

IMPLEMENTING THE SUBSTANCE USE DISORDER PROVISIONS OF THE FAMILY FIRST PREVENTION SERVICES ACT

A TOOLKIT FOR CHILD WELFARE AND TREATMENT STAKEHOLDERS

CONTRIBUTING ORGANIZATIONS:

Children and Family Futures
Strengthening Partnerships. Improving Family Outcomes

childfocus®

NASADAD National Association of State Alcohol and Drug Abuse Directors

ACKNOWLEDGEMENTS

This research was funded by the Annie E. Casey Foundation. We thank them for their support but acknowledge that the findings and conclusions presented in this report are those of the author(s) alone, and do not necessarily reflect the opinions of the Foundation.

Children and Family Futures would like to thank the following partner organizations and the individuals who contributed to this project:

ChildFocus: Rebecca Robuck and Jennifer Miller

National Association of State Alcohol and Drug Abuse Directors (NASADAD): Melanie Whitter and Heather D'Onofrio

Children's Defense Fund: Steven Olender

Children and Family Futures would also like to thank the following NASADAD's Women's Services Network representatives for their time and expertise over the course of the year, without whose input, this toolkit would not have been possible:

Marc Condojani, NASADAD National Treatment Network Vice President and Director, Adult Treatment and Recovery, Colorado Office of Behavioral Health

Wrayanne Glaze Parker, Women's Program Coordinator, Georgia Department of Behavioral Health and Developmental Disabilities

Lisa Cohen, Federal Projects Director, Women's Service Coordinator, Illinois Department of Human Services, Division of Substance Use Prevention and Recovery

Suzette Tucker, Director of Gender-specific Services, Division of Clinical Services, Behavioral Health Administration, Maryland Department of Health

Angie Smith-Butterwick, Women's Treatment Specialist, Michigan Department of Health and Human Services, Office of Recovery Oriented Systems of Care

Christine Scalise, New Jersey Department of Human Services, Division of Mental Health and Addiction Services

Maria Morris-Groves, Director of Adolescent, Women and Children's Services, New York State Office of Alcoholism and Substance Abuse Services

Starleen Scott Robbins, Human Services Program Consultant, Women's Services Coordinator, North Carolina Division of MH/DD/SAS

Hilary Daugherty, Program Specialist, State of Tennessee Department of Mental Health and Substance Abuse Services

Becky King, Program Administrator—Women, Youth and Families, Utah State Division of Substance Abuse and Mental Health

Amanda Stehura, Regional Consultant/Women's Services Coordinator, Virginia Department of Behavioral Health and Developmental Services

Sarah Pine, Behavioral Health Program Manager, FASD Programs and Special Projects, Washington State Department of Social and Health Services

CONTENTS

INTRODUCTION TO THE TOOLKIT 1

What Does it Mean to Be Family-Centered? 3

The Family First Transition Act and Improvements to the Family First Prevention Services Act 3

SECTION 1: UNDERSTAND KEY OPPORTUNITIES AND LAY THE GROUNDWORK FOR COLLABORATION 4

What Family First Does to Meet the Needs of Children and Families Affected by SUDs 4

Laying the Groundwork for Collaboration: Common Values and Differences 6

Key Questions 8

Additional Resources 8

SECTION 2: DETERMINE EVIDENCE-BASED PROGRAMS AND SERVICES MOST APPROPRIATE FOR CHILDREN AND FAMILIES IN OR AT RISK OF ENTERING FOSTER CARE 9

Evidence-Based Prevention and Treatment for Substance Use Disorders 9

Title IV-E Prevention Services Five-Year Plan 11

Transitional Payments for Evidence-Based Programs and Services 11

Other Considerations in Planning for Title IV-E Prevention Programs and Services 12

Key Questions 13

Related Resources 13

SECTION 3: LEVERAGE FAMILY FIRST TO EXPAND RESIDENTIAL FAMILY-BASED TREATMENT 14

Family-Based Residential Treatment Provision 14

Prevention Services for Children and Families in a Residential Treatment Setting 15

The State of Family-Based Residential Treatment Providers 16

Key Questions 18

Related Resources 18

SECTION 4: DEVELOP A COMPREHENSIVE UNDERSTANDING OF AVAILABLE FUNDING STREAMS 19

Primary Sources of Funding to Support Treatment and Recovery for Families Involved in the Child Welfare System 19

Key Questions 25

Related Resources 25

SECTION 5: CREATE STRONG PARTNERSHIPS TO MAXIMIZE SUCCESS 26

Best Practices for Collaboration 26

Family First Implementation Challenges and Strategies 27

Key Questions 31

Related Resources 31

INTRODUCTION TO THE TOOLKIT

The Family First Prevention Services Act (Family First), signed into law on February 9, 2018, offers a historic opportunity for child welfare agencies and their substance use disorder (SUD) treatment partners to expand and enhance family-centered interventions that improve outcomes for children and families affected by SUDs. One of the foundational goals of the law is to keep more children safely at home by providing high-quality prevention services to families. To meet this goal, it is important that child welfare and SUD stakeholders have the information and resources to work collaboratively toward successful planning and implementation of the law.



This toolkit is designed to guide state leaders in their efforts to implement the SUD-focused provisions of the law, including the development and execution of their state Title IV-E prevention program plan, which is required to draw down Title IV-E prevention services funding. While state child welfare agencies are ultimately responsible for submission of the IV-E prevention program plan, it is critical that they partner with SUD treatment systems to identify system needs, gaps, and strengths in delivering family-centered services for children and families who are eligible to receive prevention services under the law. States can use this toolkit to assist in planning efforts whether they have already begun developing their plans or have deferred submission of a plan until October 1, 2021.

The information, tools, and themes highlighted in this toolkit build on important lessons from collaborative efforts already underway, including the Regional Partnership Grants (RPGs) and implementation of plans of safe care (POSC) with families affected by prenatal substance exposure (for more information about RPGs, see the following website on the Regional Partnership Grant Program: https://ncsacw.samhsa.gov/technical/rpg.aspx). Family First implementation is another opportunity for systems to work together in the best interest of children and parents involved in the child welfare system when SUD is a factor. Most importantly, it offers an opportunity to promote and enhance family-centered treatment to keep families together whenever safely possible and for families to thrive in recovery.

Not all the provisions in Family First require the submission of a Title IV-E prevention program plan. Most notably, as of October 1, 2018, states can use Title IV-E foster care maintenance payments to support the room and board of children in foster care who are placed with their parents in family-based residential treatment for substance use. This opportunity is available regardless of how a state chooses to move forward with the other major provisions in Family First and is described in further detail in Section 3.

The toolkit is comprised of five key sections, which can be used in combination or as separate documents for jurisdictions looking to focus on one aspect of the law at a time.

SECTION 1 — UNDERSTAND KEY OPPORTUNITIES AND LAY THE GROUNDWORK FOR COLLABORATION

SECTION 2 — DETERMINE EVIDENCE-BASED TREATMENT PROGRAMS AND SERVICES MOST APPROPRIATE FOR CHILDREN AND FAMILIES IN OR AT RISK OF ENTERING FOSTER CARE

SECTION 3 — LEVERAGE FAMILY FIRST TO EXPAND RESIDENTIAL FAMILY-BASED TREATMENT

SECTION 4 — DEVELOP A COMPREHENSIVE UNDERSTANDING OF AVAILABLE FUNDING STREAMS

SECTION 5 — CREATE STRONG PARTNERSHIPS TO MAXIMIZE SUCCESS

What Does it Mean to Be Family-Centered?

