes; part of core questions asked and entered into TARGET database	No	No, not required; many providers use Strengthening Families and other parenting curriculums; providers are required to provide parenting education in Pregnant and Parenting Women Residential Programs	Yes	No	Yes	No	Yes	Children's Administration workgroups and Department of Health workgroups

*NREPP is SAMHSA's National Registry of Evidence-based Programs and Practices.

Case Studies

The nine States—Colorado, Georgia, Massachusetts, Nevada, New Jersey, Oregon, Texas, Virginia, and Washington—were selected as case study sites based on the following:

- Responses to Goal 3 and Attachment B of the 2009 Substance Abuse Prevention and Treatment Block Grant Applications;
- Responses to the follow-up questions sent to the WSN listserv;
- Their geographic variety; and
- State agency staff's belief that their model of providing services to children whose parents enroll in substance use disorder treatment could be helpful to other States.

National Association of State Alcohol and Drug Abuse Directors staff conducted telephone interviews with the Women's Services Coordinators and/or other State agency staff in each of the nine case study States. Additional telephone calls and email exchanges occurred when necessary to clarify and confirm information. Tables 2 through 9 provide a summary across all nine sites for each of the following areas:

- Table 2: How Therapeutic Services Are Defined and Who Provides These Services
- Table 3: Prevention, Early Intervention, and Therapeutic Services Provided
- Table 4: Screening and Assessment Requirements and Recommendations
- Table 5: Case Management, System Linkages, and Memorandums of Understanding
- Table 6: Funding of Therapeutic Services for Children
- Table 7: Training and Technical Assistance Required and/or Offered
- Table 8: Tracking and Monitoring
- Table 9: Other Services, Initiatives, and Collaborations

Table 2: How Therapeutic Services Are Defined and Who Provides These Services

<p>Colorado</p>	<p>Colorado requires all residential and outpatient programs licensed as Specialized Women’s Services (SWS) programs and receiving Substance Abuse Prevention and Treatment (SAPT) Block Grant funding to offer children therapeutic services that address developmental, emotional, and physical needs. There are 11 funded SWS programs, 9 of which are Special Connections Agencies funded with Medicaid to provide services to pregnant women. There are no written guidelines for how programs must operate in the provision of children’s services. However, programs are encouraged to use the protocol developed with the National Center on Substance Abuse and Child Welfare to screen and assess for and engage and retain families in treatment. Programs not licensed as SWS treatment providers are not required to provide therapeutic services to children, although some do. Programs may serve children up to the age of 18, whose parents are in outpatient treatment. In residential treatment, though, most programs serve infants and toddlers.</p>
<p>Georgia</p>	<p>Georgia defines therapeutic services to children whose parents enter substance use disorder (SUD) treatment through its Therapeutic Child Care (TCC) Guidelines. These guidelines apply to all residential providers in the six service regions throughout the State. Outpatient providers are not required to provide therapeutic services to children, though many do—especially those that have both outpatient and residential services. The guidelines include tools for screening and assessment of the parent and child, program components, training for workers, visitation guidelines, expected outcomes, and data collection and reporting. Providers are also expected to develop a separate treatment plan for children who enter residential treatment with their parents. Licensed child care programs must also adhere to the State’s Bright from the Start Child Care Center Guidelines. Though programs may serve mothers with children from birth to 13, most children are under the age of 5.</p>
<p>Massachusetts</p>	<p>Children up to age 18 can join their mother or <i>father</i>* in any of Massachusetts’s Residential Rehabilitation Services (RRS) programs (residential SUD treatment), though most programs typically serve very young children. RRS programs are required to offer services to all children who enter treatment with their parents. Any child in an RRS program is considered a collateral client and receives collateral services as described in contract and licensing regulations. Though not required to provide services to children, outpatient programs are encouraged to access screening services for young children. All programs are required to ascertain at intake whether their clients have children and whether those children are in their custody. *Note: One program is specifically for fathers and their children.</p> <p>Program staff must include:</p> <ul style="list-style-type: none"> • A Clinical Director who is a Senior Clinician; • A Family Therapist and Senior Clinician experienced in working with families with SUDs; and • Children’s services staff.
<p>Nevada</p>	<p>Nevada does not specifically define what constitutes therapeutic services for a child whose parents are in SUD treatment beyond the SAPT Block Grant requirements. Two programs, WestCare in Las Vegas and the STEP2 program in Reno, are recipients of the Women’s Set-Aside from the SAPT Block Grant and therefore charged with meeting the Block Grant requirements for therapeutic services for children.</p>
<p>New Jersey</p>	<p>New Jersey Department of Human Services, Division of Mental Health and Addiction Services, provides approximately \$21 million in public funding to a statewide network of 47 licensed substance abuse treatment providers in all modalities of care. These modalities include intensive outpatient, methadone intensive outpatient, and long-term residential and halfway house, for the substance abuse treatment to Pregnant Women/Women With Dependent Children Initiative and parents under the supervision of the Division of Youth and Family Services. New Jersey’s child welfare agency (Child Welfare Initiative) services are provided for children up to 18 years of age.</p>

Table 2: How Therapeutic Services Are Defined and Who Provides These Services

Oregon	<p>Oregon prioritized services to children whose parents enter SUD treatment for the 2009 to 2011 biennium. Oregon’s Single State Agency (SSA) contracts with all 36 counties and, in some cases, directly with Community Mental Health Programs (CMHPs) in counties, to provide these services. Each county receives SAPT Block Grant funding and, in turn, requests providers with which they contract to provide services to children. Through Oregon’s administrative rules, therapeutic services to children whose parents enter SUD treatment are required when appropriate and necessary. The SSA is not specific about which children should receive therapeutic services or about which levels of care should offer therapeutic services. Instead, the county and/or provider make these decisions. Each CMHP is able to choose how to best meet the needs of children whose parents enter SUD treatment. The goal of these services is to lay the groundwork for good mental health for children and their parents.</p>
Texas	<p>Texas defines therapeutic services to children whose parents enter SUD treatment in contract language for any provider receiving a Women’s Block Grant Set-Aside, which includes both residential and outpatient. Texas is in the process of developing new language regarding therapeutic services for children. The new contract language will include greater specificity regarding:</p> <ul style="list-style-type: none">• What therapeutic services are required;• What tools and interventions that providers should use should be evidence based;• With which agencies providers are required to develop memorandums of understanding;• Requirements for including treatment plans for children and the family in the parent’s treatment planning; and• Documentation and reporting. <p>All minor dependent children of the client should be included in the parent’s treatment and receive appropriate services. Additionally, Texas does have residential programs that allow children under the age of 12 to enter services with their mother.</p>
Virginia	<p>Virginia defines the therapeutic services to be provided to children whose parents enter SUD treatment through a yearly Performance Contract with each of the 40 Community Services Boards (CSBs). Each CSB oversees the substance abuse prevention and treatment services within its catchment area. The Performance Contract stipulates the SAPT expectations for programs serving pregnant and parenting women. Only programs that receive SAPT Block Grant funding are required to provide therapeutic services, including one residential program for women with families and eight Project LINK sites. The Project LINK programs do not have an age limit for children, but programs typically serve children under the age of 8.</p>
Washington	<p>Washington defines therapeutic services for children whose parents enter SUD treatment through its TCC Guidelines. All nine residential providers and only one outpatient provider are designated as providing TCC services for substance-abusing women. The SSA does not require or recommend specific interventions, protocols, or manuals, but it is specific about minimum qualifications and job descriptions for TCC staff. Most programs serve children up to the age of 5, but may make exceptions for older children as needed.</p>

Summary: How Are Therapeutic Services Defined and Who Provides These Services?

