National Center on Substance Abuse and Child Welfare

NCCAN Policy Forum Brief

Children's Bureau

What Works: Collaborative Practice Between Substance Abuse, Child Welfare, and the Courts

Regional Partnership Grants

July 2014

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WHAT WORKS FOR FAMILIES AFFECTED BY SUBSTANCE USE DISORDERS: COLLABORATIVE PRACTICE BETWEEN SUBSTANCE ABUSE, CHILD WELFARE, AND THE COURTS

The National Center on Substance Abuse and Child Welfare (NCSACW) presented a policy forum on April 30, 2014 at the 2014 National Conference on Child Abuse and Neglect in New Orleans, Louisiana. Attended by over 100 participants, the forum offered a three-part series on collaborative policy and practice changes for addressing the needs of families affected by substance use disorders in the child welfare system and family courts. This report summarizes and expands upon the key policy issues presented in the forum. These policy issues include: Prevalence of Substance Use Disorders in Child Welfare; Substance Use Disorders as a Chronic, Relapsing Disease—Implications for Collaborative Practice; Treatment Effectiveness; Family Well-Being; and, Bringing Collaborative Systems Work to Scale and Sustaining Them.

In 1997, the Adoption and Safe Families Act (ASFA) was enacted to address child welfare cases that lingered in the court system while parents cycled in and out of treatment. The legislation created a need to find effective responses to substance abuse and maltreatment within families. Five national reports followed addressing the co-occurring issues of parental substance abuse and child abuse and neglect. These reports are:

- Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy (Child Welfare League of America, 1998)
- Foster Care: Agencies Face Challenges Securing Stable Homes for Children of Substance Users (U.S. General Accounting Office, September 1998)
- No Safe Haven: Children of Substance-Abusing Parents (The National Center on Addiction and Substance Abuse at Columbia University, 1999)
- Healing the Whole Family: A Look at Family Care Programs (Children's Defense Fund, 1998)
- Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection (Dept. of Health and Human Services, 1999)

Blending Perspectives and Building Common Ground introduced five national goals established in response to ASFA. These goals were:

1. Building collaborative relationships
2. Assuring timely access to comprehensive substance abuse treatment services
3. Improving our ability to engage and retain clients in care and to support ongoing recovery
4. Enhancing children's services
5. Filling information gaps

Through a decade of work with over 100 collaborative sites, the NCSACW has assembled key lessons learned for developing and implementing innovative strategies to improve outcomes for child welfare families affected by substance use disorders. The sites include:

- 53 Regional Partnership Grants (RPG): Funded by the reauthorization of the Promoting Safe and Stable Families Act through the Child and Family Services Improvement Act of 2006. This legislation provided funding over a five-year period to implement regional partnerships to improve outcomes for children and families affected by methamphetamine and other substance use disorders.
- 43 Family Drug Court (FDC) Grantees: Funded by the Office of Juvenile Justice and Delinquency Prevention Family Drug Court, this grant award provided funding to establish or expand 43 specialized courts to ensure earlier access to treatment, increased judicial oversight, and a collaborative approach to families across child welfare, substance abuse treatment, and the courts.
- 12 Children Affected by Methamphetamine (CAM) Grants: Funded by the Substance and Mental Health Services Administration (SAMHSA) through the Public Health Service Act of 2000 to 12 Family Treatment Drug Courts (FTDC). Four-year funding was awarded to improve the well-being, permanency, and safety outcomes for children who are in, or at-risk of, out-of-home placement as a result of a parent's or caregiver's methamphetamine or other substance abuse.
- 23 In-Depth Technical Assistance (IDTA) Sites: An 18-24 month technical assistance program provided by the NCSACW to state, tribal, and county partnerships seeking to strengthen collaboration across child welfare, substance abuse, mental health, family courts, and other systems.

Collaborative practice between the dependency court, child welfare, substance use treatment, and other services systems offers a multitude of practical strategies and solutions to improve outcomes for child welfare involved families affected by substance use disorders. Collaborative practice results in a wider realm of resources to address the complex needs of families than is traditionally available through one system. Families present with complex needs that the child welfare system cannot address alone. For instance, children affected by trauma and pre-natal substance exposure often require interventions and treatment, in addition to substance abuse and mental health treatment provided to parents. Emphasis on treatment interventions and supports that focus only on children or parents separately, often result in fragmented and uncoordinated care. Collaborative policies and practices are required to provide access to family-centered interventions that can address the multiple needs of families. Evidence is now emerging that collaborative policy and practice positively influence five core outcomes, or the 5Rs, for families in the child welfare system impacted by substance use disorders:

1. Recovery: Parental recovery from substance use disorders
2. Remain at Home: More children remain in the care of parents
3. Reunification: Increased number and timeliness of parent-child reunification
4. Recidivism: Decreased incidence of repeat maltreatment

5. Re-entry: Decrease in number of children re-entering out-of-home care

Models of collaborative intervention vary widely in approach. They include innovative strategies such as: co-location of substance abuse specialists in child welfare offices or dependency courts; Family Drug Courts or Dependency Drug Courts; collaborative case management and planning; development of collaborative structures; wraparound services; improved cross-system communication protocols; and, cross-agency training of staff. This briefing highlights effective collaborative practices, and details common ingredients and strategies that are demonstrating improved outcomes for children and families. There is an emerging body of evidence showing that effective multi-system collaboration, at both the administrative/management level and direct practice level, can provide access to needed services and supports for children and families. If implemented to scale, these collaborations can ultimately impact system outcomes.

The NCSACW has identified several policy issues that must be considered when planning and implementing collaborative policies and practices. These issues have implications for how providers intervene with and treat families, and how effective collaborative partnerships can improve outcomes for children and families.

PREVALENCE OF SUBSTANCE USE DISORDERS IN CHILD WELFARE

Research and practical experience have long demonstrated the prevalence of parental substance use disorders among families in the child welfare system. Historically, a lack of coordination and collaboration has hindered the ability of child welfare, substance abuse treatment, and family/dependency court systems to support these families. As child welfare involved families have complex needs, improving outcomes requires a coordinated effort among systems. Studies indicate that 87 percent of children involved in the child welfare system have one parent who is using drugs or alcohol, and 67 percent have two parents using drugs or alcohol (Smith, Johnson, Pears, Fisher and DeGarmo). Approximately 8.3 million children live with one or more parent who is dependent on alcohol or illegal drugs (Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2003).

According to the National Survey of Child and Adolescent Well-Being, 61 percent of infants and 41 percent of older children in out-of-home care were from families with active alcohol or drug abuse (Wulczyn, Ernst, & Fisher, 2011).

Parental alcohol or drug use was the reason for removal for almost 31 percent of children placed in foster care in 2012, with several states exceeding 60 percent (Chart 1 AFCARS Data, 2012). While the number of children in foster care has decreased in recent years, the percentage of children removed due to parental substance abuse has increased every year since 2008. Parental alcohol and drug abuse accounted for 36 percent of children whose parents had parental rights terminated in 2012, second only to parental neglect (Chart 2 AFCARS Data, 2012).