Family-centered treatment is an approach to SUD treatment designed to meet the needs of the entire family, not just the person diagnosed with the SUD. While the length of the services, type of setting (e.g., residential, outpatient), and size of the programs may vary, the common objectives across all family-centered treatment approaches is that parents are fully supported in their parenting roles and children receive the necessary services and supports to remain with their parent(s) during the treatment and recovery process and to remediate any social, emotional, and developmental challenges or trauma they may experience.

Family-centered treatment is associated with a range of positive outcomes for both children and parents, including improved child welfare outcomes[1] (such as increased rates of reunification), better treatment outcomes[2] (such as reduced mental health symptoms and trauma effects, reduction in risky behaviors, and long program retention), and enhanced parent-child relationship outcomes[3] (such as parent-child bonding). Family-centered interventions for parents and children also save money by avoiding duplication in services and ensuring better outcomes for parents and children.[4]

Expanding access to family-centered treatment is essential to respond effectively to the needs of parents with SUDs in the child welfare system and prevent future generations of children and families from experiencing SUDs and child welfare system involvement. Family First provides an opportunity to make progress toward these goals.

1 Grella, C. E., Hser, Y. I., & Huang, Y. C. (2006). Mothers in substance abuse treatment: Differences in characteristics based on involvement with child welfare services. *Child Abuse & Neglect, 30(1), 55–73. doi:10.1016/j.chiabu.2005.07.005*

2 Zweben, J. E., Moses, Y., Cohen, J. B., Price, G., Chapman, W., & Lamb, J. (2015). Enhancing family protective factors in residential treatment for substance use disorders. Child Welfare, 94(5), 145–166. https://www.ncbi.nlm.nih.gov/pubmed/26827469

3 Wong, J. (2009). Understanding and utilizing parallel processes of social interaction for attachment-based parenting interventions. *Clinical Social Work Journal, 37(2), 163–174.*

4 Werner, D., Young, N.K., Dennis, K, & Amatetti, S. (2007). Family-centered treatment for women with substance use disorders: History, key elements and challenges. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf

The Family First Transition Act and Improvements to the Family First Prevention Services Act

The Family First Transition Act, signed into law in December 2019, provides a one-time infusion of federal funding to help states implement Family First. Specifically, the law provides $500 million in one-time, flexible funding for states to support implementation, which will be distributed according to the formula for the Title IV-B Subpart 1 of the Social Security Act (for a list of estimated allocations by state, see ACYF-CB-PI-20-04, Attachment A — Eligible Applicants and Estimated Allotments). This funding is expected to be available to states in spring of 2020. The Family First Transition Act also provides additional funding for jurisdictions whose Title IV-E waiver demonstration projects expired at the end of FY2019 and thus are facing a significant financial loss.

In addition to the opportunities in Family First, the funding available through the Family First Transition Act provides an unprecedented opportunity for child welfare and SUD stakeholders to prepare for implementation of the SUD provisions of Family First. These funds may be used to build infrastructure to support family-centered treatment, build the evidence base of services for families, and take steps to ensure that families with SUDs have the supports they need to parent their children successfully (for more information about how these funds can be used and how title IV-B agencies can apply for the transition grants, please see ACYF-CB-PI-20-4). SUD stakeholders can partner with child welfare stakeholders to ensure these funds are used to help support families affected by SUDs.

SECTION

1 UNDERSTAND KEY OPPORTUNITIES AND LAY THE GROUNDWORK FOR COLLABORATION

Family First offers exciting new opportunities to enhance and expand family-centered treatment services for children in or at risk of entering foster care and their families. This section of the toolkit provides foundational information that child welfare and SUD systems need to most effectively leverage Family First opportunities. It provides an overview of the key provisions of Family First and clarifies important concepts in both the child welfare and SUD treatment systems that should be well understood for effective planning and implementation.

What Family First Does to Meet the Needs of Children and Families Affected by Substance Use Disorders

Family First expands the way in which Title IV-E of the Social Security Act—the largest federal source of funding for child welfare—can be used to help connect families to SUD treatment services and keep children safely with their parents while they are receiving treatment. There are three primary components of Family First aimed at meeting the needs of children and families affected by SUDs:

1. **Residential Family-Based Substance Use Disorder Treatment: Reimbursement for Children's Room and Board:** Effective October 1, 2018, Family First allows states to claim Title IV-E foster care maintenance payments for a child in foster care who is placed with a parent in a licensed residential family-based treatment facility for SUDs. This component of Family First allows funds that would otherwise pay for the placement of a child in foster care to cover the room and board of the child residing with a parent in a residential family-based SUD treatment program. This funding is available for up to 12 months if the child's case plan goal supports this placement, the facility provides parenting skills training and individual counseling, and the treatment services are trauma informed.

   States can take advantage of this funding anytime, regardless of the status of their Title IV-E prevention program plan.

2. **Services to Prevent Children from Entering Foster Care: Use of Title IV-E Funds for Treatment:** Family First also creates a new funding stream, known as Title IV-E prevention services, to support certain programs and services to prevent the need for foster care and keep children safely in their homes. Effective October 1, 2019, states may draw down these Title IV-E prevention services payments to support evidence-based SUD treatment, mental health services, and in-home parenting skill-based programs, or a combination thereof, for up to 12 months at a time. These services are intended to prevent a child's placement in foster care. Two populations of children are eligible for these services:

   - "Candidates" for foster care, which means children at imminent risk of being removed from their homes and placed into foster care if services were not provided; and
   - Pregnant and parenting youth already in foster care. Parents or kin caregivers of these young people are also eligible to receive services. The criteria of "in-home" parenting programs are that the child

remains in the home, and the program may be delivered in the home or in a treatment setting.

To begin receiving these reimbursements, states must submit and receive approval for a Title IV-E prevention program plan from the federal government.

3. **Reauthorization of Regional Partnership Grants:** The law extends the RPG program through FY 2021. RPGs are three- to five-year competitive grants to support collaborative partnerships among providers of child welfare services, SUD treatment agencies, family or dependency courts, and family support services. Grantees create "regional partnerships" aimed at improving the well-being, permanency, and safety outcomes of children, and the recovery outcomes for parents whose children are in or at risk of out-of-home placement associated with a parent or caregiver's SUD.

   Although the grants are separate from Title IV-E, the collaborations enabled by RPGs are highly complementary to the opportunities in Family First. For states already operating an RPG or preparing to apply for an RPG, stakeholders involved in the RPG partnership can play an instrumental role in planning for and implementing the Family First provisions.

WHAT ARE PLANS OF SAFE CARE AND HOW DO THEY RELATE TO FAMILY FIRST?

Since 2003, federal law has required governors to provide an assurance to the Secretary of the Department of Health and Human Services that their states have policies and procedures in effect to address the needs of infants who are identified as affected by SUDs. This law includes requirements to make appropriate referrals to child protective services (CPS) and other applicable services, and to develop a "plan of safe care" for the affected infants. These plans of safe care are intended to promote the health and safety of infants after leaving the hospital, and as of 2016 require that the treatment needs of the family/caregiver be included in the plan. This assurance by governors can be a critical tool for states to promote family-centered treatment for infants and their family/caretaker who are at risk of entering the child welfare system.