Though the SAPT Block Grant does not require that States include specific language about therapeutic services for children, most of the States in the case studies used some formal mechanism, such as administrative regulations or contract language. Two States, New Jersey and Texas, describe the required therapeutic services for children whose parents enter SUD treatment through contract language. Massachusetts defines

therapeutic services to children through both contract language and licensing regulations. Georgia and Washington developed TCC Guidelines, whereas Colorado utilizes licensing regulations to define therapeutic services for children, and Oregon defines these services in administrative rules. Virginia requires providers to offer therapeutic services to children whose parents enter SUD treatment through regulation. However, Virginia clarifies what the SSA believes that these services are through a memorandum to county boards and programs that receive funding from the Women's Set-Aside of the SAPT Block Grant.

To augment written contract language and guidelines, Georgia, Massachusetts, and New Jersey have regular meetings with providers who are required to offer therapeutic services to children whose parents enroll in SUD treatment. At meetings with providers, these States discuss gaps in services, best practices, and how the providers can meet contract requirements regarding therapeutic services for children.

Providing therapeutic services for children whose parents enter SUD treatment may be costly; therefore, the nine case study States require only providers who receive funding through the SAPT Block Grant Women's Set-Aside to offer such services. Services for children are more likely to be provided in residential treatment settings, though services may be provided in other modalities of care. In Colorado, Nevada, New Jersey, and Texas, both residential and outpatient providers are recipients of the Women's Set-Aside funding and are therefore required to offer therapeutic services for children. In Georgia and Massachusetts, only residential providers receive this funding and are required to provide therapeutic services for children. Though not required, Massachusetts encourages outpatient programs to access screening services for children. In Washington, nine of the 10 providers are residential and one provider offers only outpatient services. Oregon and Virginia contract directly with counties or CSBs, thus leaving decisions regarding the level of care for such services to the local jurisdictions.

All nine States agreed that even when SUD treatment providers do not receive additional funding, and are therefore not required to provide therapeutic services to children, they still initiate referrals to appropriate services for children to ensure their needs are addressed.

Table 3: Prevention, Early Intervention, and Therapeutic Services Provided

<p>Colorado</p>	<p>All providers receiving Substance Abuse Prevention and Treatment (SAPT) Block Grant funding provide or ensure children receive prevention and early intervention services through referrals/linkages: medical/pediatric care, follow-up assessments and appropriate interventions, and immunizations. The three women’s residential programs employ child care workers and have child care available on site but refer children out for specialized service needs. One program has dedicated Infant Mental Health Specialists and Child Psychologists who provide the range of services to children and parents onsite. The backgrounds and credentials of children’s services staff vary across sites.</p> <p>The Special Connections Substance Abuse Treatment Program provides an additional period of substance use disorder (SUD) treatment during the challenging postpartum period. This additional period of treatment ensures that the mothers who enter treatment during pregnancy remain drug free and able to care for their new infants.</p> <p>One program works in partnership with the University of Colorado’s Irving Harris Program in Child Development and Infant Mental Health for training, program consultation, advocacy, and research in infant and early childhood mental health.</p>
<p>Georgia</p>	<p>All programs are required to provide Nurturing Parenting and to develop separate treatment plans for each child. Programs serving infants must provide Infant Massage and developmentally appropriate therapeutic child care. Other recommended programs include Here, Now and Down the Road and Mommy and Baby Groups. Providers are encouraged to collaborate with community prevention programs to bring in other programming and to use the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Children’s Activity Kit, Too Good for Drugs/Violence,” Second Step, and AI’s Pals as needed.</p>
<p>Massachusetts</p>	<p>As defined in the contract and licensing regulations, the following services must be provided:</p> <ul style="list-style-type: none"> • Assessment of physical, mental, developmental and/or other needs of children is conducted and/or provided through linkages with relevant services. • Client treatment plans must address parenting skills education, child development education and early child care, parent support and family preservation, family planning, nutrition, violence, and other relevant issues. • Formal linkage agreements must be maintained, in addition to those listed above, with services including: early intervention programs, high-risk infant/family support programs, Healthy Start, pediatric medical care, parenting skills and baby care, and violence prevention programs. • Opportunities for parent/child relational development groups must be provided and/or coordinated. Client treatment plans must address structured developmental activities for parents/children. <p>An individualized client aftercare plan must be developed and must include: referrals to family transitional/permanent living opportunities, child care services, vocational and educational rehabilitation services, primary health and mental health services (including pediatric and specialized pediatric care), support services for domestic violence, and other social services as needed. Eight residential programs have implemented the Project BRIGHT (Building Resilience through Intervention: Growing Healthier Together) program for children birth to age 5, and the WELLChild Curriculum through the Institute for Health and Recovery for children ages 5to 10 years. The WELLChild Curriculum is a group program that helps children learn self-protection skills, develop skill in self-soothing, enhance personal relationships, and strengthen self-esteem and self-identity.</p>

Table 3: Prevention, Early Intervention, and Therapeutic Services Provided

<p>Nevada</p>	<p>In addition to services defined in the SAPT Block Grant requirements, the two Nevada programs provide the following:</p> <ul style="list-style-type: none"> • WestCare offers transportation to medical/dental appointments and school, onsite sign language classes to improve speech and language development, and in-class observation for children with behavioral problems. In addition, WestCare organizes family days, birthday parties, and weekend activities for children and families. • STEP2 offers a weekly family playgroup and provides other services by referral as needed. Transportation is provided to medical, dental, and family appointments and to other group services as needed.
<p>New Jersey</p>	<p>Services are provided to parents with SUDs and their children through three initiatives:</p> <ul style="list-style-type: none"> • Pregnant Women/Women With Dependent Children Initiative: A coordinated network of services for this population; • Child Welfare/Women with Children Initiative: Substance abuse treatment services to women and children under the supervision of the Department of Youth and Family Services (DYFS). First priority is given to referrals made by the Child Protection Substance Abuse Initiative (CPSAI), a program funded by DYFS to provide substance abuse assessment and referral to treatment integrated into DYFS assessment and case planning. Second priority is given to self-referrals or referrals made by other agencies for women who are under DYFS supervision. Third priority is given to eligible women with dependent children who are in need of treatment and are not under DYFS supervision; and • Child Welfare/Fathers with Children Initiative: Provides substance abuse treatment to fathers with children under the supervision of DYFS. Three counties provide intensive outpatient level of care treatment. The CPSAI program makes referrals. <p>Services may include:</p> <ul style="list-style-type: none"> • Linkages with primary pediatric care and other child-focused services; • Therapeutic interventions for children to address any developmental, physical or sexual abuse, or neglect issues; • Case management; • Transportation and child care; • Family-centered and gender-specific treatment, including Seeking-Safety for women and specialized programming for fathers with dependent children; and • Strengthening Families Program.
<p>Oregon</p>	<p>In Oregon, most screening and assessment services to children whose parents enter SUD treatment are provided by referral to partner agencies.</p> <p>SUD treatment providers can also help families to access screening, case management, and home visiting programs through the statewide Healthy Start program, which follows the research-based Healthy Families America model. In the Healthy Start program, trained home visitors offer parenting education, administer developmental screenings to children, and provide referrals to pediatric care and immunizations.</p> <p>Oregon requires all SUD treatment and prevention providers to use evidence-based practices when providing direct therapeutic services to children whose parents enroll in SUD treatment. The Single State Agency in Oregon publishes a list of approved evidence-based practices on its Website (http://www.oregon.gov/DHS/mentalhealth/ebp/practices.shtml). This list includes evidence-based mental health disorder and SUD prevention and intervention practices for children whose parents enter SUD treatment. Several commonly used evidence-based practices for this population include Parent Child Interaction Therapy (PCIT), Brief Strategic Family Therapy, the Loving Touch, Parent-Infant Massage Program® and Incredible Years.</p>