Chart 1: Parental AODF as Reason for Removal – 2012

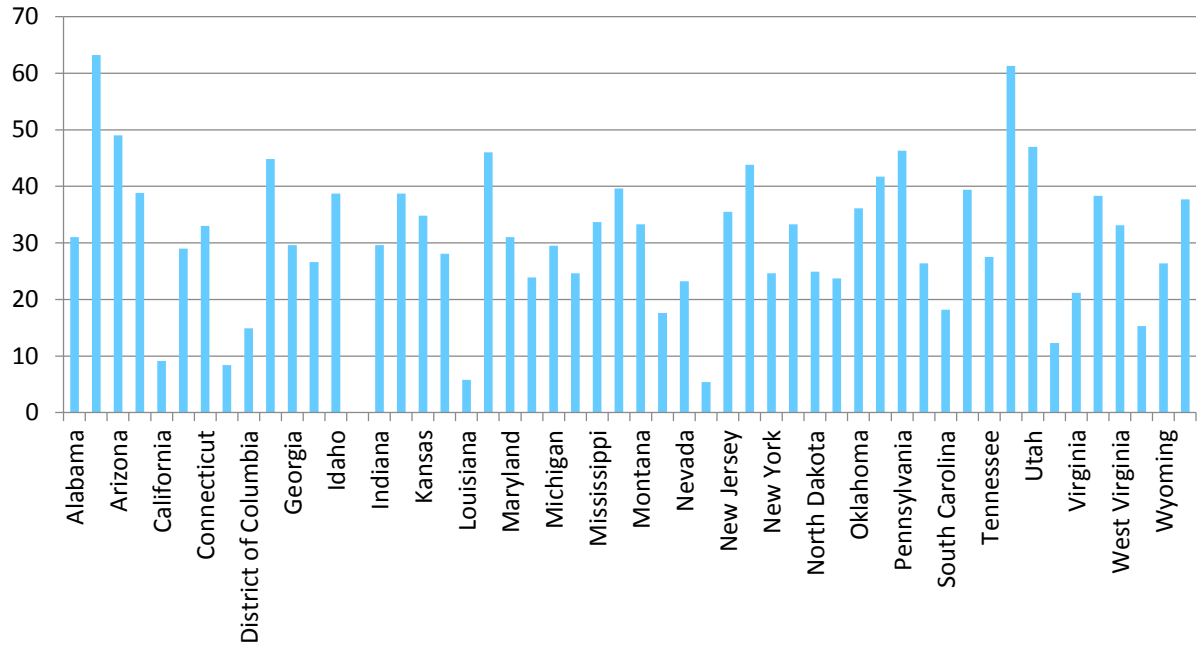
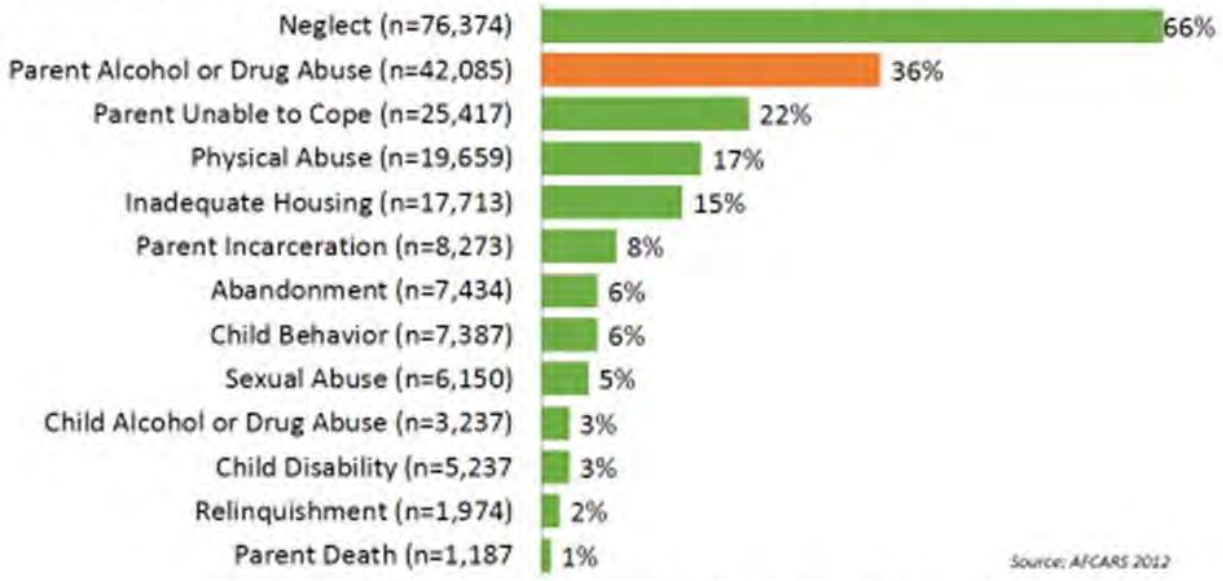


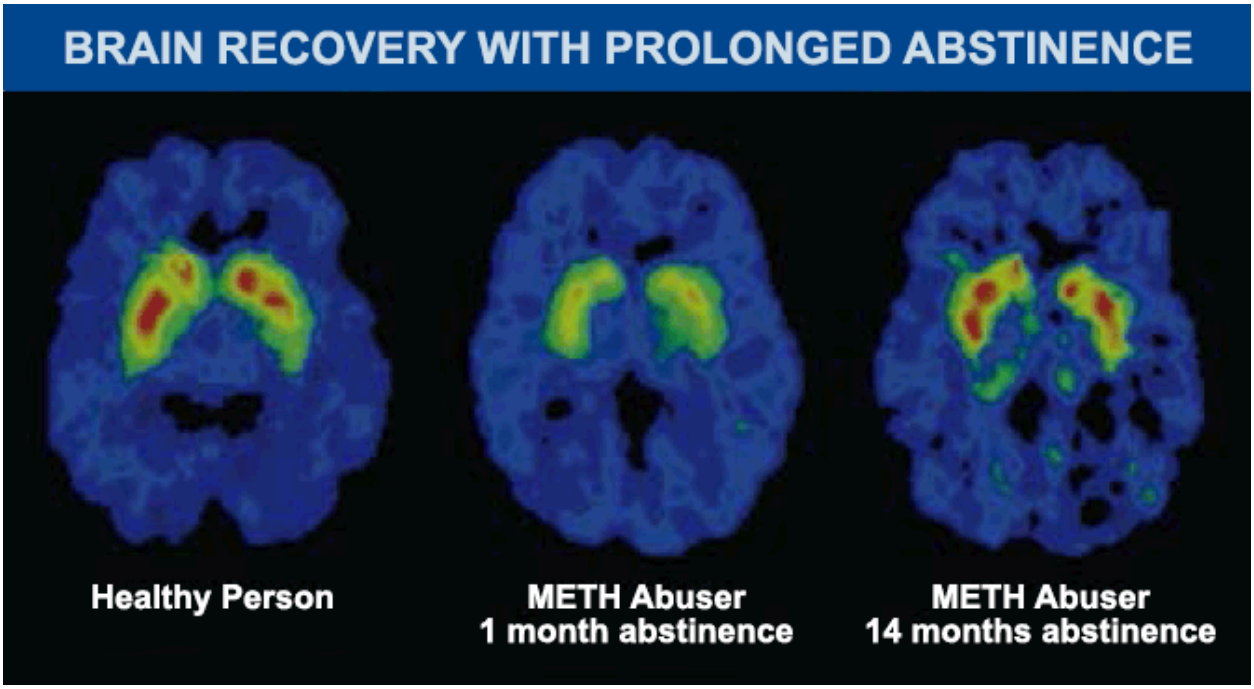
Chart 2: Percent and Number of Children with Terminated Parental Rights by Reason for Removal - 2012



Adoption and Foster Care Reporting System (2012) [Data file]. Ithaca, NY: National Data Archive on Child Abuse and Neglect.

SUBSTANCE USE DISORDERS AS A CHRONIC, RELAPSING DISEASE: IMPLICATIONS FOR COLLABORATIVE PRACTICE

The American Society of Addiction Medicine defines addiction as "a primary, chronic disease of brain reward, motivation, memory, and related circuitry." Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations, such as an individual pathologically pursuing reward and/or relief by substance use and other behaviors (American Society of Addiction Medicine, 2011). Achieving sobriety and sustaining a life of recovery is a fundamental and profound bio-psycho-social and spiritual process for an individual. The individual in recovery is making lifestyle changes to support healing and regain control of his or her life, and accepting responsibility for his or her behavior. He or she may have a new job, a different living situation and/or location, and a new set of friends. Their new friends may be peer and self-help group members instead of former substance-using friends. Additionally, newly recovering people are coping with brain changes resulting from their substance use. The brain can be physically injured and altered by drug use; this injury can last for a long time.