Like plans of safe care, Family First aims to connect families to needed SUD treatment services to prevent the need for foster care in the future and keep the family safely together. There may be circumstances in which infants born with prenatal exposure are considered at imminent risk of entering foster care, and therefore eligible to receive SUD prevention services under Family First. In general, however, plans of safe care will be developed further "upstream" compared to Family First—in other words, before a determination of "candidacy" is made.

Recent federal reforms aimed at strengthening the plan of safe care requirement, which were made in response to the national opioid crisis, have focused new attention on state- and local-level implementation of this statute. This implementation work has led to robust collaborations between SUD treatment, mental health, child welfare, and maternal and child health providers, and this collaboration is leading to meaningful improvements in connecting families and children to services to help them succeed. Family First implementation can build on the lessons from plan of safe care implementation, and in many cases, some of the same partners should be at the table. For more information about how states are implementing plans of safe care, please see *On the Ground: How States Are Addressing Plans of Safe Care for Infants with Prenatal Substance Exposure and Their Families* listed in "Additional Resources" at the end of this section.

The SUD-focused provisions in Family First are notable because they do not require states to apply an income eligibility standard that has traditionally been required for states to receive Title IV-E foster care reimbursements.[5] This means that states can claim Title IV-E reimbursement for SUD services for three groups of children, regardless of the income of their parents: (1) all children in foster care whose case plan specifies their placement is with a parent in a residential family-centered SUD treatment setting; (2) all children who are deemed at imminent risk of entering foster care for whom SUD services are needed to prevent placement in foster care; and, (3) all youth already in foster care who are pregnant or parenting and would benefit from SUD services.

Laying the Groundwork for Collaboration: Common Values and Differences

Child welfare and SUD treatment systems in the early stages of collaboration can most effectively partner on Family First implementation if they have a common understanding of their shared values, which provide an important foundation for their work together. As the partnership progresses, it is only natural for the differences between the systems to emerge, and partners can revisit the shared values to help them stay on track in the collaboration. Some of these core values include:

- Recovery from substance use disorders is possible. When families have access to appropriate services that meet their needs, they can thrive.
- Children and parents experience better outcomes when they remain together during treatment.
- Families are the experts of their own family units.
- Services should be tailored to the specific needs of the family; provided in a timely manner; and provided in a culturally relevant, gender-specific, and trauma-informed manner.
- Multi-system approaches are necessary to meet the full range of family needs.

Despite these common values, these systems also have some differences that cannot be overlooked when working together on behalf of families. If partners in the collaboration do not acknowledge these differences, it can lead to misunderstanding and conflict. These include:

- Differences in perspectives about who the "client" is, with child welfare primarily concerned about the safety of the child and SUD systems working primarily on treatment and recovery of the parent
- Lack of understanding about the chronic nature of SUDs and unrealistic expectations regarding the pace of treatment and recovery within the child welfare system
- Differences in funding streams and diverse accountability structures that guide the use of the funding
- Lack of common understanding about the service continuum in each system
- Variability in what professionals from each system know to be effective to support parental treatment and recovery and help children meet critical development milestones
- Different definitions of the word "prevention," particularly in the context of Family First. Prevention opportunities in Family First refer to efforts to strengthen families to safely prevent a child from being removed from his or her family and placed into foster care. SUD systems typically consider prevention as preventing a SUD from occurring in the first place

Child welfare systems must also work with their SUD partners to understand new developments in the SUD treatment field, so that misunderstandings about the role of various treatment strategies do not affect services to families. For instance, there

5 This standard ties eligibility for Title IV-E foster care support to a requirement that the child must have been removed from a home that met the 1996 income criteria for a needy family under the Aid to Dependent Families (AFDC) program, without adjustment for inflation.

are some misunderstandings about the use of medication-assisted treatment (MAT), which is an evidence-based approach to treating SUDs with medications in combination with counseling and behavioral therapies—including family-centered approaches—to provide whole-patient care. Child welfare professionals may view a woman who tests positive for substances while under the care of a doctor for MAT as just another form of substance use and consider it a risk to the child. Understanding the role of MAT and other treatment approaches to help parents through recovery is an important step in working together to leverage the SUD provisions under Family First.

One form of MAT has already been approved for reimbursement under the new Title IV-E prevention services program: Methadone Maintenance Therapy (MMT) has been reviewed and rated as "Promising." Although well-supported scientific evidence supports MMT for the treatment of opioid and alcohol use disorders, this rating of "Promising" is based on the more limited number of studies on MMT's efficacy with child welfare populations. The use of MAT is the recommended best practice for opioid use disorders, including for the care of pregnant women with opioid use disorders. However, many child welfare professionals may not be familiar with MAT or how it can help families affected by SUD.

Neonatal Abstinence Syndrome (NAS) is another concept that may impede making informed decisions about the level of risk to an infant and effective strategies to support a parent's recovery. NAS is the term for conditions that newborns experience after prenatal exposure to substances. Some infants will experience NAS when a parent has been provided MAT during pregnancy and is under the care of a medical provider. Even though MAT is a safer alternative than continued substance use during pregnancy, some child welfare agencies do not understand its intended effect and will separate parents and children when "expected" NAS is occurring.



KEY QUESTIONS

1. Who leads the Family First work in the state? Given that Family First has many other provisions, where does the planning around the SUD provisions fit in the state's planning efforts?
2. Is the state moving forward with the option to provide prevention services through Title IV-E, or is it taking a 2-year delay?
3. What has the state done to implement plans of safe care? Has the state benefited from a Regional Partnership Grant? Who are the relevant stakeholders engaged in that work and what can you learn from them about the opportunities and barriers in working across these systems?
4. What does the service array in the state look like, and where are the gaps?
5. What are the current barriers to providing services to families across the substance use treatment continuum—outpatient, intensive outpatient, family-based residential treatment, partial hospitalization, inpatient? How can Family First help address those barriers for eligible individuals and families?
6. Where in the state are family-centered best practices being implemented, and how can those be replicated?

ADDITIONAL RESOURCES:

- Detailed Summary of Family First prepared by the Children's Defense Fund
- Information Memorandum (IM-18-02) providing basic information about the Family First Act
- 2017 Information Memorandum on Plans of Safe Care
- On the Ground: How States Are Addressing Plans of Safe Care for Infants with Prenatal Substance Exposure and Their Families
- Implementing the Family First Prevention Services Act
- Resources on the Regional Partnership Grants
- Provider Readiness Assessment Survey published by Chapin Hall for Kentucky

SECTION 2

DETERMINE EVIDENCE-BASED PROGRAMS AND SERVICES MOST APPROPRIATE FOR CHILDREN AND FAMILIES IN OR AT RISK OF ENTERING FOSTER CARE

From the outset of Family First implementation, SUD and child welfare partners can work collaboratively to determine which evidence-based programs and services are most appropriate for the children and families who are eligible for the new prevention services available. Family First gives states flexibility in choosing the services that best suit the needs of their states or jurisdictions. SUD stakeholders can play an important role in strengthening their state's Title IV-E Prevention Plans by engaging early in the planning process to ensure that the needs of children and families with SUDs are considered. The following steps may be helpful when SUD treatment professionals are considering how to get involved.