Table 3: Prevention, Early Intervention, and Therapeutic Services Provided

<p>Texas</p>	<p>The contract language for Women’s Block Grant Set-Aside providers stipulates the following services shall either be provided directly or through referral:</p> <ul style="list-style-type: none"> • Pediatric care, including immunizations and treatment for perinatal effects of maternal substance abuse; • Early childhood intervention services; • Educational opportunities in accordance with the requirements of the Texas Education Agency; • Substance abuse prevention services; and • Other therapeutic interventions that address their developmental needs and any issues of abuse and neglect. <p>The contract does not specify what programs or interventions must be used.</p>
<p>Virginia</p>	<p>The memorandum of understanding with Community Services Boards identifies therapeutic interventions for children as follows:</p> <ul style="list-style-type: none"> • Developmental Screenings • Early Intervention Services • Infant Massage • Therapeutic Child Care • Mother-Infant/Child Play Groups • Play Therapy • Individual/Group/Family Therapy <p>Services can be provided by the program or through referrals to service providers. Most of the Project LINK sites offer Mommy and Me parent-child development and enrichment classes for parents with children ages birth to 4. Other services vary across sites, with some sites focusing more on case management and others providing direct services in addition to intensive case management.</p>
<p>Washington</p>	<p>The Therapeutic Child Care (TCC) Guidelines define TCC services as:</p> <ul style="list-style-type: none"> • Developmental screening and assessments using recognized, standardized instruments; • Play therapy; • Behavioral modification; • Individual counseling; • Self-esteem building; and • Family intervention to modify parenting behavior and/or the child’s environment to eliminate/prevent the child’s dysfunctional behavior. <p>Programs are required to provide TCC services, as defined above, for a minimum of 4hours per day, 5days per week. The programs vary across service providers, but include: Positive Parenting, Strengthening Families, Love and Logic, Making Parenting a Pleasure, Incredible Years, and Parent-Child Interaction Therapy (PCIT).</p>

Summary: What Prevention, Early Intervention, and Therapeutic Services Are Provided?

All nine States require or recommend that programs deliver, either directly or by referral, a variety of prevention, early intervention, and therapeutic programs to children whose parents enter SUD treatment. These programs and services address physical health and nutrition, developmental delays, mental health issues, and parent-child relationships—all of which are intended to result in improved cognitive, social-

emotional, and behavioral outcomes for children. Many of these interventions are delivered to women and their children at the same time, with the goal of improving parent-child and family relationships, attachment and bonding, and parenting capacities.

Though none of these programs have been evaluated specifically for children whose parents enter SUD treatment, Project BRIGHT and Celebrating Families were developed specifically for use with children and families whose parents are in recovery from SUDs. Information on the models and effectiveness of these programs can be found at SAMHSA's National Registry of Evidence-Based Programs and Practices, an online registry of evidence-based interventions. Many of these programs require training to administer, and are proprietary (AI's Pals, Too Good for Drugs/Violence, Mommy and Me, Incredible Years, and others).

Table 4: Screening and Assessment Requirements and Recommendations

Colorado	Gender-specific women’s treatment providers must screen and assess for developmental, emotional, and medical needs of the children in the custody of the client. These providers are encouraged to work with county departments of social services or with custodians/guardians in order to identify and address such needs. There are no requirements for specific screening tools, though most providers use the Ages and Stages Questionnaire (ASQ). Screening is done onsite and/or referrals are made to the Individuals with Disabilities Education Act (IDEA) Part C programs. Hospital staff make referrals that meet the criteria for Child Abuse Prevention and Treatment Act (CAPTA) regulations at birth to the Department of Human Services/Child Protective Services agency. Programs are also encouraged to screen for fetal alcohol spectrum disorders (FASD), and are required to screen for child safety issues and to ensure children are current with immunizations.
Georgia	All programs administer the Adult and Adolescent Parenting Inventory to all parents who enter treatment. Providers may conduct screening and assessments for all children onsite, or they may work with other children’s services providers. These providers work to ensure all children are screened, and clinical/developmental assessments occur when warranted, within 30 days of the children’s entry into the program. Recommended child screening and assessment tools include: Connors Rating Scale (CRS-R), Achenbach Child Behavior Check List (CBCL), Denver II, BRIGANCE Early Childhood Screens® and Ages and Stages Questionnaire (ASQ), and Ages and Stages Questionnaire: Social-Emotional (ASQ: SE). The State is training all providers on the ASQ and ASQ: SE and is using these as standardized screening tools across all sites.
Massachusetts	The State Bureau of Substance Abuse Services does not dictate the screening or assessment tools to be used; however, it does provide funding for behavioral health screenings for all children in treatment caseloads. The department also works with the Children’s Behavioral Health Initiative to ensure children receive screenings. Pediatricians or Early Intervention Specialists will go onsite to conduct screening and assessments in some areas. If the child is involved with the child welfare system, the Department of Children and Families provides screenings and other therapeutic services for children whose parents enter outpatient substance use disorder (SUD) treatment.
Nevada	All providers screen pregnant women or women with children for alcohol use during current and past pregnancies to identify children who may need further assessment for FASD. WestCare provides screening for disabilities and potential special education needs for children ages 3 and older. For additional or further assessment of developmental needs, parents are referred to Nevada Early Intervention Services and to the University Medical Center (UMC) Family to Family Program.
New Jersey	Providers may provide screening on site or link children to screening and assessment. New Jersey’s network of 11 Child Evaluation Centers provides comprehensive multidisciplinary evaluations of children with congenital or acquired neurodevelopmental and behavioral disorders and develops an individualized service plan. In addition, six of the centers provide diagnostic services for children who may have fetal alcohol spectrum disorders. Children involved with the Department of Youth and Family Services (DYFS) will have screening, assessment, and appropriate interventions coordinated through their DYFS case plans.
Oregon	Most providers refer out for developmental screenings and assessments. Children who are placed in foster care receive a comprehensive mental health assessment within 60 days of placement and medically necessary interventions. Oregon’s Department of Education also conducts screenings and assessments. In accordance with CAPTA regulations, children under the age of 3 with a founded allegation of abuse or neglect are referred to a Part C IDEA Early Intervention program for screening and additional assessment where indicated. SUD treatment providers also can help

Table 4: Screening and Assessment Requirements and Recommendations

	families to access screening, case management, and home visiting programs through the statewide Healthy Start program.
Texas	Currently, most providers refer out for developmental and physical health assessments. The Women’s Services Coordinator collaborated with the Texas Maternal and Child Health Agency and with Dr. Ira Chasnoff, Children’s Research Triangle, to develop a series of trainings related to substance use during pregnancy. All providers are trained in the impact of prenatal substance use on children, screening and assessment for developmental delays and other concerns, what tools to use, and how to use them. Providers will learn what tools to use to screen children on site.
Virginia	Pregnant and Parenting Women (PPW) programs are required to screen/assess children’s development, their safety and health care needs, and the need for additional intervention at regular but unspecified intervals. Though no particular tool is specified at this time, the State has provided training on the ASQ screening tool.
Washington	Designated PPW providers are required to provide or arrange for an initial assessment for each child within 2 weeks of admission to the program, or as recommended by the well-baby schedule. Though no specific tools are required, the assessment must include a developmental screen and a medical assessment. A referral for a more in-depth assessment will be made when appropriate. Assessment results are documented in the child’s record, and a statement of medical necessity is available to the Single State Agency (SSA) for the child to remain in the program. Providers can also make referrals to the Washington State Fetal Alcohol Syndrome Diagnostic & Prevention Network. It is a network of four Washington State community-based interdisciplinary FASD diagnostic clinics linked by the core clinical, research, and training clinic at the Center on Human Development and Disability at the University of Washington.