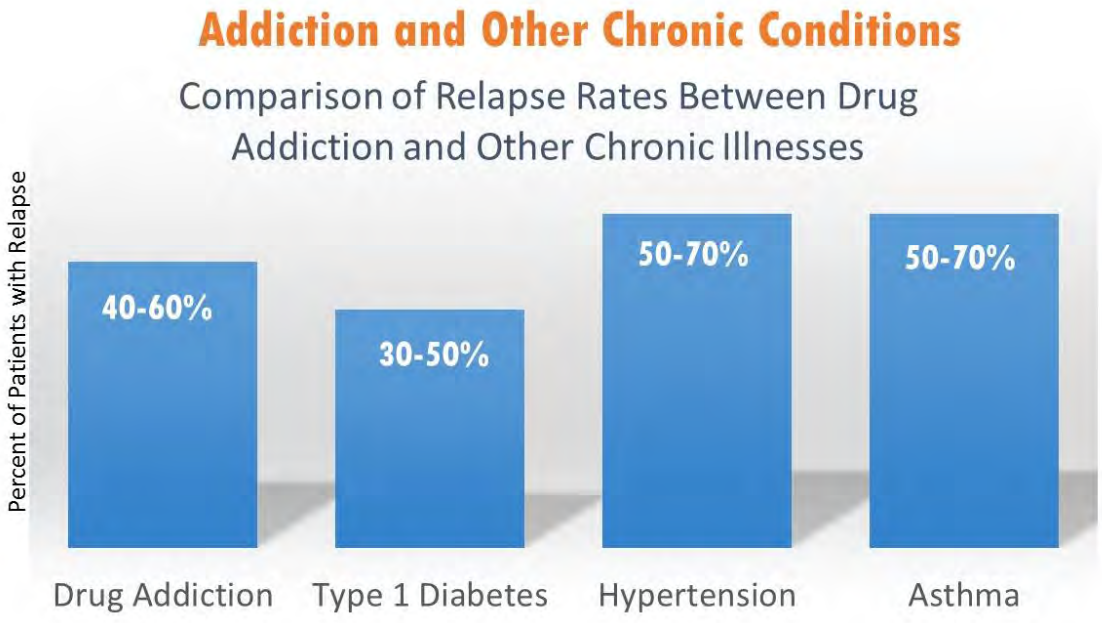


The brain scans depicted above show that drug abuse alters the brain's structure and function, resulting in changes that persist after drug use has ceased (National Institute of Drug Abuse, 2013). These changes may explain why drug abusers are at risk for relapse even after periods of abstinence and despite the potentially devastating consequences. The scans also indicate a return of brain function after 14-months of abstinence, implying that many changes are not long-term, and time can positively affect how a parent engages in child welfare and substance abuse services as recovery progresses.

The changes in the brain that occur with substance use disorders have led scientists to consider these disorders to be brain-based diseases.

RELAPSE IN CHRONIC DISEASE

Treating substance use disorders involves the ongoing management of a lifelong disease similar to diabetes, asthma, or high blood pressure. Short-term interventions without ongoing disease management and support are usually ineffective. The treatment of chronic diseases involves lifestyle changes to accommodate medical and behavioral recommendations. Behavioral changes rarely progress in a straight line, but instead involve periods in which people return to their old behaviors despite negative consequences. Diabetes, asthma, and hypertension patients struggle with relapse at nearly the same rate as people with substance use disorders. Despite the threat of severe medical complications, relapse rates for Type I diabetes are 30-50 percent, with hypertension and asthma at 50-70 percent. These rates mirror substance abuse relapse rates of 40-60 percent (McClellan, Lewis, O'Brien and Kleber).



Understanding the difference between a lapse and relapse will help one understand how to engage a person back into recovery. A lapse may include a temporary return to substance use but the person returns to treatment, re-engages in the recovery process, and does not return to a pattern of drug-seeking behaviors and detrimental consequences (Larimer, Palmer and Marlatt Annis). Many parents in child welfare lapse and, when child safety has not been compromised, the relapse is characterized by an on-going pattern of continued alcohol or drug use despite experiencing negative consequences. A parent who has relapsed would likely need structured intervention, motivational tactics to re-engage in services, and an increase in the intensity of services.

Relapse is not the same as treatment failure; instead, both a lapse and a relapse can be viewed as a learning lesson, allowing the recovering person to adjust their treatment and lifestyle. Treatment professionals can view relapse as a step toward sobriety and use it as an integral part of the treatment process. Whereas for the child welfare professional, relapse may present a risk to the parents' ability to safely care for their children. Child safety and well-being should always be re-assessed when a relapse occurs. What both professionals have in common are parents who

likely feel guilty when they relapse because they have not yet demonstrated their capacity to maintain long-term sobriety, and have jeopardized their ability to care for their children. While the relapse may eventually result in a greater commitment to recovery, in the short-term it may result in delays in reunification or changes in permanency planning. Ideally for parents receiving treatment when a relapse occurs, a coordinated response from treatment and child welfare professionals will serve to motivate the parent to resume their recovery. However, relapse may also indicate a need to expedite permanency planning as it becomes evident that a parent's ongoing addiction will continue to compromise his or her ability to care for their children.

Parents involved with child welfare who need substance abuse treatment, and who are under the Adoption and Safe Families Act (ASFA) clock to meet statutory deadlines set by the dependency court, may relapse and require professionals to offer motivational enhancement strategies to reengage them. The courts and child welfare system are driven by ASFA timelines and goals, but substance abuse recovery does not fit neatly into a predetermined timetable. Information sharing between child welfare and substance abuse professionals regarding differing timetables, compliance expectations, and service access will bring awareness to both systems, as well as to the parent, and will aid in meeting overall treatment and permanency goals. Throughout this process social workers and treatment professionals may need to help parents understand the most critical timeline of all, that of their child's development.

Families need to be presented with clear expectations for meeting the goals of their child welfare case plans and substance abuse treatment plans, and the consequences of not actively working to achieve those goals, on an on-going basis.

TREATMENT EFFECTIVENESS

There is a variety of scientifically based approaches to treatment, including behavioral therapy, medications, or a combination of the two. Behavioral therapies[1], such as counseling, cognitive therapy, or psychotherapy, seek to provide strategies to cope with cravings, avoid substances, prevent relapse, and manage overall recovery stressors. When substance-related behavior puts an individual at risk for AIDS or other infectious diseases, behavioral therapies can also help reduce the risk of disease transmission. Case management and referral to other medical, psychological, and social services are crucial components of treatment for many people. Treatment can also include referral and linkages to mutual support groups, such as Alcoholics Anonymous and Narcotics Anonymous. Although substance abuse treatment needs to be customized for the unique treatment needs of each individual, treatment programs generally share common overall goals, including the following (Landry, 1995; Center for Substance Abuse Treatment, 1997; American Psychiatric Association, 1995):

[1] "As the name implies, this approach focuses on behavior-changing unwanted behaviors through rewards, reinforcements, and desensitization. Desensitization, or Exposure Therapy, is a process of confronting something that arouses anxiety, discomfort, or fear and overcoming the unwanted responses. Behavioral therapy often involves the cooperation of others, especially family and close friends, to reinforce a desired behavior" (Substance Abuse and Mental Health Services Administration, 2003, para 2)

- Improvements in bio-psychosocial functioning;
- Reduced substance use and increased sobriety; and,
- Prevention or reduction in the frequency and severity of relapse.

Research indicates that the best programs provide a combination of therapies and other services, delivered with a trauma-informed approach, designed to meet the unique needs of each family member (National Institute on Drug Abuse, 2012; Amaro, Chernoff, Brown, Arevalo, & Gatz, 2007). Each individual has a complex set of needs, including a combination of age, race, culture, sexual orientation, gender, pregnancy, parenting, housing, and employment, as well as a potential history of physical and sexual abuse or other trauma (National Institute on Drug Abuse, 2012). Integrating trauma-informed services within each agency, or in partnerships with mental health facilities, continues to take on increased importance for addressing co-occurring disorders. The National Institute on Drug Abuse (NIDA) provides principles of effective substance abuse treatment, including the need for readily accessible and individualized treatment, integration of medications as a necessary component for effective treatment, and the acknowledgement that recovery from dependence is a long-term process that may require multiple episodes of treatment. For details and a complete listing of the principles, see http://www.nida.nih.gov/PODAT/Principles.html.

NIDA reports that individuals need at least 90 days of treatment to significantly reduce their drug use (National Institute on Drug Abuse, 2012).

HOW QUICKLY WILL THE PARENT BE ENGAGED IN SUBSTANCE ABUSE TREATMENT?

Timely access to treatment, or the time it takes between a client's initial evaluation or assessment, and the engagement in treatment services, is a critical component for treatment success. Clients coming into treatment with substance use disorders often struggle with feelings of ambivalence towards treatment. When an individual makes the choice to enter services, the window of opportunity for engagement will often be short. Regional partnership grantees worked collaboratively to decrease wait times for access to treatment. The partnerships tracked engagement time, reporting an average of 13 days between assessment and treatment engagement, with 36 percent of organizations reporting only three days. Parents went on to remain in treatment a median of 4.8 months, with 65.2 percent staying in treatment more than 90 days (Center for Children and Family Futures, October, 2013). Clients also need quick access when reaching out for substance use disorder assessments, the first step on the journey towards recovery. As treatment agencies continue to refine their access procedures, time to assessment has dropped to 24 hours for some agencies, with many agencies offering walk-in assessments.