1. Begin with a needs assessment of children and families who are likely to meet the eligibility requirements for the prevention provisions of Family First. A needs assessment can ensure that programs and services are appropriate for the population that will be served.
2. Take stock of which evidence-based programs and services are already offered in the state and if more are needed to meet the needs of families.
3. Identify evidence-based programs and services from SUD-focused clearinghouses and other sources that may not be well-known to child welfare partners.
4. Ensure that evidence-based programs and services most appropriate for the target population's needs are included in the state Title IV-E Prevention Plan that will be submitted to the Department of Health and Human Services (HHS).
5. Work with child welfare partners to build the evidence for programs that are having positive outcomes for children and family in the child welfare system who are affect by SUDs.

Evidence-Based Prevention and Treatment for Substance Use Disorders

Family First requires programs funded through Title IV-E Prevention Services to meet evidentiary standards specified in the law, which are intended to indicate the program's efficacy for child welfare populations. To categorize these programs, the law required HHS to establish a public Clearinghouse, known as the Title IV-E Prevention Services Clearinghouse, to rate and review programs that are nominated by state and local administrators, experts, and the public. Once a program has been reviewed and rated as having met the criteria, it appears on the Clearinghouse's website. Programs will be reviewed and rated on a rolling basis; therefore, state administrators should check the website regularly for the most up-to-date list.

The law also specified that the Clearinghouse must rate the programs according to three evidentiary standards: *promising*, *supported*, and *well supported*. These standards are guided by the number of studies that show evidence of improved outcomes and the rigor of the evaluations.

MORE ON THE EVIDENTIARY STANDARDS IN FAMILY FIRST

All practices eligible for Title IV-E prevention funding must meet the following requirements:

- **Book or manual:** The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer the practice.
- **No empirical risk of harm:** There is no empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.
- **Weight of evidence supports benefits:** Outcome measures are reliable and valid and are administered consistently and accurately across all those receiving the practice.
- **No case data for severe or frequent risk of harm:** There is no case data suggesting a risk of harm that was probably caused by the treatment and that was severe or frequent.

PROMISING	The practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that: • Was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed • Utilized some form of comparison group (such as an untreated group, a placebo group, or a wait list study)
SUPPORTED	The practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that: • Was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed • Was a rigorous randomized-controlled trial (or, if not available, a study using a rigorous quasi-experimental research design) • Was carried out in a usual care or practice setting • Established that the practice has a sustained effect (when compared to a control group) for at least 6 months beyond the end of the treatment.

WELL-SUPPORTED	The practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of: • At least two studies that were rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed • At least two studies that were rigorous random-controlled trials (or, if not available, studies using a rigorous quasi-experimental research design) • At least two studies that were carried out in a usual care or practice setting • At least one of the studies must have established that the practice has a sustained effect (when compared to a comparison group) for at least 1 year beyond the end of treatment

Title IV-E Prevention Services Five-Year Plan

States who wish to draw down Title IV-E prevention services payments must first submit a five-year Title IV-E Prevention Plan to HHS that includes, among other things, the following components:

- **Services and oversight:** How the state will assess children and families to determine eligibility and describe which services the state will provide and the target population(s), as well as how it will ensure program fidelity.
- **Evaluation strategy:** How the state will evaluate the services and their efficacy in meeting the needs of the target population(s). *[NOTE: Children's Bureau may waive this requirement for a well-supported practice if the evidence of its effectiveness is compelling and the Title IV-E agency meets certain continuous quality improvement requirements.]*
- **Coordination and consultation:** How the state coordinated and consulted with other agencies and stakeholders to develop the five-year state plan.

(For more information about the requirements for state Title IV-E Prevention Plans, please see ACYF-CB-PI-18-09.)

Transitional Payments for Evidence-Based Programs and Services

The primary mechanism available for states to receive Title IV-E prevention services payments to support their prevention services is by getting programs reviewed and rated by the Title IV-E Prevention Services Clearinghouse. Recognizing that many states are eager to begin implementation, and the programs currently available on the Clearinghouse are limited, HHS has also established another mechanism for states to identify and claim reimbursement for programs that meet the standards under Family First but have not yet been rated by the Clearinghouse. This process is known as "transitional payments."

Under this pathway, states may include in their prevention plans programs not yet reviewed by the Clearinghouse, so long as they conduct their own independent systematic review and submit sufficient documentation of evidence of the program or service. States can then claim "transitional payments" for

these services until they are officially rated by the Clearinghouse. Once a program receives approval from HHS through the transitional payments process, this program is officially "approved" for reimbursement, and all states can begin claiming Title IV-E prevention services for that program. These transitional payments are available until October 1, 2021. For more information about transitional payments and how they will work, please see PI-19-06.

Other Considerations in Planning for Title IV-E Prevention Programs and Services

Family First allows state Title IV-E agencies to draw down reimbursement for prevention services and programs beginning October 1, 2019, so long as their Title IV-E prevention services state plan has been approved. However, there are a few additional requirements that child welfare and SUD stakeholders planning for implementation should keep in mind.

OPTION TO DELAY: Title IV-E agencies can only access Title IV-E prevention funding if they also commit to implementing provisions of the law aimed at limiting certain types of group care that are currently supported by Title IV-E foster care maintenance payments. The law also gives Title IV-E agencies the option to delay implementing the requirements for a "qualified residential treatment program" (QRTP) for up to two years—until October 2021. (For more information about limitations on group care and the definition of a QRTP, please see ACYF-CB-IM-18-02.) For states who need more time to implement the provisions related to placements that are not foster family homes, they must also wait to draw down Title IV-E prevention services funding to support prevention activities under the law. Child welfare and SUD stakeholders in states that have chosen to delay their implementation may find that this additional time is especially helpful for readying a high-quality service array that best meets the needs of children and families affected by SUDs.

TRAINING COSTS: Title IV-E may claim at a 50 percent federal reimbursement rate for costs



related to training personnel in the programs and services included in the state plan.

SCOPE OF IMPLEMENTATION: The Children's Bureau has made clear in federal guidance that states do not have to administer their prevention services and programs statewide, and instead may decide to provide programs and services in only some areas of the state. States also do not have to provide the same services in all areas where preventive services are being provided. This means that states can choose to move forward with providing SUD prevention and treatment services, even if they do not move forward with the other categories of services (mental health and in-home parenting skill-based programs), although they will most likely find that these three categories of services complement one another.

50 PERCENT REQUIREMENT: When it was first enacted, Family First required that 50 percent of the total expenditures by the state be on services meet the "well-supported" category. However, recent federal legislation (the Family First Transition Act) delayed this requirement. In FY2022 and FY2023, at least 50 percent of the total expenditures by the state for the Title IV-E Prevention Program must be for services that meet both the "supported" and "well-supported" evidence-based practice criteria. In FY2024 and beyond, the original 50 percent requirement will be fully phased in.

KEY QUESTIONS

1. What programs are already being offered in my state? What is the landscape of providers offering these services?
2. What other evidence-based programs and services do we need to implement to ensure children and their families are getting the services they need to thrive?
3. How can I ensure that the SUD prevention and treatment programs already offered in my state are included in my state's Title IV-E prevention plan?
4. What other evidence-based programs should we be using to build an array of services in our Title IV-E prevention plan?
5. What training do providers need to deliver these evidence-based programs and how will the state support capacity building for providers?
6. Where in the state are these services needed most and how can we build those services in the areas of greatest need?