Summary: Screening and Assessment Requirements and Recommendations

All of the case study States require providers, either directly or through referrals, to screen and/or assess children for developmental and medical needs. It is important for providers to ensure that children whose parents enter SUD treatment are screened for developmental, emotional, and physical needs and then referred for further assessment when warranted. Early detection of developmental delays and social-emotional and behavioral concerns improves outcomes, especially for infants and very young children. Since developmental delays and other behavioral health problems often develop over time, regular screenings can help to identify challenges as they arise.

Colorado and Virginia both require treatment providers to assess the safety of children. Georgia requires that providers conduct an assessment of the child soon after intake. Virginia requires that providers screen children for developmental progress at regular, repeated intervals.

None of the States require that a particular screening tool be used, but both Georgia and Virginia suggest the Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire: Social-Emotional (ASQ: SE). The SSA in Oregon also has worked with pediatricians to train them to use these questionnaires. In Massachusetts pediatricians and Child Development Specialists often go on site to conduct screening. The ASQ and ASQ: SE are standardized screening tools that have been used effectively to identify potential developmental and social-emotional delays in children from 1 month (2 months for ASQ: SE) to 5½ years of age. Georgia also recommends several other potential tools, all of which are proprietary and therefore must be purchased. This may be a financial burden to States that are using these tools to screen children.

Table 5: Case Management, System Linkages, and Memorandums of Understanding

Colorado	Providers are encouraged, but not required, to sign memorandums of understanding (MOUs) with other agencies that serve women and their children. This list includes, but is not limited to, pediatricians, child welfare agencies, child care centers, and Part C agencies. Child welfare licensed providers must offer case management and care coordination.
Georgia	All programs work closely with Individuals with Disabilities Education Act Part C and child welfare agencies. The Department of Family and Child Services completes a First Placement/Best Placement family evaluation on all children who enter substance use disorder (SUD) treatment from a foster care placement. The results of this evaluation are available to the SUD treatment provider. Staff may participate in Family Team Meetings and utilize information from the First Placement/Best Placement family evaluations in their treatment planning.
Massachusetts	Formal linkage agreements must be maintained with children’s services providers, including, but not limited to, Part C Early Intervention Programs, high-risk infant/family support programs, Healthy Start, pediatric medical care, parenting skills and baby care, and violence prevention programs.
Nevada	Programs are encouraged to have MOUs in place with all partner agencies. WestCare and STEP2 work with the Division of Child and Family Services to coordinate care and ensure services are provided for those children who are in the child welfare system.
New Jersey	Programs are required to hold interdisciplinary meetings every 30 days with the Department of Youth and Family Services caseworker and client. Providers are asked to sign Affiliation Agreements with other child-serving agencies in their communities to ensure coordination of care and appropriate documentation of services.
Oregon	SUD treatment providers help families to access screening, case management, and home visiting programs through the statewide Healthy Start program, which follows the research-based Healthy Families America model. In the Healthy Start program, trained home visitors offer parenting education, administer developmental screenings to children, and provide referrals to pediatric care and immunizations. Providers work closely with local child protective services (CPS) to ensure coordination of services for children in the child welfare system.
Texas	All providers that receive a Women’s Block Grant Set-Aside must have an MOU with a comprehensive resource network. This network must include other community and social services agencies and resources, including the Department of Family and Protective Services; other treatment services funded by the Department of Social and Health Services; and prevention and intervention services for mental health, substance use, and co-occurring disorders. The contract does not specify what programs or interventions must be used.
Virginia	The MOU the State sends to SUD treatment providers describes Federal (Child Abuse and Prevention Treatment Act) and State legislation requiring physicians, nurses, and SUD treatment providers to file a report to CPS for newborns who are suspected of having been exposed to either illicit drugs or alcohol. It also includes a list of resources that children’s providers can access when linking children and their parents to appropriate services, including: Part C Early Intervention Services, Medicaid funding for intensive case management for children, Baby Care services, and Healthy Start/Loving Steps. The Project LINK program offers intensive case management services to pregnant and parenting women with SUDs.
Washington	Programs are required to hold bi-monthly meetings with the parent to discuss progress with the child’s goals and objectives as well as their own. Designated Pregnant and Parenting Women

Table 5: Case Management, System Linkages, and Memorandums of Understanding

programs are required to consult with CPS on children who are involved in the child welfare system. They are encouraged to establish a working agreement, which delineates responsibilities of the treatment program and CPS, with CPS offices. When children are discharged from the program, with or without their parents, providers must document the services the child received, the reason for the exit, and recommendations for future services. This exit report must be shared with CPS within 3weeks of the child’s exit. Providers also are encouraged to work with the Washington First Steps Program to provide case management to children.
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Summary: Case Management, System Linkages, and MOUs

Eight of the nine case study States (Colorado, Massachusetts, Nevada, New Jersey, Oregon, Texas, Washington, and Virginia) emphasized the importance of case management and care coordination in providing services for children whose parents are enrolled in SUD treatment. Oregon, specifically, pointed to the role of care coordination in ensuring that children receive the services that they need in a timely, cost-efficient manner.

Colorado, New Jersey, Oregon, and Washington emphasized linkages with their child welfare systems. Such linkages are critical because studies have shown that 50–80% of parents who have contact with the child welfare system also have an SUD (Grella et al., 2006). A recent study from Chapin Hall reported that almost 61 percent of infants and about 41 percent of older children in out-of-home care had a primary and/or secondary caregiver who reported active alcohol and/or drug abuse (Wulczyn et al., 2011).

Several of the case study States (specifically Colorado, New Jersey, Washington, and Virginia) indicated that a large percentage of referrals to SUD treatment come from the CPS/child welfare agencies. SUD treatment programs help women navigate the child welfare system by maintaining compliance with appointments and court requirements, meeting deadlines, and achieving goals. Child welfare agencies are often involved in treatment and discharge planning for women involved in both systems. Finally, in Colorado, New Jersey, and Oregon, child welfare agencies are often the agency with primary responsibility for providing appropriate services to children whose parents enroll in SUD treatment.

Each of the nine States emphasized the importance of establishing linkages with pediatricians and other primary care providers, a requirement of the Substance Abuse Prevention and Treatment Block Grant.

Only Texas and Massachusetts require that providers sign formal MOUs or linkage agreements with other agencies, though the Single State Agency is not specific about which agencies those should be. Colorado “recommends” that providers develop formal MOUs with other agencies, whereas Washington “encourages” providers to develop a written agreement with CPS offices. Nevada, Oregon, and Virginia simply require that providers develop informal linkages with other social service providers. States noted that because each community has different resources available, it would be impossible to dictate the agencies with which SUD treatment providers should be connected. To improve linkages at the State level, the Women’s Services Networks in each of these nine States participate on a variety of interagency coordinating committees with the goal of improving services for children and families through increased coordination, collaboration, and integration of services.

Many social and health services systems have programs that can and should be accessed for children whose parents enter SUD treatment. However, these systems are sometimes difficult to navigate, and often, parents and SUD providers are unaware of available, low-cost/no-cost services and eligibility requirements. SUD treatment programs can ensure that other agencies and providers are aware of services that children are receiving, as well as the results of those services. Sharing information across systems helps to reduce duplication and ensure that children and their families are receiving the most appropriate services.