While decreased wait times are good news, as noted above many RPG clients—even in positive circumstances—had to wait 13 days or more for treatment access. In some communities, the wait for a residential treatment bed may be several months.

While the appropriate level of care may not be accessible on a timely basis, engaging the parent quickly in interim services is critical.

Motivational enhancement groups are a developing practice designed to provide individuals in need of treatment continued support and access to addiction professionals, while waiting for access to treatment. These groups do not offer the full level of treatment needed, but take advantage of the precipitating crises that often motivate parents to participate in services, and help to bolster motivation and address feelings of denial and ambivalence.

Progressive outcomes for treatment are closely linked to: quick access to assessment and treatment; specific strategies used to enhance engagement and retention (e.g., recovery coaches, peer mentors, motivational interviewing, etc.); reduced barriers to participating in treatment; and, dosage and length of stay in treatment. Likewise, child welfare outcomes, including: increased rates of reunification; children being able to remain at home; lower rates of repeat maltreatment; and, fewer re-entries into foster care, have been associated with early engagement and retention in treatment.

Establishing protocols for referral, assessment, access to treatment, joint case planning, and information sharing between child welfare, local treatment programs, and the court, can have a positive impact on parents' participation in services.

MEDICATION ASSISTED TREATMENT

For some clients, particularly opiate users, substance use disorder treatment includes the use of medication-assisted treatment (MAT)[2]. Opioid dependence develops from the repetitive use of heroin and the misuse of prescription opioid analgesic medications such as Codeine, Morphine, and Oxycodone. There are different types of medications used to treat opioid dependence. The medications work differently; their effects include suppression of opioid cravings and withdrawal symptoms, and/or blockage the effects of opioids. The most recognized and frequently used form of MAT is methadone. Methadone has been available since the 1960s, and is currently accessible through federally monitored opiate treatment programs (OTP). While methadone must be received through an OTP, newer medications such as Suboxone, Subutex, and Vivitrol can be administered by private physicians who qualify for a federal waiver.

MAT has been gaining increased attention in efforts to address substance use disorders, with the steady growth of prescription drug use in recent years. Recent announcements, such as those by the governors of Massachusetts and Vermont, highlight the growing public health crises of opiate abuse and addiction. The use of MAT with pregnant women with opioid dependencies, and families involved with the child welfare system, has complicated relationships between treatment providers, dependency courts, and child welfare. As a result, a myriad of practice and policy concerns have been raised in working with these families, highlighting the need for thoughtful guidance, greater awareness, and continuing education regarding the science and efficacy of MAT with pregnant and post-partum women. The National Center on Substance Abuse and

[2] "Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful" (Substance Abuse and Mental Health Services Administration, 2014, para. 1).

Child Welfare (NCSACW) convened a national work group to study, understand, and share what is required to create a supportive, system-wide response to pregnant women with opioid dependence. Coordinated services needed for opioid dependent women and their infants, during the immediate post-natal period, include MAT and the identification and treatment of neonatal abstinence syndrome (NAS). The work group is developing a guidance document for use by states in developing protocols for working with individuals with opioid-related addiction, especially pregnant and post-partum women.

While MAT is used for persons with opiate dependence to maintain abstinence and avoid withdrawal, in pregnant women MAT carries the additional benefit of helping to avoid preterm labor or miscarriage through withdrawal.

Birth outcomes for women on MAT show positive trends including fewer pre-term births, fewer low birth weight babies, and less maternal drug use. (Jones, et al., 2008; Center for Substance Abuse Treatment, 2005; Association of State and Territorial Health Officials (ASTHO), 2014)

The majority of opiate dependent, pregnant women who use MAT use methadone, although there are increasing numbers of pregnant women using Suboxone (bupernorphine). While the use of MAT during pregnancy correlates with positive birth outcomes, some babies will experience some withdrawal symptoms (e.g. Neonatal Abstinence Syndrome). NAS and withdrawal symptoms can be effectively managed and treated with a combination of pharmacological and non-pharmacological interventions. Not all infants with NAS will require medication.

MAT is an important component of the treatment continuum, identified by NIDA as a principle of effective treatment when indicated. The American Society of Addiction Medicine (ASAM) and the American College of Obstetricians and Gynecologists (ACOG) published a paper jointly recommending that opioid dependent, pregnant women initiate and continue opioid maintenance treatment whenever possible. More information is available at the link below: http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Opioid_Abuse_Dependence_and_Addiction_in_Pregnancy

IMPLICATIONS FOR COLLABORATIVE PRACTICE

When family members with substance use disorders are referred to treatment, they are often involved in multiple systems, including child welfare, substance abuse and mental health treatment, and the courts. It is important to remember that as these individuals attempt to navigate these systems, they are dealing with the effects of substance use on their brain chemistry. A parent who is still using substances, or with a minimal period of abstinence, is not likely able to comprehend or act on multiple, simultaneous tasks characteristic of child welfare case plans and substance abuse treatment plans. Depending on the substances used, changes in their brain chemistry may significantly impair their capacity for follow through. As a result, they might present as difficult to engage, in denial, or non-compliant, with cognitive impairment affecting their ability to process, retain, and act on expectations required of them.

Collaborative efforts to improve outcomes for these parents should consider:

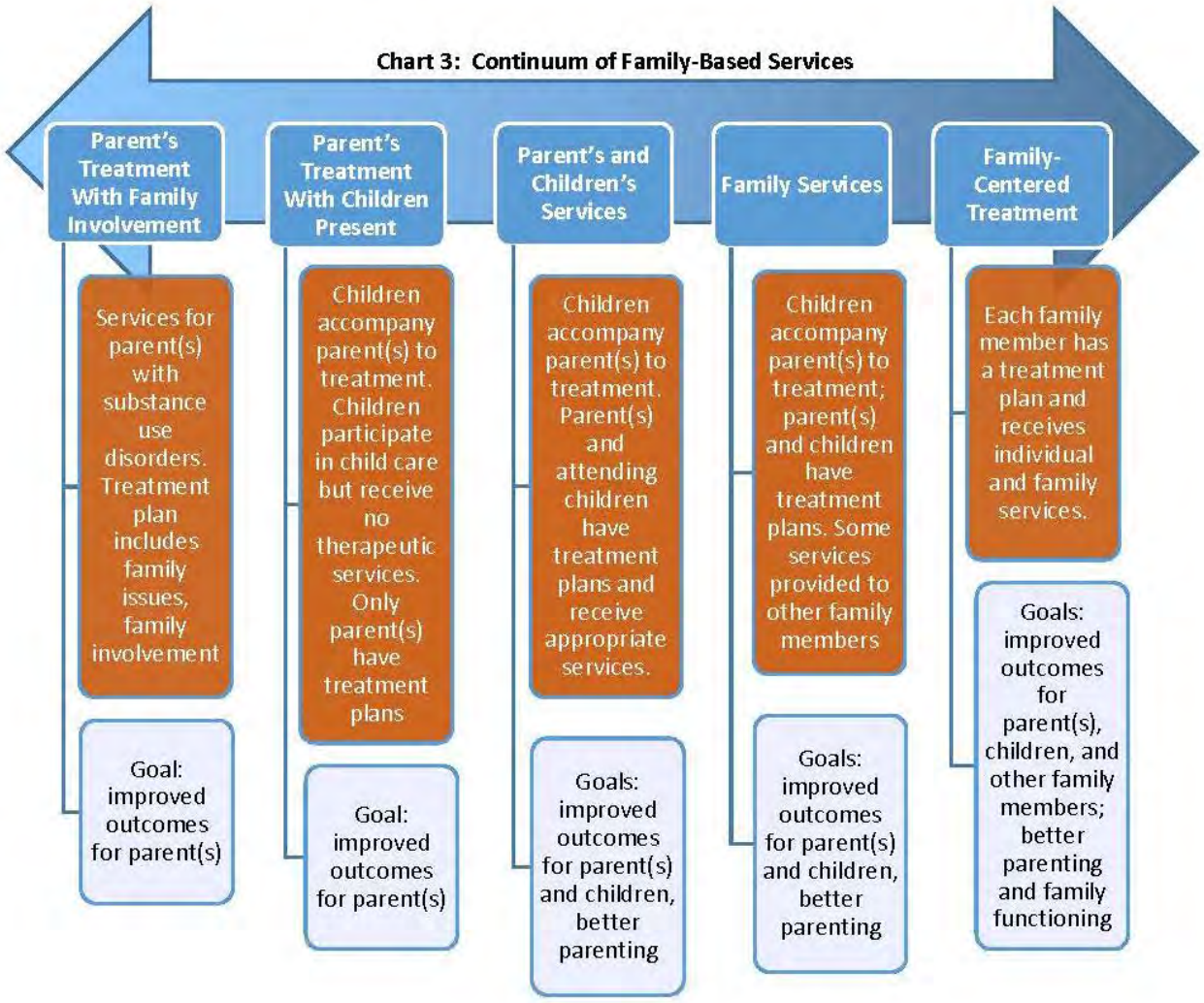
1. How do the collaborative partners view the disease of addiction? Are relapse and recovery viewed as long-term disease management issues or as acute care episodes? Is there a coordinated, collaborative response to relapse for parents in treatment?
2. How do treatment and recovery timelines work with or against permanency planning timelines, especially from the perspective of the child?
3. How is screening addressed in each system? Is child welfare regularly screening parents for substance use disorders? Are treatment professionals screening for child safety and parenting capacity?
4. What criteria are used to determine the substance abuse treatment modality the parent is referred to or engaged in?
5. What practices are being used by the collaborative to deliver effective treatment while minimizing wait times? How quickly are parents engaged in substance abuse treatment?
6. Are there policies or practices in place that are barriers to accessing MAT?
7. How has the collaborative decided to work with parents who use MAT? If an infant is born dependent to MAT, to a mother who is engaged in recovery, will the collaborative work with the family to send that child home?
8. Is MAT available to an expectant mother? Does the collaborative work to swiftly engage a mother on MAT to avoid possible negative effects to the fetus?
9. What is the communication protocol between collaborative partners? Have agreements and protocols been developed for sharing clinical and case information (e.g. treatment success or relapse)? What written agreements exist to address issues of confidentiality?