RELATED RESOURCES:

- ACYF-CB-PI-18-09: State Requirements for Electing Title IV-E Prevention and Family Services and Programs
- ACYF-CB-PI-19-06: Transitional Payments for the Title IV-E Prevention and Family Services and Programs
- Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures
- SAMHSA Evidence-Based Practices Resource Center

SECTION

3 LEVERAGE FAMILY FIRST TO EXPAND RESIDENTIAL FAMILY-BASED TREATMENT

Family First provides two new mechanisms for SUD agencies to access Title IV-E funds to support families involved in the child welfare system: (1) the use of Title IV-E foster care maintenance payments to support the placement of children in foster care with parents in a licensed residential family-based treatment facility for SUDs, and (2) the availability of new Title IV-E prevention services funding to support evidence-based SUD programs and services for children at imminent risk of entering foster care. While these are separate opportunities and can be implemented independently of one another, both provide new opportunities for states to support residential treatment for families—a more intensive level of treatment that is suitable for some, but not all, families. This brief explains the opportunities to support and expand residential family-based treatment using both mechanisms.

ASAM LEVELS OF CARE

The American Society of Addiction Medicine (ASAM) developed the ASAM criteria to guide placement, continued stay, and transfer/discharge of patients along four broad levels of treatment service and an early intervention level. Within the five broad levels of care, there are additional gradations of intensity of services. While child welfare professionals do not need have intimate knowledge of these levels of care, it is helpful to understand how different SUD treatment services can occupy different points along the continuum of treatment services available to families. Residential treatment is just one type of treatment, which is more intensive than many of the services eligible for Title IV-E prevention services that are offered in community-based settings. For more information about the ASAM levels of care, visit https://www. asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/.

Family-Based Residential Treatment Provision

The **family-based residential treatment provision** offers a critical opportunity to improve family connections for children already in foster care—allowing them to remain safely with their parents during treatment and increasing the likelihood of remaining together throughout the parent's recovery. This provision allows state child welfare agencies to claim Title IV-E foster care maintenance payments to support the room and board for children in foster care with a parent(s) in a family-based residential treatment center for up to 12 months. To be eligible for this opportunity, treatment agencies must provide parenting skills training, parent education, and individual and family counseling as part of the SUD treatment. These services must be provided under a trauma-informed organizational approach and providers must be

licensed.[6] Child welfare agencies can reimburse the treatment agency for these services through a new or existing contract with the treatment agency.

The family-based residential treatment provision became effective on October 1, 2018 and is unrelated to whether a state has begun claiming reimbursements, or even planning, for Title IV-E prevention services. This means that states can begin drawing down Title IV-E foster care maintenance payments for room and board for children in family-based residential treatment any time, regardless of the status of their IV-E prevention services implementation.

As noted in Section 1, traditional income eligibility criteria for the Title IV-E program do not apply to this provision. This means that Title IV-E agencies can claim federal foster care maintenance payments on behalf of *all* children in foster care who are placed with a parent in a licensed residential family-based treatment program for substance use. Title IV-E agencies may also claim federal Title IV-E administrative reimbursements during those 12 months for activities related to administration of the Title IV-E program, such as case management and some aspects of staff training.

Prevention Services for Children and Families in a Residential Treatment Setting

The **prevention services provision** allows state child welfare agencies to draw down Title IV-E prevention services payments for evidence-based SUD prevention and treatment services that meet the evidentiary standards articulated in the law. These prevention services payments can support services for children and families across the treatment continuum, including in family-based treatment settings for children who are not in the custody of the state. Like the other prevention services, these services are available to candidates



6 The statute is not specific on who must license the treatment facility. This is a state-level decision.

for foster care, including children and youth at imminent risk of entering foster care, pregnant and parenting youth in foster care, and parents or kinship caregivers in need of SUD treatment services. Similar to the family-based residential treatment provision, child welfare agencies can reimburse SUD service providers through new or existing contracts.

Prevention services may be available for up to 12 months at a time beginning on the date the state identifies the child as either a candidate for foster care or a pregnant or parenting youth in need of services. Like the family-based residential treatment provision, this prevention services provision does not apply the income eligibility standard that is typically applied for Title IV-E reimbursement. States also have the option of extending services beyond one year if a candidacy determination is made again and the rationale for extending services is documented in the child's case plan.

The State of Family-Based Residential Treatment Providers

Based on the listing of residential treatment providers generated in the annual National Survey of Substance Abuse Treatment (NSSAT), Volunteers of America conducted a survey of residential

SUMMARY OF TWO NEW OPPORTUNITIES TO SUPPORT FAMILY-BASED TREATMENT

TITLE IV-E FOSTER CARE MAINTENANCE PAYMENTS FOR CHILDREN ALREADY IN FOSTER CARE	TITLE IV-E PREVENTION SERVICES FOR CHILDREN AND FAMILIES AT RISK OF OUT-OF-HOME PLACEMENT
• Applies to children already in, or entering, foster care • Intended to help connect children already in foster care to their families when possible • Allows children in foster care to be placed with their parent or caregiver in a family-based residential treatment facility in lieu of a kinship care or foster care placement • Covers the room and board costs of placing a child with their parent • Traditional income eligibility criteria for children in foster care do not apply	• Applies to children deemed eligible for prevention services and their parents/caregivers • Intended to prevent the need for foster care by providing SUD treatment services to families • Allows children and families to benefit from SUD treatment services, including a range of outpatient services that can be delivered in the community or the home, and residential treatment • Can be claimed for programs and services that meet the evidentiary standards specified in the law • Traditional income eligibility criteria for children in foster care do not apply

providers to learn how many of them can accept children. The directory they developed based on the survey includes 363 family residential treatment programs across the country, representing an estimated 299 organizations across 48 states, Puerto Rico, and the District of Columbia.[7] Many of these treatment providers have already partnered successfully with child welfare systems to keep families safely together.

Residential family-based treatment centers are typically funded using a creative blend of private and public funding sources, which may include the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), Medicaid, private insurance, self-pay, federal funding aimed at the opioid crisis, the Temporary Assistance for Needy Families (TANF) program, and various state and local funding streams. Funding challenges, including the complexity of weaving together the myriad of resources needed to meet the complex needs of parents and children, are often cited as one of the major reasons why these programs struggle to keep up with the demand. Many communities currently lack family-based residential treatment options. For communities that do have residential family-based treatment options, the programs are often small, with limited beds available for parents and restrictions that prevent parents from having all their children stay with them during treatment.

The Title IV-E foster care maintenance payments and prevention services funding in Family First offer a critical resource to expand the availability of residential family-based treatment nationwide.

7 Wilder Research and Volunteers of America. (2019). *Family-based residential treatment: Directory of residential substance use disorder treatm ent programs for parents with children.* https://www.voa.org/pdf_files/family-based-residential-treatment-directory

PARTNERSHIPS BETWEEN UTAH CHILD WELFARE AGENCY AND RESIDENTIAL FAMILY-BASED TREATMENT PROVIDERS

Prior to the passage of Family First, the Utah Division of Children and Family Services (DCFS) was sometimes able to place a child in foster care with the parent in a SUD residential treatment program at the end of the foster care case when a child was preparing to return home to their parents. However, DCFS was not able to make a payment for the child's care while in these placements. Under Family First, DCFS created a joint contract in partnership with the Division of Substance Abuse and Mental Health to enable children in foster care to be placed with a parent in residential SUD treatment, and for a foster care payment to be made to the facility for the child's care, specifically their room and board. These residential SUD treatment programs also entered into a contract with DCFS that included Family First provisions, such as a requirement to strengthen the parenting skills component of their programs. If a SUD treatment facility already had a contract with the state SUD agency, the child welfare agency agreed to accept their criteria for licensing as meeting their standard for family placement. A single state rate was agreed upon, which means that local communities and local metropolitan areas are receiving the same rate.