Table 6: Funding of Therapeutic Services for Children

Colorado	Substance Abuse Prevention and Treatment (SAPT) Block Grant, Medicaid, State General Funds, and Colorado Department of Human Services/Child Welfare Division. The Division of Behavioral Health contracts with four Managed Service Organizations to provide treatment services through subcontracts with programs that offer gender-specific treatment for women.
Georgia	SAPT Block Grant, Medicaid, Temporary Assistance for Needy Families (TANF), Child Welfare Funding, and Department of Public Health Prevention Division. The majority of women are referred through the child welfare system; programs receive a bundled rate for TANF and/or child welfare parents.
Massachusetts	SAPT Block Grant, State General Funds, Medicaid and Other Insurance Plans, and Department of Children and Families. Eight residential treatment programs receive an enhanced rate for family treatment. Other programs receive an enhanced rate for pregnant women with children, and these women stay in the program with their children from 6months to 1year.
Nevada	SAPT Block Grant, State Revenues, the Department of Children and Family Services, and Nevada Check Up (State Children’s Health Insurance Program). Medicaid funding has decreased in recent years because of the budget crisis, but the State is currently working on a plan that will expand Medicaid coverage and allow SUD treatment providers to access this funding source. Private or public grants are used to provide services for children.
New Jersey	SAPT Block Grant, Medicaid and Funding From the Division of Youth and Family Services, New Jersey’s Child Welfare Agency. SUD treatment providers are able to access Medicaid funding for children’s case management, medical services, and psychiatric care.
Oregon	SAPT Block Grant. State general funds are also used to provide therapeutic services through the Intensive Treatment and Recovery Services, an initiative funded by the 2007 Legislature for families with SUDs who are involved in the child welfare system. The initiative is a collaborative effort between the Addiction and Mental Health Division and Children, Adults and Families. The Family Early Advocacy and Treatment program is an early intervention program that was funded through a grant from the Federal Administration for Children and Families to develop a family-centered model for the identification, notification, and safe care of substance-exposed newborns. Oregon’s Department of Education uses funding from the Individuals with Disabilities Education Act, Parts B and C, to offer developmental screenings for children.
Texas	SAPT Block Grant, State General Funds, Title V, and Medicaid. Texas is currently working on a Medicaid benefit for SUD treatment utilizing Medicaid for clinical services and State General Funds for room, board, and other supports.
Virginia	SAPT Block Grant, Medicaid, and State General Funds. Project LINK sites have successfully used Medicaid funding to pay for targeted case management services.
Washington	Medicaid and State General Funds. Therapeutic Child Care services in Washington are funded entirely through Medicaid. The Parent Child Assistance Program for women who abuse alcohol and other drugs during pregnancy is State funded. The Safe Baby Safe Moms program is funded by Medicaid and State funds.

Summary: Funding Therapeutic Services for Children

States have been able to braid funding from a variety of sources to provide therapeutic services for children whose parents enter SUD treatment. Typical funding sources include the SAPT Block Grant Women’s Set-Aside, Medicaid, and State General Funds. Single State Agencies (SSAs) also have collaborated with other agencies, including child welfare (Colorado, Georgia, and Nevada), TANF (Georgia), the Department of Public

Health (Georgia), the Department of Education (Oregon), and the Department of Housing and Community Development (Massachusetts). Both Colorado and New Jersey receive funding from the child welfare agency for child welfare designated providers. SSAs and providers have also received grants from the Federal government and private donors to fund therapeutic services to children whose parents enroll in SUD treatment.

Seven of the nine case study States (Colorado, Georgia, Massachusetts, Nevada, New Jersey, Oregon, and Virginia) rely primarily on funding from the Women's Set-Aside of the SAPT Block Grant to fund services for children. The Block Grant has been flat funded for the past 3 years, so SSAs and providers have had to work collaboratively across agencies to identify supplemental funding to maintain programming.

Medicaid is recognized as an important source of funding for additional therapeutic services for children in Georgia, Massachusetts, New Jersey, and Washington. However, Medicaid is the sole source of funding in Washington for therapeutic services for children whose parents enter SUD treatment. Most women who enter publicly funded SUD treatment with their children are eligible for either Medicaid or the Children's Health Insurance Program (CHIP). This program, administered by the U.S. Department of Health and Human Services, provides matching funds to States for health insurance to families with children. It was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. The *Children's Health Insurance Reauthorization Act of 2009* expanded Medicaid coverage to potentially cover an additional 4 million children and pregnant women, including for the first time legal immigrants without a waiting period.

The services covered by Medicaid and CHIP vary by State, but in many States, Medicaid/CHIP will pay for intensive case management, developmental screenings/assessments, immunizations, and other primary care health services. In some States, Medicaid/CHIP funding will pay for counseling and psychiatric care for children. However, this funding capability requires providers to give and bill services on a fee-for-service basis, to be a licensed Medicaid facility, to have knowledge of billing codes and procedures, and to have staff with the appropriate credentials. (Federal data through the National Survey of Substance Abuse Treatment Services system indicate that in 2009, only 53.8% of all treatment facilities were able to be reimbursed by Medicaid.)

Table 7: Training and Technical Assistance Required and/or Offered

Colorado	All staff in substance use disorder (SUD) programs licensed to serve child welfare families are required to complete the National Center on Substance Abuse and Child Welfare’s(NCSACW’s) online tutorial, <i>Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals</i> . Additionally, they must document completion of 14 hours of continuing education per year related to child development, child safety and family dynamics, or equivalent education units in solution-focused philosophy.
Georgia	The Department of Behavioral Health and Developmental Disabilities contracts with a Therapeutic Child Care (TCC) Coordinator to provide training and technical assistance to sites throughout the State on appropriate and evidence-based services for children. Site-specific technical assistance and clinical supervision are provided at no cost to the site. Quarterly meetings are held with TCC providers to provide training, address any ongoing issues, and identify gaps in services for children and their parents. The Georgia TCC Guidelines specify academic, background, and training requirements for TCC Coordinators, Leads, and Child Care Workers. In addition to a child development background, TCC Coordinators must also have a background and related training in providing services for children of women/parents with SUDs.
Massachusetts	Recovery Support Services (RSS) providers and their staff are required to attend monthly staff meetings with the Single State Agency (SSA). Discussions include best practices for family members, with an emphasis on supportive services for children. In addition, Project BRIGHT (Building Resilience through Intervention: Growing Healthier Together) staff members are training staff from the eight RSS programs to administer the Child-Parent Psychotherapy protocol.
Nevada	The SSA contracts with University of Nevada, Reno Center for the Application of Substance Abuse Technologies to provide training to all programs. In addition, the SSA provides technical assistance on SUDs and onsite support as needed or requested.
New Jersey	The SSA holds five meetings a year with providers who offer special child welfare services. Staff and providers address barriers to and gaps in services and how contract requirements can be met. New Jersey also encourages all providers to complete NCSACW’s online tutorial, <i>Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals</i> , to more effectively address the co-occurrence of substance abuse and child maltreatment.
Oregon	The SSA provides training in therapeutic services for children at the annual Oregon’s Women’s Treatment Conference. The Women’s Services representative works closely with the Child and Adolescent Mental Health Program Specialist to provide support and technical assistance to providers on a range of therapeutic interventions for children. The Oregon Pediatric Society also has become involved with training pediatricians to provide services to children whose parents enter SUD treatment. The society has conducted a series of Screening Tools and Referral Trainings for pediatric providers about how to administer a series of developmental screenings and assessments for children. These screenings include the Ages and Stages Questionnaire and the Modified Checklist for Autism in Toddlers. The goals of this program are to expand the use of developmental and behavioral screening in pediatric practices, improve providers’ understanding and utilization of screening tools, educate providers on documentation and coding of screening tools, and improve awareness of community resources for evaluation and intervention.
Texas	All providers who receive Women’s Set-Aside funding are required to participate in monthly conference calls with the SSA and in cross-trainings organized by the SSA and with other State agencies. Many of these calls relate directly to the provision of therapeutic services for children. Because more than half of the referrals to women’s SUD treatment services originate from the child welfare system, many of the cross-trainings are focused on issues relating to both child