FAMILY WELL-BEING: WHY EFFECTIVE CHILD WELL-BEING STRATEGIES MUST ADDRESS IT

Substance abuse by one family member affects the entire family. When a parent has a substance use disorder it can undermine the family system, breaking apart binding relationships and fracturing the balance of the family system. Substance use disorders are family diseases because there can be an intergenerational transmission that affects the entire family unit and its individual members. Subsequently, treatment must be family-centered, addressing the impact of substance use disorders on every family member. Family-centered treatment should provide comprehensive services to help return families to a healthy, functional state where the well-being of all family members is supported and parents are able to provide a safe and nurturing environment for their children. Family-centered treatment offers a solution to the intergenerational cycle of substance use, abuse and neglect, and related consequences, by helping families reduce substance use and improving child well-being and safety.

Family-centered treatment grew out of the residential programs for pregnant and parenting women that developed in the early 1990s. These programs were designed to support women bringing infants and small children with them to residential treatment. The concept was that

these women could continue to meet their parenting responsibilities while bonding with children was protected and childcare was provided. These supports allowed for women's participation in treatment while staying connected to their children. These programs continue to serve women, who are the majority of participants in dependency courts and family drug courts, underscoring the importance of gender-specific treatment. As family-centered treatment becomes a priority, communities have begun to develop initiatives aimed at engaging fathers in treatment services. These initiatives range from offering residential treatment for fathers and their children, to altering the times of family drug court hearings to be conducive to parents' work schedules. Effective treatment should be individualized, trauma-informed, gender- and cultural-specific, and provide opportunities for improving parent-child interaction and relationships.



EFFECTS ON CHILDREN

Children from homes characterized by parental substance use disorders often experience considerable chaos and an unpredictable home life. They may receive inconsistent emotional responses and inconsistent care from substance using adults. Issues of abandonment and emotional unavailability are themes one finds in children of parents with substance use disorders.

Children respond in different ways to parental substance abuse. Teachers and others may see a child as withdrawn and shy. Conversely, a child may be explosive and express rage. Some children strive to be perfect, while others become family caretakers by assuming responsibility for other siblings and by "parenting" their parents. As these children enter adolescence, they may begin to experience the early signs of substance use disorders. Emotionally and developmentally, an abused or neglected child of parents with substance use disorders is likely to develop issues with trust, attachment, self-esteem, and autonomy.

Services to children must be addressed by the collaborative, as treating the parents alone ignores the effects of substance abuse on the children. Services such as developmental assessments and early intervention for children should be trauma-informed and family-oriented. Parental drug treatment, in which parents feel secure and trust the provider, provides an ideal time to assess children, identify their therapeutic needs, and provide services accordingly. If the cycle of substance abuse cannot be interrupted in a family, children will likely repeat the same pattern of substance abuse, and child abuse and neglect in which they were raised.

Child well-being is inextricably linked to family well-being and a parent's capacity to care safely for and nurture their children.

Parents with substance use disorders are inconsistent in their child rearing. Addressing children's needs, becoming interactive and engaged with children, and accepting the subtle successes of parenthood are not easy tasks. For the parents, previous personal history of childhood abuse and trauma can result in parenting problems, as well as increasing the likelihood of substance use disorders. Family-centered treatment programs can offer evidenced-based parent-child interventions to help develop parent-child bonding and parental capacity. Treatment programs can offer a safe place to integrate learned skills by supporting frequent, quality visits with children in out-of-home placement. Recovery and well-being occur in the context of family relationships; family-centered treatment and recovery offer a path to family well-being.

SUBSTANCE EXPOSED NEWBORNS

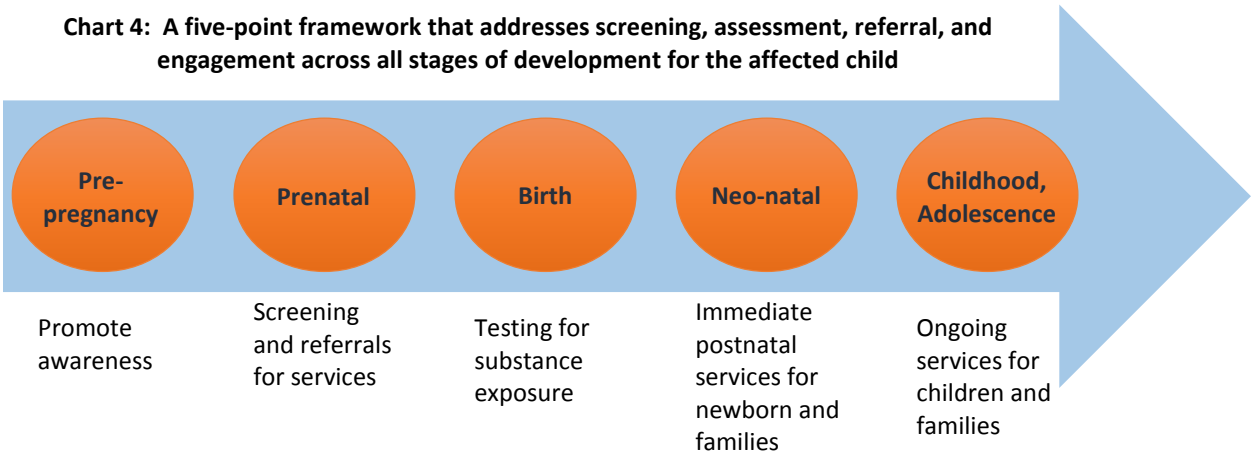
Each year, an estimated 400,000 – 440,000 infants (10–11 percent of all births) are affected by prenatal alcohol or illicit drug exposure (Young, Gardner, and Otero). Prenatal exposure to alcohol, tobacco, and illicit drugs has the potential to cause a wide spectrum of physical, emotional, and developmental problems for these infants. The harm caused to the child can be significant and long-lasting, especially if the exposure is not detected and the effects are not treated early. Most of these infants are not identified as prenatally-exposed, despite federal legislation in the Child Abuse Prevention and Treatment (CAPTA) amendments of 2010 that requires states to have a plan for safe care of prenatally-exposed infants and a plan for receiving referrals of such births from child protective services.[i] The intent of these agreements is to enable mothers' enrollment in treatment and to ensure safety for children.[ii]

Prenatal substance exposure is often viewed from a narrow perspective focused primarily on the birth event (i.e. identification of prenatally-exposed newborns through toxicological testing and screening for maternal risk factors).

Prenatal substance exposure should be viewed from a comprehensive, family-based perspective that extends beyond the birth event to include the wider issues of pre-pregnancy prevention, prenatal, and postnatal intervention, and support for affected children throughout childhood and adolescence.