The providers currently partnering with DCFS include: Odyssey House (Salt Lake City), House of Hope (Salt Lake and Utah County), Valley Phoenix (Salt Lake County), Weber Human Services Tranquility Home (Northern Utah), and Southwest Behavioral Health Desert Haven (Southern Utah).

KEY QUESTIONS

1. What is the capacity of residential family-based treatment centers in my state, and where are they located?
2. Are they currently serving families involved in the child welfare system and if so, what has worked well?
3. What other family-based treatment systems exist in my state? What can I learn from them regarding how treatment can play a role in the family's child welfare case plan?
4. What funding streams are available to support family-based outpatient and residential treatment in my state?
5. How can I address barriers to cross-systems collaboration, including confidentiality issues and reconciling licensing standards between SUD and child welfare systems?
6. How can we engage child-serving agencies such as child care, children's mental health and developmental services to partner to ensure children's social, emotional and developmental needs are met while in residential treatment with parents?
7. What recovery support services exist in my area, and how can we ensure access to these services for families in family-based residential treatment?

RELATED RESOURCES:

- Funding Family-Centered Treatment for Women with Substance Use Disorders
- Family-Centered Treatment for Women with Substance Use Disorders: History, Key Elements and Challenges
- National Directory of Drug and Alcohol Abuse Treatment Facilities
- National Survey of Substance Abuse Treatment Services (N-SSATS)
- Tools for Treatment: Family-Centered Behavioral Health Support for Pregnant and Postpartum Women

SECTION

4 DEVELOP A COMPREHENSIVE UNDERSTANDING OF AVAILABLE FUNDING STREAMS

Once a state's Title IV-E Prevention Plan is submitted and approved by the federal government—which may take several months—the state is permitted to claim Title IV-E prevention services payments for evidence-based programs and services for eligible children and their caregivers. Many state child welfare agencies will partner with SUD treatment and other providers to deliver the services approved in their state plan. States rely on multiple funding sources to provide SUD treatment, and the number of funding sources and how these funds are procured and administered can vary a great deal from state to state. Family First funding will need to be blended with other funding sources to support the full array of services that can keep children safe and support treatment and recovery for the parents.

To understand how best to finance and sustain an array of services that meets the holistic needs of families, stakeholders should consider four key questions. These build off key considerations from Section 2 related to evidence-based programs for parents with SUDs whose children are candidates for foster care:

1. What are the services and supports families need to stay together and prevent out of home placement?
2. What services and supports are necessary to regain and maintain the health of the family?
3. What services and funding are already available in communities to help these families and where are the gaps?
4. How can Title IV-E funding work together with other funding streams to support treatment and recovery for the family and provide for the developmental needs of children?

Primary Sources of Funding to Support Treatment and Recovery for Families Involved in the Child Welfare System

There are six primary sources of funding on which child welfare and SUD treatment partners rely to keep families together, ensure child safety, and support treatment and recovery for all eligible populations. These funding sources are summarized in the table that follows.

A WORD ABOUT CLINICAL NEED: The majority of state agencies and SUD treatment providers use the ASAM criteria or similar criteria to determine the most appropriate service levels of care for adults and youth who need SUD treatment. A biopsychosocial assessment is used to determine the composition of the individual's treatment plan, including the most appropriate level of the care for treatment. It is important for child welfare agencies to understand that treatment services and costs vary by the levels of care. Therefore, to keep a parent and child in a more intensive setting (i.e., residential treatment) for longer than is required is both clinically inappropriate and not cost-effective.

PRIMARY SOURCES OF FUNDING TO SUPPORT TREATMENT AND RECOVERY FOR FAMILIES INVOLVED IN THE CHILD WELFARE SYSTEM

TITLE IV-E FOSTER CARE MAINTENANCE

New funding for family-based residential treatment available through Family First for children already in foster care

ELIGIBLE USES	OTHER USES
Title IV-E can pay the cost of room and board for children in foster care when they are placed with their parents in residential family-based SUD treatment settings. These costs include food, clothing, shelter, and daily supervision for the child. Child welfare agencies can also claim administrative costs, such as case management and related activities, as well as training costs. Title IV-E can pay as long as Medicaid is not paying; typically, Medicaid does not support the cost of room and board for children in family-based residential treatment.	States must submit a Title IV-E amendment to HHS to begin claiming costs associated with placing a child in foster care with their parent. The Title IV-E income eligibility guidelines from 1996 do not apply to this provision. Title IV-E is an open-ended entitlement, so it is available to all eligible children (eligibility requirements are outlined in step 6 of this resource). States submit claims for funding through their state child welfare agency in their usual IV-E claiming reimbursement system. States are reimbursed for the residential family-based treatment program at the federal medical assistance percentage Federal Medical Assistance Percentages (FMAP) rate – between 50-83%.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

Federal block grant supporting an array of support services for low-income families

ELIGIBLE USES	OTHER USES
Many states have used TANF funds to support SUD treatment services. TANF can be used for nonmedical aspects of SUD treatment services such as screening and needs assessments that are performed by counselors, technicians, social workers, and others not in the medical profession and not provided in a hospital or clinic. Assistance is limited to needy families with children, as defined by each state. In general, states have broad flexibility in setting eligibility requirements and can choose to vary eligibility.	Inclusion of substance use treatment in service provided in the state's TANF plan varies across states. To meet the goals of TANF, state plans must specify work readiness activities that include substance use disorder services for a recipient to become self-sufficient. Cannot be used to provide medical services but leaves it to states to determine which services are medical and which are not.

PRIMARY SOURCES OF FUNDING TO SUPPORT TREATMENT AND RECOVERY FOR FAMILIES INVOLVED IN THE CHILD WELFARE SYSTEM

TITLE IV-E PREVENTION SERVICES

New funding available through Family First for "candidates" for foster care and pregnant and parenting youth in foster care

ELIGIBLE USES	OTHER USES
Title IV-E can pay for SUD prevention and treatment services on behalf of children and youth at risk of entering foster care. Services can be provided to: • Parents • Children/youth • Kinship Caregivers • Pregnant and parenting youth in foster care whose children are at risk of entering care. Other eligible services include mental health prevention and treatment services and in-home parent skill-based programs. Services can be provided for up to 12 months and can be extended if it is documented in a child's case plan that more time is needed. Title IV-E can pay as long as Medicaid is not already funding these services.	To claim Title IV-E prevention services, states must submit a five-year state plan to HHS that details the services they plan to use, how they will monitor and oversee the safety of children receiving the prevention services, plans for evaluation of the program, consultation and coordination among other agencies, steps to support the child welfare workforce, and other requirements. Treatment agencies must provide parenting skills training, parent education, and individual and family counseling as part of the treatment of SUDs; these services must be provided under a trauma-informed organizational approach; and providers must be licensed.[8] Programs are rated by the federal Title IV-E Prevention Services Clearinghouse. Title IV-E income eligibility guidelines do not apply to this provision. Title IV-E is an open-ended entitlement, so it is available to all children who are candidates for foster care. The definition of candidacy will be determined by each state. States submit claims for the funding through their usual child welfare reimbursement system. States are reimbursed for the prevention provision at 50 percent and state funds must be used to match 50 percent. Maintenance of effort (MOE) provisions require that states maintain their previous level of spending on foster care prevention services to ensure that Title IV-E prevention funding supplements (not supplants) previous spending on allowable child welfare prevention services.