Table 7: Training and Technical Assistance Required and/or Offered

	welfare and SUD treatment.
Virginia	The State provides training in the use of the Ages and Stages screening tool. In addition, the Women’s Services Coordinator holds bi-monthly meetings with staff from the eight Project LINK sites, providing training and information on a range of topics, including therapeutic services for children. The Project LINK program also includes a strong cross-site and peer mentoring model, matching new employees with experienced staff from other sites.
Washington	The TCC Guidelines stipulate that providers must “provide or arrange for regular training opportunities for TCC staff and document attendance in and completion of training.” Washington’s annual addiction conference provides opportunities to meet these requirements.

Summary: Training and Technical Assistance Required and/or Offered

The Substance Abuse Prevention and Treatment Block Grant requires that SSAs provide continuing education for the employees of facilities that provide prevention activities and/or treatment services (42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)). States are not required to specifically provide training about therapeutic services for children, but many of the case study States have done so. Georgia, Massachusetts, New Jersey, Texas, and Virginia hold regular meetings with providers who are required to provide therapeutic services to children whose parents enroll in SUD treatment. At these meetings, providers and State staff discuss best/promising practices, and how to meet contract and licensing requirements. Virginia offered an Ages and Stages Questionnaire workshop for participants across systems, including SUD treatment providers, and has used cross-site mentoring as part of its training efforts. Oregon and Washington address services for children whose parents enroll in SUD treatment as part of their annual conferences for treatment providers, whereas Georgia offers bi-annual trainings specifically for TCC providers. Massachusetts is collaborating with the Institute for Health Recovery to train providers to administer the Project BRIGHT protocol.

Table 8: Tracking and Monitoring

Colorado	For Special Connections (Medicaid-funded) treatment programs, site visits are conducted every 3 years. Licensing visits are also conducted (in different years) to ensure adherence to the Department of Behavioral Health (DBH) women’s treatment rules. DBH conducts contract monitoring visits every 10 years to ensure Managed Service Organization (MSO) compliance with DBH contracts. MSOs also conduct annual site visits, including chart reviews, to ensure compliance with the MSO/subcontractor contract. All sites must adhere to the DBH licensing requirements and are routinely monitored for compliance. Providers are required to document whether clients have children and, if so, their children’s names, ages, and custody status. Treatment notes also are reviewed to ensure the family is included in treatment and that parenting issues are addressed throughout treatment.
Georgia	Providers submit monthly reports that capture data on both parents and children. Documentation must include the number of children served, referrals to other programs for developmental services, drug-free births, and partnerships with other programs. Monitoring visits include case reviews.
Massachusetts	Massachusetts tracks the number of children who enter residential substance use disorder (SUD) treatment with their parents by requiring that an admission record be opened in the management information system for each child. Currently, children who are not present at admission are not tracked in the system. The State also is working on the development of a child-specific module in its Reporting on Outcome Measurement Project (ROMP). When completed, ROMP is expected to track children across age-specific categories and four primary domains. Contract monitoring and annual site visits also ensure children are receiving appropriate services.
Nevada	The Single State Agency (SSA) conducts annual site visits and chart reviews. The State’s monitoring tool ensures compliance with the Substance Abuse Prevention and Treatment (SAPT) Block Grant/Women’s Set-Aside. The tool is reviewed annually and updated as needed. The Nevada Health Information Provider Performance System (NHIPPS) is a Web-based computer system for SAPT Block Grant-funded providers that captures demographic, service, and clinical data on substance abuse clients, their children, and families. In addition, NHIPPS allows the exchange of valuable client data between providers and networks across the State.
New Jersey	The SSA ensures that children whose parents enter SUD treatment receive appropriate services through site visits, case file reviews, and ongoing monitoring. Providers are required to ask all adults at admission how many children they have (regardless of custody status) and whether they are involved with child protective services. The information is entered into the New Jersey Substance Abuse Monitoring System and is shared with the Division of Youth and Family Services. Providers are required to ensure all services conform to current New Jersey licensing standards for substance abuse treatment.
Oregon	Counties are not required to report either the number of children entering services with their parents or the services they receive. However, all children who receive mental health treatment in the Oregon mental health care system are tracked. Oregon does track the numbers of children who are served and the services they receive through the Family Early Advocacy and Treatment program and the Statewide Children’s Wraparound Initiative. These programs are also required to track each child’s developmental and behavioral progress. These programs all work closely with SUD providers to ensure children receive the services they need.
Texas	Providers are required to document the following information in the child’s file, whether services are provided directly or through referral: <ul style="list-style-type: none"> • Age of child; • Developmental, social, educational, emotional, and physical needs; • Family background and legal status;

Table 8: Tracking and Monitoring

	<ul style="list-style-type: none">• Provision of daycare, referral for daycare support, or supervision of children; and• Coordination with other children’s service providers. <p>The SSA identified the need to utilize its electronic health record (EHR) system to capture more data on the children who receive therapeutic services when their parents enter SUD treatment. Additional data elements are currently being identified, with improvements pending.</p>
Virginia	<p>The SSA monitors the number of children served in the Project LINK sites. The sites are required to track the number of children who receive services and the outcomes of those services, including:</p> <ul style="list-style-type: none">• Birth weights that are above or below the average range for gestational age, including very low, low, and high;• Diagnoses of fetal alcohol spectrum disorders;• Other developmental and physical disorders;• Reunifications;• Adoptions; and• Infant/child deaths. <p>The number served and outcomes are reported quarterly to the Office of Children and Family Services using a standardized reporting form. SSA staff are revising the reporting forms and expect to track the number of children receiving specific services in the future. These services include developmental screenings, safety assessments, and referrals to Part C services.</p>
Washington	<p>Residential facilities that receive funding from the Women’s Set-Aside are required to submit monthly reports about the number of children who receive Therapeutic Child Care (TCC) services. In addition, the SSA monitors Medicaid data regarding the units of TCC for which providers are reimbursed by Medicaid. During the State fiscal year 2009, 593 children whose parents were in SUD treatment were provided 31,933 therapeutic service units. Of these 593 children, 37 also received 176 units of TCC home visits.</p> <p>The Parent Child Assistance Program is funded by the State to serve 700 women and their children in nine counties and one Tribe. The Safe Baby, Safe Moms program is funded by the State to serve 250 women and their children in three counties. The case managers in both programs link parents with Pregnant and Parenting Women’s programs in those counties.</p>

Summary: Tracking and Monitoring

All nine case study States conduct site visits and case reviews as one means of ensuring therapeutic services for children are appropriately provided. Massachusetts and New Jersey require providers to ask clients at admission how many children they have and whether those children are in their custody. Providers in Georgia, Massachusetts, New Jersey, Virginia, and Washington track the number of children who receive therapeutic services, and report this number, and the services received, to the SSA, either via a management information system (Massachusetts and New Jersey) or via monthly reports (Georgia, Virginia, and Washington). Washington also monitors Medicaid utilization data about the units of Therapeutic Child Care for which providers are reimbursed. Georgia and Virginia track outcomes data about children who receive services, including improved functioning and parent-child reunifications. Nevada captures data in its electronic health system, and Texas is working on similar improvements in its EHRs to capture additional data on children’s services.