A broader view (depicted in Chart 4) addresses the prevention and treatment of substance disorders among women of childbearing age, pregnant women, and parents, as well as the ongoing effects of these disorders on the women's children and families.

Chart 4: A five-point framework that addresses screening, assessment, referral, and engagement across all stages of development for the affected child



Substance abuse treatment provides an opportunity to intervene and engage pregnant women at risk of delivering a substance exposed infant. Health care providers should screen for early identification, refer for comprehensive assessments, and make a timely connection to appropriate substance abuse treatment services. Treatment for women requires that the focus of treatment be organized around maintaining affiliations and creating healthy connections to others, especially children and other family members. Such treatment provides a full range of services to address the array of problems women with substance use disorders, their children, and other family members must tackle to reduce substance use and improve individual and family outcomes (Werner, Young, Dennis, and Amatetti). Family-centered treatment attempts to treat the family through a comprehensive strategy that addresses the bio-psycho-social-spiritual nature of substance use disorders, and seeks to capture the critical components needed to address the multi-faceted needs of families.

Elements of Effective Family-Centered Treatment include:

1. Family-centered treatment is comprehensive
2. Women define their families
3. Treatment is based on the unique needs and resources of individual families
4. Families are dynamic, thus treatment must be dynamic
5. Conflict is inevitable but resolvable
6. Meeting complex family needs requires coordination across systems

7. Substance use disorders are chronic, but treatable
8. Services must be gender-responsive, individualized, and culturally competent
9. Family-centered treatment requires an array of staff professionals, as well as an environment of mutual respect and shared training
10. Safety comes first
11. Treatment must support creation of healthy family systems

IMPLICATIONS FOR COLLABORATIVE PRACTICE

Understanding the type of exposure that children have experienced is critical to meeting their safety, prevention, intervention, and treatment needs. Exposure can include prenatal exposure to alcohol or other drugs, family environments that are not nurturing or safe as a result of addiction, or communities in which drug cultivation, manufacturing, or sales are pervasive. Children's services must include an assessment of the child's individual strengths and challenges that addresses the full range of potential physiological, developmental, social-emotional, and behavioral effects of the child's exposure to substance use disorders and child abuse or neglect.

Questions a collaborative should ask include:

1. Does the collaborative include a broad array of community service providers to address the families' long-term recovery needs?
2. Are all children screened for developmental delays in a way that eliminates duplication across systems?
3. Are agreements in place to provide children age 0-3 access to early intervention services, other developmental services, and mental health services?
4. Does the data being tracked include CAPTA notifications by health care professionals to child welfare services? If so, how many children are assessed for developmental impact of substance exposure, and how many children receive early intervention or Part C services?
5. How is child development information shared across systems?
6. Is there a process for screening all adolescents involved in child welfare system for substance use disorders? Does the collaborative have an efficient system for referral and service engagement for these adolescents?

WHAT'S WORKING: EMERGING COLLABORATIVE SOLUTIONS

As introduced earlier in this briefing, collaborative practice between the dependency court, child welfare, substance use treatment, and other services systems offers a multitude of practical strategies and solutions to improve outcomes for child welfare involved families affected by substance use disorders. No single system or set of workers has the authority, capacity, or skills to respond to the array of challenges faced by families with substance abuse disorders who become known to the child welfare system. Partnerships that reach across system boundaries are needed to provide families with the comprehensive services necessary to ensure family well-

being, recovery, and child safety. Collaboration among child welfare, substance abuse, and court systems is necessary if families are to succeed, but effective collaboration at all levels of each system is not simple to accomplish and requires much more than convening a meeting to share information.

The National Center on Substance Abuse and Child Welfare (NCSACW) has developed a 10-Element Framework and set of policy tools to help dependency courts, child welfare agencies, and substance abuse treatment providers establish cross-system collaborations to improve outcomes for child welfare involved families affected by substance use disorders. For cross-system collaboration to be effective and sustainable, the following ten areas should be addressed:

1. Underlying values and principles of collaborative relationships
2. Daily practice in AOD screening and assessment
3. Daily practice in engaging and retaining parents
4. Daily practice in services to children of substance abusers
5. Joint accountability and shared outcomes
6. Efficient communication and shared information systems
7. Budgeting and program sustainability
8. Training and staff development
9. Working with other agencies
10. Working with the community and supporting families

As systems move towards collaboration, there are a variety of tools and resources to aid in the process. Collaborative tools should be assessed based on their ability to:

1. Assist partnerships with establishing a baseline understanding of key processes and practices
2. Help collaborative groups understand challenges in working together, and provide approaches and methods to address those changes
3. Frame choices facing collaborative groups when defining their shared mission, and in monitoring whether they are achieving shared outcomes for families they are serving

No one tool alone will be a magic bullet to collaboration, but if a handful of thoughtfully selected tools are used as part of a larger collaborative effort, by a group of committed professionals across agencies and systems, institutional changes are possible.

More information on the 10-element framework and examples of collaborative tools, can be found here: http://www.cffutures.org/files/PracticeModel.pdf

While there is no one model of effective collaborative practice, there are common elements associated with improved outcomes for children and families. The following discussion provides examples of collaborative practices that have demonstrated positive results.

FAMILY DRUG COURTS

The Family Drug Court (FDC) model is characterized by court-based collaboration among child welfare, substance abuse treatment providers, and the legal system. Its design seeks to protect children from abuse and neglect through timely decisions, coordinated services, provision of substance abuse treatment, and safe and permanent placements (Young, Wong, Adkins, and Simpson). In 2013, the Center for Children and Family Futures (CCFF), under a contract with the Office of Juvenile Justice and Delinquency Prevention Office of Justice Programs, published *Guidance to States: Recommendations for Developing Family Drug Court Guidelines* (Available at http://www.cffutures.org/files/publications/FDC-Guidelines.pdf). CCFF utilized research, practice-based evidence, expert advisers, and existing state standards to develop this resource tool to outline the FDC principles and assist states in developing state-specific guidelines that reflect their own needs and context. The guidelines provide a collaborative framework for building a foundation of shared mission and vision to support client services and agency collaboration, and achievement of shared outcomes. The guidelines include 10 recommendations for implementing FDCs:

1. Create a shared mission and vision
2. Develop interagency partnerships
3. Create effective communication protocols for sharing information
4. Ensure cross-system knowledge
5. Develop a process for early identification and assessment
6. Address the needs of parents
7. Address the needs of children
8. Garner community support
9. Implement funding and sustainability strategies
10. Evaluate shared outcomes and accountability

FDCs have shown positive outcomes including higher treatment completion rates, less time in out of home care, less time to reunification, and cost-savings. Over the past decade, the number of FDCs have grown, with current estimates indicating that FDCs are serving between 10 and 20 percent of families with substance use disorders in the child welfare system nationally. While this is a substantial number of families, it still leaves opportunities for tremendous growth. A national discussion is emerging on infusing core drug court processes into the broader dependency court system. Several state court improvement offices have initiated strategies to strengthen collaborative practices among courts, child welfare, substance abuse, and mental health systems by expanding the number of family drug courts, the number of families they can serve, or by developing a system that incorporates core FDC processes in dependency courts. The core processes, or six key ingredients, offered by FDCs that have demonstrated positive outcomes include:

1. A system of identifying families in need of treatment services
2. Earlier access to assessment and treatment services

3. Increased judicial oversight
4. Increased management of recovery services and compliance
5. Responses to participant behaviors (sanctions & incentives)
6. Collaborative approach across service systems and court

REGIONAL PARTNERSHIP GRANTS

The Regional Partnership Grant (RPG) program was created through the Child and Family Services Improvement Act of 2006, which reauthorized the Promoting Safe and Stable Families program (PSSF). The legislation included a new competitive grant program funded by the Children's Bureau in the Administration on Children, Youth, and Families. Over a five-year period, 53 sites were awarded grants to implement regional partnerships with the purpose of improving outcomes for children and families affected by methamphetamine and other drugs. The legislation was reauthorized in 2011, allocating funds for 17 RPG-II awards, and two-year extensions to eight RPG-I sites. Over the course of the five-year grant period, grantees provided services to almost 18,000 adults, over 25,000 children, and 15,000 families. Outcome data collected through the RPG program has resulted in the largest data set ever compiled on families with substance use disorders in or at risk of entering the child welfare system.