8 The statute is not specific on who must license the treatment facility. This is a state-level decision.

PRIMARY SOURCES OF FUNDING TO SUPPORT TREATMENT AND RECOVERY FOR FAMILIES INVOLVED IN THE CHILD WELFARE SYSTEM

MEDICAID

Federal health insurance program for low income families

ELIGIBLE USES	OTHER USES
Can cover SUD treatment services, depending upon what services a state covers under its Medicaid plan and the eligibility criteria it applies. Does not pay for room and board. Not all parents involved in the child welfare system are eligible for Medicaid; approximately 99 percent of children are eligible. Some states may opt to include a parent's stay in residential family-based treatment with Medicaid funds in their state plan while Title IV-E pays the cost for the child's placement. States that have taken up Medicaid expansion available through the Affordable Care Act (ACA) will have different considerations for how it can be used to support families involved in the child welfare system than non-Medicaid expansion states. These include services consistent with the ACA essential benefits and defining eligible populations.	Medicaid is an open-ended entitlement like Title IV-E, but state eligibility requirements vary significantly. States are reimbursed for Medicaid at the Federal Medicaid Assistance Percentages—between 50 and 83% across states. If the Medicaid state plan includes a service that cannot be provided in a timely way to families involved with the child welfare system, Title IV-E can pay for the service temporarily and receive reimbursement from the state Medicaid agency for the service.

STATE GENERAL FUNDS

Funding can be used to fill gaps in federal funding streams and ensure sustainability

ELIGIBLE USES	OTHER USES
State general funds allocated to prevention and treatment varies in terms of services provided and how they are administered. State funding can be highly flexible (or designated to a specific purpose) and can be used to match Title IV-E and Medicaid funded services.	Funding levels and provisions on specific eligible populations and services vary depending on state priorities. In some states, local funds are a significant portion of states' matching for Maintenance of Effort (MOE) requirements.

PRIMARY SOURCES OF FUNDING TO SUPPORT TREATMENT AND RECOVERY FOR FAMILIES INVOLVED IN THE CHILD WELFARE SYSTEM

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG)

Federal block grant dollars to state substance use disorder treatment agencies to allocate to local jurisdictions or directly to community-based service providers

ELIGIBLE USES	OTHER USES
Funds priority treatment and support services for individuals without insurance or for whom coverage is terminated. SAPTBG funds priority treatment and support services not covered by CHIP, Medicaid, Medicare, or private insurance for low-income individuals. SAPTBG is an annual formula grant awarded to states, and states have certain requirements for funding that must be expended to ensure federal funds do not supplant other funding sources. States have flexibility in how they use the SAPTBG to support treatment and recovery, including child care, job training, and transportation.	States have certain set asides they must meet in their expenditures for the block grant, including prevention, HIV early intervention, and services for pregnant and parenting women. Pregnant women must be given priority in treatment admissions. At a *minimum*, services for pregnant women and women with children should include: • Primary medical care, including referral to prenatal care and day care while women receive services; • Primary pediatric care, including child immunization; • Gender specific SUD treatment; • Therapeutic interventions for children with women in treatment; and • Case management and transportation.

CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA)

Funding to support prevention and treatment for abused and neglected children

ELIGIBLE USES	OTHER USES
The Community-Based Child Abuse Prevention program (often referred to as CB-CAP) supports community-based efforts to prevent child abuse and neglect. CB-CAP funding is used in different ways across states, and can be braided with other funding streams, including Title IV-E and SAPTBG, to support children and their families and prevent removal and placement into foster care.	Recent increases to CAPTA can be used to support foster care prevention efforts, particularly for children identified as affected by prenatal substance exposure who are at risk of foster care entry, and for whom child welfare and other systems are developing a plan of safe care that is required by CAPTA.

KEY QUESTIONS

1. How does my state currently support residential family-based treatment?
2. What are the gaps in funding for residential family-based treatment and how can the Title IV-E new opportunities be used to fill these gaps?
3. How can CW and SUD partners work together to expand capacity for community-based outpatient services?
4. How can funding such as the Individuals with Disabilities Education Act (IDEA) and Head Start, for early childhood services, be used to pay for developmental services for the child who is either placed with the parent in residential care or who remains at home but is a candidate for foster care?

RELATED RESOURCES:

- Funding Family-Centered Treatment for Women with Substance Use Disorders

SECTION

5 CREATE STRONG PARTNERSHIPS TO MAXIMIZE SUCCESS

Family First can lay the groundwork for successful new collaborations across systems and serve as a sustainable mechanism to ensure families have access to family-centered treatment in the long-term. Even in states with strong collaborations already in place, agencies need to constantly educate new leadership and frontline staff on policies governing placement and service delivery, reinforce best practice principles, and communicate leadership priorities that are consistent with new research and changing understandings of what works to helps families stay together. Those with sustainable partnerships can more readily work together on new policy opportunities as they emerge and measure their progress toward achieving better outcomes over time.

This section in the toolkit highlights best practices that have already emerged through collaborative work, including implementing plans of safe care and the Regional Partnership Grants, as well as some key policy and practice challenges that are unique to Family First implementation.

Best Practices for Collaboration[9]

1. **Clarify mission, underlying values, and principles of collaboration:** Family First provides an opportunity to define the shared mission of the partners, mandates of each system, and how they contribute to implementation. This process helps to builds trust between the systems. Often these agreements are captured through a Memorandum of Understanding, which is developed by an Advisory Council or Steering Committee. This step serves as a critical foundation for Family First implementation and helps to ensure that implementation efforts remain focused on a shared mission rather than focused solely on compliance with the requirements of the law.
2. **Screening and assessment:** Effective screening and assessment on the part of both child welfare and SUD system partners is essential to match children and families to appropriate services to meet their needs, including the right evidence-based programs, as well as the most appropriate level of care, including family-centered residential treatment and other family-centered treatment approaches.
3. **Engagement and retention in care:** Along their path to recovery, parents must make behavioral changes and learn new coping skills that will take time. This process may require multiple attempts before it is successful. Working together, child welfare, SUD treatment, and community partners can provide support and encouragement for parents' long-term recovery goals, including keeping the family intact.
4. **Services to children of parents with SUDs:** Parental SUDs can have a major impact on children, and partners must work together to ensure that children receive specialized prevention and early intervention services. In addition to the EBPs reimbursable under the new Title IV-E prevention funding stream, the

9 Adapted from *The Collaborative Practice Model for Family Recovery, Safety and Stability,* Children and Family Futures, 2011.

child welfare system can help ensure that other interventions are available to meet the developmental needs of the children.