Table 9: Other Services, Initiatives, and Collaborations

<p>Colorado</p>	<p>Colorado licenses approximately 100 program sites as “child welfare” programs. These programs may receive additional funding from the Department of Health Services and are required to provide coordinated case management and care coordination with the county child welfare agency. These are primarily outpatient programs, and funding is allocated only for open child welfare cases.</p>
<p>Georgia</p>	<p>Georgia has a strong partnership with the Department of Human Services, Division of Family and Children Services. This collaboration allows Georgia to have 21 residential programs, 15 outpatient programs, and transitional housing in 14 sites. Georgia also collaborates with the Georgia Council on Substance Abuse to train Certified Addiction Recovery Empowerment Specialists (CARES). This partnership creates workforce development opportunities for peer specialists to work in treatment and recovery while supporting families in the child welfare system. Many of the CARES professionals are women who are in recovery and have been involved with the child welfare system. Such professionals are working in the women’s programs and can aid women by performing in a different role from that of the counselors.</p> <p>The Women’s Services Coordinator (WSC) is on the steering committee for Georgia’s Early Childhood Comprehensive Systems called Peach Partners. This steering committee focuses on the coordination of services for Georgia’s children ages birth to 5. This collaboration ensures that the very young children receive seamless transitions and referrals to all services (i.e., medical, emotional, and educational).</p>
<p>Massachusetts</p>	<p>Massachusetts has contracted with the Institute for Health and Recovery, Inc. (IHR), to implement the Project BRIGHT (Building Resilience through Intervention: Growing Healthier Together) protocol at eight Recovery Report Services programs across Massachusetts. This program is designed to address traumatic stress in children ages birth to 5 and their parents. Project BRIGHT uses Child-Parent Psychotherapy (CPP) to address complex trauma symptoms and build resilience in young children through provision of therapeutic interventions focused on building the parent-child relationship. As part of this contract, IHR also is working in these RRS programs to implement the WELLChild Curriculum for children over 5 years of age.</p> <p>The Single State Agency (SSA) in Massachusetts is actively working to improve collaboration between child-serving agencies at the State level. The WSC participates in the statewide Children’s Behavioral Health Initiative, which strives to integrate and standardize policies, financing, management, and delivery across publicly funded behavioral health services, thereby increasing access to children’s services. The WSC also serves on the Young Children’s Interagency Workgroup, which consists of senior staff across all child-serving agencies who are working together to improve cross-system collaboration.</p>
<p>Nevada</p>	<p>WestCare is part of a collaborative that was the recipient of a 5-year Regional Partnership Grant (RPG). The purpose of the RPG funding is to improve outcomes for children in the child welfare system affected by parental use of methamphetamine and/or other substance abuse. Specifically, this grant has allowed WestCare to provide direct services for children.</p> <p>The STEP2 program is a member of the Washoe County Fetal Alcohol Spectrum Disorders (FASD) Prevention Workgroup.</p>
<p>New Jersey</p>	<p>New Jersey has a number of major services, initiatives, and collaborations in place that work together to ensure that children’s needs are met for substance-abusing families involved in the child welfare system as follows:</p> <ul style="list-style-type: none"> ● Work First New Jersey - Substance Abuse Initiative (WFNJ-SAI): The Department of Human Services (DHS), Division of Family Development (DFD), designed WFNJ-SAI to provide substance abuse assessments, as well as access to substance abuse

Table 9: Other Services, Initiatives, and Collaborations

	<p>treatment, and to monitor attendance and participation for eligible WFNJ recipients. The goal of WFNJ-SAI is to identify and remove substance abuse-related barriers that may prevent an individual from becoming self-sufficient. WFNJ-SAI is intended to transition Temporary Assistance for Needy Families (TANF) and General Assistance (GA) clients with substance abuse barriers to work activities.</p> <ul style="list-style-type: none"> • Child Protection Substance Abuse Initiative (CPSAI): CPSAI is a program contracted by the Division of Youth and Family Services (DYFS) that provides substance abuse assessment and referral to treatment integrated into DYFS assessment and case planning. Through CPSAI, a Certified Alcohol and Drug Counselor (CADC) is located in each of the DYFS local offices. The goal of the CPSAI-CADC is to assist DYFS with the identification of a child who may be at risk because of his or her parent’s or caretaker’s involvement with substance use. • DYFS Child Welfare Substance Abuse Consortia: Consortia meetings are held monthly with staff from child welfare, Division of Mental Health and Addiction Services (DMHAS), DFD, CPSAI, licensed substance abuse treatment providers, and Boards of Social Services. The DYFS Child Welfare Substance Abuse Consortia allow for cross-system collaboration with local treatment programs and other community partners that can provide the expertise needed to better serve families in the child welfare system. • New Jersey Fetal Alcohol Spectrum Disorders and Other Perinatal Addictions Task Force Through the Department of Human Services, Office for Prevention of Developmental Disabilities: The primary goal of this task force is to educate the public about the harmful effects of alcohol, drugs, and cigarettes on fetal development. The New Jersey Women’s Services Network (WSN) coordinator participates on the task force. • In-Depth Technical Assistance (IDTA): New Jersey awarded IDTA through the National Center on Substance Abuse and Child Welfare (NCSACW) in January 2009. This initiative is led by the State of New Jersey’s Division of Mental Health and Addiction Services (DAS),DYFS, as well as the Administrative Office of the Courts, and will help the State do the following: <ul style="list-style-type: none"> ○ Achieve joint accountability and shared outcomes relating to child safety and permanency, and family recovery and wellness; ○ Improve cross-system training and workforce development capacity to more effectively address the co-occurrence of substance abuse and child maltreatment; and ○ Develop a pilot project for integration of DTFS Child Welfare Substance Abuse Consortia and Family Drug Court (FDC). • Department of Children and Families (DCF), Office of Early Childhood Services (OECS): DCF’s OECS coordinates prevention services to families with children ages birth to 6. Early Childhood programs include: the Home Visitation Program that provides services to families challenged by complex health-related and/or social problems. This program focuses on young families who are at risk for abuse and neglect with primary prevention and early intervention services for pregnant women and children up to age 5.
<p>Oregon</p>	<p>Oregon has a number of major initiatives in place to ensure children receive appropriate therapeutic services:</p> <ul style="list-style-type: none"> • The Intensive Treatment and Recovery Services (ITRS) initiative offers substance use disorder (SUD) treatment, safe housing, and case management for parents with SUDs and their children. These services are specifically for families in which at least one parent has an SUD and for those who do not have health insurance. The State provides the money to the counties, and the county determines their local needs.