> The results of the RPG program demonstrate that when collaborative partnerships provide timely access to effective services, positive outcomes for this population can be achieved.

Highlights from the RPG program outcomes include:

- 92.0% of children who were in the custody of their parent or caregiver at the time of RPG program enrollment remained at home through RPG program case closure
- Within the first six months following RPG program enrollment, only 4.2% of children experienced maltreatment
- 63.6% of children were reunified within 6 months; almost 18% were reunified in less than 3 months
- Only 7.3% of children re-entered foster care at any point within 24 months following reunification
- Parents/caregivers entered substance abuse treatment within 13 days of entering the RPG program; 36.4% entered treatment within 3 days
- 65.2% remained in substance abuse treatment more than 90 days
- The majority of adults (between 61.1% and 76.2% depending on the substance) reduced their use of alcohol, marijuana, cocaine, methamphetamine, and heroin
- The percentage of adults employed (full or part time) increased significantly from 22.8% to 41.3%
- 80% reported decreased criminal behavior (among adults with any recent arrests prior to treatment admission)

These grantees illustrate successes and challenges in establishing and sustaining cross-systems collaboration and service integration. Key program implementation lessons emerged from the experiences of these 53 grantees. These lessons include:

- Collaboration is essential to address the complex and multiple needs of families and to sustain integrated service delivery.
- Establishing collaborative cross-systems linkages and effective sustainability planning takes time and is developmental and iterative in nature.
- The collaborative must continually assess its progress and adapt its program and services to meet families' unmet and emerging needs and to facilitate client engagement and retention.
- Treating the family system is far more effective in addressing a family's underlying and complex issues than working with an individual child or adult in isolation.
- Broadening the partnership beyond child welfare and substance abuse treatment to work with other community agencies is critical to securing important core treatment and supportive services.
- Clear roles, responsibilities, and expectations are required of partners, providers, and families to promote both individual and shared accountability.
- Ongoing communication, information sharing, monitoring, and supervision are crucial at both the system and direct service levels.
- The partnership and program need to be integrated into existing systems' efforts and infrastructures, and all available resources need to be leveraged to facilitate sustainability.

For more information in the RPG program, please see *Targeted Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Methamphetamine or Other Substance Abuse: First Annual Report to Congress*.

http://www.cffutures.org/files/RPG%20Third%20Report%20to%20Congress%20with%20Appendices.pdf

IN-DEPTH TECHNICAL ASSISTANCE

NCSACW provides In-Depth Technical Assistance (IDTA) to state, county, and tribal sites. Since 2003, the NCSACW has worked with 23 separate jurisdictions. NCSACW works with these sites to strengthen collaborative practices and policies by developing a Scope of Work for the in-depth technical assistance that includes working with the substance abuse, child welfare, and court systems, as well as local tribes. NCSACW's Consultant Liaisons facilitate the development of a strategic plan tailored to the needs of each site, identifying and bringing in additional technical assistance as needed by the site, and assist the site in the implementation of the plan.

Through the IDTA project, NCSACW has worked with two sites that have been very successful in their efforts to improve outcomes for child welfare families affected by substance use by leveraging multiple initiatives in their jurisdictions. The examples of these efforts in Nebraska and Iowa can offer lessons to the field. In both states, the Court Improvement Project (CIP) in

the offices of state court administration was the lead agency in developing and implementing innovative strategies that have resulted in positive outcomes. Their individual stories follow below:

NEBRASKA

In the State of Nebraska the Judicial Branch, Center on Children, Families and the Law was the lead agency on three major initiatives: the Court Improvement Project (CIP) *Through the Eyes of the Child*; In-Depth Technical Assistance through the NCSACW; and, the Children Affected by Methamphetamine (CAM) Grant. All three initiatives were implemented in partnership with several other agencies, including:

- Child Welfare
- Behavioral Health
- Medicaid
- Public Health
- Parent/Family Advocate
- Managed Care
- Courts

Through their Court Improvement Project, the state undertook a case review of 400 randomly selected case files of child abuse/neglect court cases. Anecdotally, judges knew that the identification of parental substance use often did not occur until after adjudication, three or more months into the case, which typically resulted in poor outcomes for the family. An extensive review of these cases yielded the following major findings:

- 56% had parental substance abuse as contributing problem
- High co-occurrence of mental health (85%) and domestic violence (40%)
- Median time from petition to entry into treatment was four months
- Many parents received only a low dose of treatment, typically consisting of eight weekly sessions of outpatient care
- Drug testing was frequently used without treatment; 1/3 of cases had only regular UA testing with no treatment
- Many substance abusing parents "drop off" the treatment trajectory

Policy and practice changes resulting from the various initiatives include:

- An enhanced Family Treatment Drug Court
- A specialized Substance Abuse Court docket

- An increased focus on child well-being—especially for infants/toddlers in child welfare system
- Adoption and dissemination of shared principles and recommended cross-agency protocol
- The development of "Better Together" – a combined substance abuse treatment/housing model
- State leaders addressed problems with the Medicaid system that inhibited parents' access to treatment when children were not in their care
- A shift in understanding across all partners that addiction is a chronic, progressive, intergenerational disease that requires treatment to get better
- An understanding of the impact of prenatal substance exposure on a child's brain development, and the services that NAS children need whether they are living at home or are in out-of-home placement
- The adoption of Child/Parent Psychotherapy (CPP) with families participating in five FDCs in three counties. The utilization of this evidence-based program has resulted in enhanced identification of families' needs and in determining parenting ability and progress. At a system level, the project has resulted in the addition of CPP as a covered service under Medicaid. Previously, children under the age of three were not covered under Medicaid for Infant Mental Health Services.

For more information, please contact Victoria Weisz, Nebraska Court Improvement Director, at vweisz1@unl.edu.

IOWA

The Iowa State Supreme Court Administration, Judicial Branch of Iowa was the lead agency on three major initiatives in Iowa: The Iowa Children's Justice Council (formerly known as the Court Improvement Project); IDTA; and, two Promoting Safe and Stable Families funded Regional Partnership Grants (RPG-I & II). In RPG-I, FDCs were established in six counties, with the sites demonstrating improved outcomes for children and families. The State was funded through the RPG-II program to broaden services to non-FDC families, or to all substance-involved families with children who have been placed, or at risk for placement, in foster care. There is a significant focus on child and family well-being and addressing trauma for both children and their families. Partners in these initiatives included:

- Department of Human Services (DHS), State Child Welfare Agency
- Department of Public Health, State Substance Abuse Agency
- Office of Drug Control Policy

Prior to seeking technical assistance or grant funding, Iowa state partners identified the following concerns:

- 70% of the open cases in DHS were due to parental substance abuse
- In 2007 Iowa was ranked 3rd in the nation in terms of methamphetamine use

- Termination of Parental Rights were rising as families with parental substance abuse could not meet ASFA guidelines
- Cross-systems collaboration was critical to successfully serving families

Iowa's initiatives have resulted in a range of practice and policy changes, including:

- The first treatment court was started with no extra funding, when the state child welfare agency and substance abuse treatment agency were asked to work together differently
- A Cross-systems Memorandum Of Understanding was established, detailing how the departments work collaboratively
- A joint drug-testing protocol and bench card were developed
- Multi-disciplinary release form and information sharing protocol between state agency and substance abuse agencies was created
- Institutionalized early substance abuse assessments and entry into treatment for parents
- Conduct regular, frequent judge-led court hearings
- Ensure recovery support services for families throughout life of case and up to a year beyond official case closing
- Provide coordinated delivery of services for families
- Conduct multi-disciplinary training to broaden professional knowledge, including agreement to take part in online learning opportunities available on the NCSACW website
- Selected evidence-based practice models, including Strengthening Families, Celebrating Families!, and Recovery Support Specialists
- Provide an annual update to legislature

The RPG data has demonstrated the following outcomes:

- **77%** of the children remained in the custody of their parent
- For those children who were removed, 78% were reunified in less than 12 months
- 94% of the children did not have a recurrence of maltreatment within 6 months of entry into the program
- 98% of the parents entered substance abuse treatment (versus a 68% entry rate for the matched comparison group)

For more information, please contact Gail Barber, Director of Iowa Children's Justice State Court Administration, at gail.barber@iowacourts.gov.