5. **Working with the community-based treatment organizations:** Many community-based organizations provide evidence-based SUD treatment services eligible for Title IV-E reimbursement under the law. When supporting families with SUDs, it is important that partners understand the landscape of community-based organizations, (e.g., funding, reporting, staffing) and other family support systems available to the family.
6. **Efficient communication and information systems:** Without efficient communication protocols, families must navigate multiple complex systems that may involve duplicative or conflicting steps, requiring them to tell their story multiple times and delaying effective service delivery. If implemented well, Family First can help encourage partnerships that streamline the assessment and referral process to quickly connect families to the services they need.
7. **Budgeting and program sustainability:** Long-term sustainability for innovative approaches requires diversification of funding resources from multiple agencies in a state or community. Family First is significant in part because it provides a long-term, sustainable source of funding to support family-centered treatment approaches. For more information about additional funding streams available to serve families who are affected by SUDs, see Section 4 of this toolkit.
8. **Training and staff development:** Cross-training for personnel at all levels within child welfare and SUD treatment agencies is necessary to promote a shared understanding and respect for each other's agencies. Without such training, conventional practices can reinforce barriers caused by agencies working in silos.
9. **Working with related agencies:** Most families affected by SUDs require assistance from multiple agencies to address their complex issues, including child and adult mental health, child development, domestic violence, primary health care, housing, and employment-related services. In the context of Family First implementation and effective SUD treatment, it is important to holistically meet the needs of families affected by SUDs to improve their long-term recovery outcomes.
10. **Joint accountability and shared outcomes:** For collaboration to be effective and sustainable, partners should measure outcomes for the whole family—both parents' recovery as well as children's safety and permanency. Outcomes measurement for the whole family is critical to reflect a family-centered approach to monitoring effectiveness.

Family First Implementation Challenges and Strategies

Family First planning and implementation presents an excellent opportunity to reinforce the goals of both child welfare and SUD treatment agencies, and to establish successful practice and policy strategies to help children and families. The chart below highlights practices to avoid, as well as strategies to successfully plan and implement Family First.

POSSIBLE PITFALLS	STRATEGIES FOR SUCCESS
Embarking on collaborative efforts without understanding the perspectives of other systems: With so many other priorities competing for the attention of child welfare and SUD systems, it can be tempting to rush into Family First implementation without taking the time to recognize and discover the different perspectives each system brings to the partnership. This oversight can lead to misunderstandings and blame, which typically comes at the expense of families they are serving.	**At the outset of implementation, gain an understanding of the perspective, goals, and mandates each system brings to the partnership:** Through a coordinating team or leadership committee, set the stage for implementation by both defining shared goals and acknowledging the differing perspectives each partner brings to the partnership. These goals, as well as specific roles and responsibilities for each partner engaged in Family First, can be articulated in an MOU.
Using plans of safe care to bring more children into foster care: Plans of safe care and Family First provide important new pathways to connect families to family-based substance use treatment services. Unfortunately, in some states, plans of safe care have increased attention on families with SUDs and, in the worst cases, led to more children being removed from their parents and placed into foster care. This outcome runs counter to the intent of federal law, as well as what research shows to be best practice when working with families affected by SUDs. This practice can also have a chilling effect for families who need treatment but may be reluctant to trust the child welfare agency to help connect them to services for fear of having their child removed and placed into foster care.	**Take advantage of new federal opportunities to help keep families together:** Plans of safe care and Family First are intended to keep children with their families whenever safely possible by connecting families to needed SUD treatment services. These federal reforms support more proactive measures to keep families together. In keeping with the spirit of these laws, stakeholders must ensure that implementation leads to more families experiencing recovery—rather than being separated. An appropriate goal for working with a family with a SUD is to understand and help create conditions that lead to change. Motivational Interviewing, a practice technique used by many SUD treatment professionals, is an approach that may be helpful for child welfare caseworkers to help parents improve their self-esteem and feelings of competence and develop the feeling that he or she is able to change.
Having child welfare outreach to treatment providers without involving SUD systems: Child welfare agencies may be tempted to reach out directly to providers to develop contractual relationships, without involving the SUD public administrators. Engaging these administrators is critical, as they have responsibility for oversight of individual providers and can assess whether they are equipped to work with families. They also understand how current SUD funding streams work and how they can be blended effectively with Title IV-E prevention funding.	**Involve SUD systems experts from the outset of Family First implementation efforts:** Treatment systems leaders are important sources of information for child welfare agencies. They can help child welfare systems develop contracts that are aligned with the current state and federal SUD funding and ensure that best practice principles in the SUD system are being followed. They can also help to reinforce policies and practices that reduce confusion and fragmentation for the family and improve coordination of services.

POSSIBLE PITFALLS	STRATEGIES FOR SUCCESS
Treating medications used in MAT as an inappropriate substance: MAT is not always well-understood by the child welfare system, which can lead to inappropriate decisions about the family's treatment and safety plans, as well as unrealistic expectations about recovery timelines and other recovery supports that may be needed for the family.	**Educate all stakeholders about the role of MAT and how to incorporate it into child welfare case planning:** The Title IV-E Prevention Services Clearinghouse has already approved Methadone Maintenance Therapy as a promising practice, and child welfare and court personnel should be educated on how the broad range of MAT treatment options can help keep families safely together.
Placing families into residential treatment without assessing their need for that level of care: Residential treatment is appropriate for some, but not all, families. It is a highly structured and intensive placement option, and although it offers numerous benefits, it is not necessary for families who can be served through outpatient or in-home services.	**Reinforce the importance of a continuum of SUD services and placement options:** It is important that a whole continuum of family-centered treatment services be available to families, and that patient placement criteria help to determine the level of treatment required to meet their needs. For Medicaid reimbursement, medical necessity determinations are required for treatment.
Promoting family-centered treatment without engaging all family members: Although Family First is intended to address the needs of the entire family when making a referral to SUD treatment services, this is not always the norm. For example, some states do not have a mechanism for paying for programs for a father. In addition, many family-based residential providers do not accept children over a certain age, or more than one or two children in treatment with a parent. Other family members still living in the home may also need income support and other supportive services.	**Use the new resources available through Family First to strengthen the capacity of treatment providers to work with the whole family:** Central to a family-centered approach is meeting the needs of all family members. In addition to providing therapeutic, health, developmental, and other services to meet the needs of children in SUD treatment with their mothers, family-centered treatment should also engage fathers, as well as other children (i.e. siblings) in the family.
Relying solely on SUD treatment services to meet family needs: SUD treatment alone will not keep families together, and planning teams will need to engage a variety of stakeholders to meet the holistic needs of families.	**Ensuring families have access to a range of services to meet the whole family's needs:** Successful family-centered treatment depends on a blend of services that are tailored to the unique needs of the families being served. Families with SUDs may have a variety of other needs that must be met for treatment to be successful, including housing, transportation, legal support, recovery support, parenting, and mental health treatment. While Family First will not pay for all these supports, it is important to leverage the support of other systems for successful outcomes.

KEY QUESTIONS

1. What is each represented system's role in achieving shared priorities and outcomes?
2. What are some barriers to collaboration between these two systems?
3. What does each partner believe about the nature of substance use disorders and the role of treatment to improve family outcomes?
4. What does each partner believe about the role of child welfare to improve family outcomes?
5. Do partners agree on the markers of effective practice and service delivery? What are those markers?
6. How is "best interest" defined for children? For mothers? For families? Do families have sufficient input in determining this?
7. What do partners believe constitutes recovery?

RELATED RESOURCES:

- Synthesis of Cross System Values and Principles: A National Perspective
- A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders
- Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers
- Family-Centered Treatment for Women with Substance Use Disorders: History, Key Elements, and Challenges
- Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health
- Addiction Technology Transfer Center (ATTC) Network
- HealtheKnowledge Course: Supporting Recovery with Medications for Addiction Treatment (MAT)
- Tutorial for Substance Abuse Treatment Professionals
- Tutorial for Child Welfare Professionals


Children and Family Futures
Strengthening Partnerships, Improving Family Outcomes


childfocus®


NASADAD
National Association of
State Alcohol and Drug Abuse Directors