Table 9: Other Services, Initiatives, and Collaborations

	<ul style="list-style-type: none"> • Treatment providers in Lane County participate in the Family Early Advocacy and Training (FEAT) program, which is a pilot program that has currently been implemented in one county to identify and provide appropriate services to substance-exposed newborns (SENs). The FEAT team helps women to access SUD treatment, creates safety plans for SENs, offers parenting education, and provides transportation services for children. • In 2009, the Statewide Children’s Wraparound Initiative (CWI) became law. The intent of this legislation was to develop an integrated system of care to maximize positive outcomes for children with behavioral needs who are in the custody of child protective services, part of DHS. Many of these children have parents with SUDs. <p>The Oregon Pediatric Society has also become involved with training pediatricians to provide services to children whose parents enter SUD treatment. The society has conducted a series of Screening Tools and Referral Trainings for pediatric providers about how to administer a series of developmental screenings and assessments for children, including the Ages and Stages Questionnaire and the Modified Checklist for Autism in Toddlers. The goals of this program are to expand the use of “developmental and behavioral screening in pediatric practices, improve providers’ understanding and utilization of screening tools, educate providers on documentation and coding of screening tools, and improve awareness of community resources for evaluation and intervention.</p>
Texas	<p>The SSA engaged in a number of cross-agency collaborations to address the needs of pregnant and parenting women with SUDs and their children. The Office of Developmental Disabilities is piloting the Choices curriculum for the prevention of fetal alcohol spectrum disorders (FASD). The Maternal Child Health (MCH) department worked with the SSA to develop a training series for providers and other community partners on prenatal substance use. MCH Services Block Grant, Title V, funding was used to contract with Dr. Ira Chasnoff to develop a 20-Webinar series and train providers. Topics include prenatal screening for substance use, working with pregnant women, and recognizing and working with children impacted by prenatal and environmental substance use. The MCH department also identified the following “overarching initiative” in its strategic plan: Focused efforts on integrating prevention and treatment for mental health and substance abuse throughout the Title V direct and population-based services.</p>
Virginia	<p>To improve cross-agency collaboration and to ensure that children’s needs are met, Virginia’s Office of Child and Family Services comprises a team of interdisciplinary specialists who have expertise in early intervention/children’s services. The WSC works closely with this team to ensure ongoing communication between agencies, increase awareness of available programming for children and families, and create consistent policies across agencies. The WSC is also a member of Virginia’s Home Visiting Consortium, which is exploring the utilization of a high-risk screening instrument that would be used by home visitors across all systems. She also participates in the Infant and Toddler Mental Health Workgroup.</p>
Washington	<p>The Therapeutic Child Care (TCC) Guidelines stipulate that providers must provide or arrange for regular training opportunities for TCC staff and document attendance in and completion of training. Washington’s annual addiction conference provides opportunities to meet these requirements.</p>

Summary: Other Services, Initiatives, and Collaborations

All nine case study States recognize the critical importance of working collaboratively with other agencies and departments to better serve this identified population of parents and their children. The SSAs, specifically the WSN Coordinators, and the local providers either lead or are involved in a number of statewide and local initiatives aimed at high-risk infants and children and their parents:

- All nine States report working closely with both the State and local child welfare agencies.

- Georgia, Massachusetts, Oregon, and Virginia are involved with the Early Childhood Education and Infant Mental Health systems.
- Colorado, Oregon, New Jersey, Nevada, Texas, Virginia, and Washington report significant cross-agency efforts aimed at substance-exposed infants and FASD.
- Georgia, New Jersey, Virginia, and Washington work collaboratively with other agencies in home visitation models that address complex health and social issues for parents and their young children.
- Colorado, Massachusetts, New Jersey, Texas, and Virginia have all been recipients of the NCSACW In-Depth Technical Assistance Program, which has supported their cross-agency collaboration and helped them address issues related to parents and their children who intersect the substance abuse, mental health, child welfare, and court systems.

Barriers to Services

Even in these advanced States, there are many barriers to providing appropriate therapeutic services for children. Fragmented systems and policies at the local level were cited by a majority of these States (Colorado, Georgia, Massachusetts, New Jersey, Oregon, Texas, and Washington) as a major barrier to providing therapeutic services to children whose parents enter substance use disorder (SUD) treatment. Collaborations at the State level are difficult to build, and they often do not translate into community-level collaborations. Services are often fragmented, and communication and collaboration across multiple agencies serving children and families are difficult to achieve.

In addition, as budgets across agencies are cut, waitlists for services for children grow, and the qualifying criteria for children to be served become more stringent. As a result of the tighter qualifying criteria and the decrease in funding for services for children, SUD treatment providers are having increased difficulty in securing services for families.

Family-centered treatment is still a relatively new model. Finding treatment programs that serve the parents and children together can be difficult because of lack of adequate funding for these program models. Additionally, the Single State Agency in Virginia noted that providers are often not aware of the available resources for children. Staff struggle with the sheer complexity of working closely with the number of systems they need to in order to deliver comprehensive services to children and families.

The Women's Services Networks from Georgia and Oregon noted that providers have specifically struggled to provide services to children whose parents are enrolled in outpatient services. Often, these children do not attend treatment with their parent, so the provider cannot offer them direct services. In addition, many outpatient providers do not have appropriate facilities or enough space to offer services for children. Most States do not fund outpatient care with the Women's Set-Aside, and/or most women are admitted to outpatient providers that do not have Women's Set-Aside funding. State Medicaid coverage also can affect the availability of family-based treatment and children's developmental services.

Conclusions

Single State Agencies (SSAs) responsible for substance abuse prevention, treatment, and recovery have limited budgets, as well as many competing demands and requirements. Among these is the requirement contained in the Substance Abuse Prevention and Treatment Block Grant to provide therapeutic services to children whose parents enter substance use disorder (SUD) treatment. States have responded to this requirement in a variety of ways. Although this study highlighted the diversity of programs and practices being utilized to address the needs of children who accompany their parents to treatment, several themes also emerged:

- States define therapeutic services to children through various mechanisms: contract language, administrative rules, licensing regulations, and Therapeutic Child Care Guidelines. Through these mechanisms, providers are either required or encouraged to screen children for developmental, physical, and emotional needs and, when found necessary, to deliver a variety of prevention/early intervention services to children whose parents enroll in SUD treatment.
- Providers are encouraged to create and maintain formal and informal linkages with a comprehensive resource network including, but not limited to, child welfare agencies, child care providers, early intervention programs, and pediatricians and other primary care providers.
- SSAs and providers have found that care coordination and case management are key in providing cost-effective, appropriate services for children whose parents enroll in SUD treatment. Information sharing reduces duplicative services and helps to ensure that children receive appropriate services. Although establishing effective communications is essential, it is not without challenges. Such challenges include determining which agency has primary responsibility for ensuring that children receive appropriate services while their parents receive SUD treatment and sharing information across programs and agencies.
- SSAs report that services to children are typically provided through referrals to other available services and by collaboration across other agencies, particularly with their child welfare counterparts, to leverage existing services, areas of expertise, and additional sources of funding. Medicaid is an important additional source of funding for therapeutic services to children and appears likely to increase in importance under the Affordable Care Act.
- Fragmented systems and often conflicting agency policies at both the State and local levels can be major barriers to providing therapeutic services to children whose parents enter SUD treatment. In addition, as budgets across agencies are cut, waitlists for services for children increase and eligibility criteria become more stringent, making it harder for SUD treatment providers and families to navigate other health and social services systems.
- The screening and assessment tools used with and programs and services provided to children whose parents enter SUD treatment vary within and across States. Most of the nine case study States are using evidence-based tools and approaches, many of which were designed for children and families experiencing multiple risks—including parental SUDs. However, very few of these evidence-based tools and approaches have been evaluated for their effectiveness in outpatient or residential settings.

As SSAs and SUD treatment providers move toward offering family-centered treatment, they find that providing therapeutic services to children whose parents enter SUD treatment can in many cases be a challenge. The needs of these children are often unique and numerous, and collaborating across agencies is a necessary component in meeting these needs. However, these nine case study States recognize that they have unique and critical opportunities to intervene in the lives of perhaps the most vulnerable children when these children enter SUD treatment with their parents. They have taken innovative

approaches to defining what therapeutic services for children are. They also have worked with providers to improve the likelihood that children whose parents enter SUD treatment receive appropriate, timely, and cost-effective services, thus greatly improving these children's chances of positive health and developmental outcomes.

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