SUSTAINING COLLABORATIVE INITIATIVES

The Children's Bureau required regional partnership grantees to address how their programs would be sustained when awarding discretionary grants to applicants. CCFF, with the support and participation of Federal Project Officers, provided focused technical assistance to the grantees to develop and implement sustainability strategies. Sustaining their programs has been challenging for grantees, as the Great Recession began during the first year of RPG implementation, often resulting in funding cuts to partners' services and staff. In addition to barriers related to the economic climate, the RPG sites experienced other barriers, including staff turnover and retention and difficulty engaging key leadership stakeholders. Despite these challenges, 33.3 percent of grantees sustained their entire project, slightly more than half sustained specific components or a scaled down or modified version of the project, and almost 75 percent of the major services and activities provided as part of the RPG program have been sustained.

Overwhelmingly, grantees achieving higher levels of collaboration had higher rates of sustainability than those grantees at lower levels of collaboration.

Themes that emerged from the RPG programs, as mitigating factors for facilitating sustainability, include:

- Experienced and consistent project leadership
- Grantees experiencing higher levels of collaboration (e.g. changing rules or systems changes) had higher rates of sustainability than those grantees at lower levels of collaboration (e.g. information sharing).
- Ability to demonstrate program efficacy and results
- Ability to identify and engage key leadership and stakeholders in sustainability conversations
- Successful financing strategies, including widening the definition of available or potential resources, redirection of existing funding sources, negotiation of third party payments, integrating new practices or programs with other improvements or initiatives, transitioning services and staff to partners, and joining with larger health care reform and care coordination efforts

Sustainability can have multiple meanings when working with health and human services programs. It can refer to a program that is refunded, a successful program that is replicated and expanded, or a much broader impact when an innovation is fully institutionalized. Tapping into the full range of funding or other resources available to a state or community, for comprehensive services to families, is the only way to develop multi-year stability for innovative cross-system approaches. Sustainability planning should include multiple strategies as agencies and systems utilize varied approaches, such as legislation, administrative rules, operating procedures, or services contracts to institutionalize their policy and practice changes. When federal and other one-time funding is time-limited, sustaining a project with other funding and support becomes an important task for project managers and agency leadership. Collaborative initiatives will not be

sustained solely by obtaining another federal grant. Tapping into funding or services capacity that already exist in a community provides a larger resource pool than is available through grant funding. The regional partnership grantees demonstrated that those partnerships with a high level of collaboration (changing the way they do business) had greater success in sustaining their programs.

The collaborative strategies regional partnership grantees used to conduct sustainability planning included: developing and maintaining steering or leadership committees; holding regular cross-system meetings to identify and problem solve funding challenges and methods; and, reporting key quantitative and qualitative data. Sustainability planning must be initiated from the beginning of a collaborative effort. If these issues are deferred until the final year of the project, replacement or expansion funding will be harder to find than if a full sustainability plan is developed during the early phases of external funding.

Sustainability planning requires a series of six logical steps that move from the project's launching to its results, and on to future funding:

1. Inventory current funding
2. Identify potential targets for future funding
3. Document the effectiveness of the innovation to prospective funders
4. Select priorities for redirected or other funding sources
5. Assess sustainability options in terms of political support
6. Institutionalization

For more information:
http://www.cffutures.org/files/publications/Sustainability%20Discussion%20Guide.pdf

CONDUCTING A COST STUDY: THE PROMISE AND CHALLENGE

While cost studies (i.e., cost determination, cost-effectiveness analysis, or cost-offset analysis) should be an important component of effective sustainability strategies, most collaborative partnerships are challenged with designing and implementing these studies. Producing a detailed cost study is a significant challenge due to the complexity of documenting all costs and benefits across multiple systems. RPG collaborative groups included service providers from many different agencies and community-based organizations, an array of integrated and specialized services, and support from several different funding streams (in addition to the RPG funding), as well as in-kind expenses and matching dollars. Grantees reported difficulties in obtaining partner buy-in and support for cost analysis. This may largely have been a function of the fiscal environment during the grant period, when time and resources were increasingly restricted, and the substantial evaluation requirements of the RPG program.

Nonetheless, by the end of the grant period, nearly one-third (32.1 percent) of regional partnership grantees had either completed, were currently conducting, or were in the planning stages of a cost analysis or cost studies. Several grantees reported promising results, primarily related to cost benefits from reduced lengths of stay in foster care and increased and expedited

reunifications. One grantee reported cost avoidance of $3.51 million to $6.75 million in out-of-home care costs as result of their program. For every $1.00 spent on the program, the State saves up to $2.52 on the cost of out-of-home care.

A regional partnership grantee, who implemented the *Strengthening Families Program*, found the typical child participant spent 190 fewer days in out-of-home care compared to a comparison group of children in out-of-home care. With an average out-of-home care state rate of $86 per child per day, the program saved approximately $16,340 in out-of-home care costs per child. Every $1.00 invested in the program yielded an average savings of $9.83 (Johnson-Motoyama, Brook, Yan, and McDonald).

In three published studies of family drug courts in Baltimore, Maryland (Burrus, Mackin, and Finigan), Jackson County Oregon (Carey, Sanders, Waller, Burrus, and Aborn), and Marion County Oregon (Carey, Sanders, Waller, Burrus, and Aborn), evaluators identified cost savings per family of $5022, $5593, and $13,104, respectively.

CONCLUSION

Subsequent to the passage of the Adoption and Safe Families Act in 1997, the report to Congress, *Blending Perspectives and Building Common Ground,* identified five national goals to improve outcomes for children and families in the child welfare system affected by parental substance use disorders. The goals included:

1. Building collaborative relationships
2. Assuring timely access to comprehensive substance abuse treatment services
3. Improving our ability to engage and retain clients in care and to support ongoing recovery
4. Enhancing children's services
5. Filling information gaps

At that time, there was limited knowledge and experience about the best strategies for achieving these goals, nor was there evidence as to which specific strategies might actually improve outcomes for children and families. Through the leadership of SAMHSA, the Children's Bureau within the Administration on Children, Youth, and Families, and the Office of Juvenile Justice and Delinquency Prevention, multiple initiatives have been implemented to try to answer the question, *What Works for Families Affected by Substance Use Disorders?,* particularly for those families in or at risk of entering the child welfare system. These initiatives included the creation of the National Center on Substance Abuse and Child Welfare, three rounds of Regional Partnership Grants, and other discretionary grant programs such as Fostering Connections, Abandoned Infants Assisted Funded Projects, Children Affected by Methamphetamine, and Family Drug Courts. Through the innovation and commitment of state, county, tribal, and community-based agencies, evidence has emerged that collaborative policy and practice models are essential to serving these families. We have learned that there is no single model, tool, or magic bullet that will achieve better outcomes. Success for these families starts with a cross-system commitment and shared value that children and families can recover from the effects of

substance use disorders. This briefing summarizes what the experience and evidence tell us about what works for children and families. We can no longer say, "*We don't know what to do.*" Now we must ask ourselves if we have the resolve and leadership necessary to transform the best practices from these initiatives into standard practice throughout child welfare, substance abuse treatment, and court systems. Considering the prevalence of substance use disorders among families in the child welfare system, can we afford not to?

Resources for substance use disorders and child welfare, family-centered treatment, and prenatal exposure to substances:

Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Legal Professionals

http://www.ncsacw.samhsa.gov/tutorials/tutorialDesc.aspx?id=3

Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals

http://www.ncsacw.samhsa.gov/tutorials/tutorialDesc.aspx?id=1

Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers

http://www.ncsacw.samhsa.gov/files/Understanding-Substance-Abuse.pdf

http://www.ncsacw.samhsa.gov/tutorials/tutorialDesc.aspx?id=2

Family-Centered Treatment for Women with Substance Use Disorders History, Key Elements, and Challenges

http://womenandchildren.treatment.org/documents/Family_Treatment_Paper508V.pdf

Substance Exposed Infants: State Responses to the Issue

http://www.ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf

Screening and Assessment for Family Engagement, Retention, and Recovery:

http://www.ncsacw.samhsa.gov/resources/SAFERR.aspx

Resources for Collaboration and Sustainability:

A Discussion Guide for the Sustainability of Programs for Children and Families

http://www.cffutures.org/files/publications/Sustainability%20Discussion%20Guide.pdf

The Collaborative Practice Model for Family Recovery, Safety, and Stability:

http://www.cffutures.org/files/PracticeModel.pdf

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[ii] Children's Bureau, Administration for Children and Families. (2014). *Adoption and Safe Families Act of 1997 P.L. 105-89.* Retrieved from https://www.childwelfare.gov/systemwide/laws_policies/federal/index.cfm?event=federalLegislation.view