Family-Based Facilities for Treating Substance Use Disorders: A Title IV-E Funding and Planning Brief

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Abstract

Current research has found that when parents can access family-based substance abuse treatment programs and can enter treatment while able to live with their children, they are much more successful in completing the program and, more importantly, in continuing to improve their capacity to care for their children. This funding and planning brief outlines some of the planning dimensions that states could consider as part of providing more fiscal support for the child's care (foster care maintenance) while placed with a parent in family-based substance use residential treatment, using Title IV-E, Medicaid, and other funds. It also highlights some material from two high quality and comprehensive resources that are essential reading for anyone considering this kind of program:

- ASPE. (2021). *How some states use Title IV-E foster care funding for family-based facilities that treat substance use disorders*. https://aspe.hhs.gov/sites/default/files/2021-09/FFPSA_family_based_facilities.pdf
- Children and Family Futures, ChildFocus, and the National Association of State Alcohol and Drug Abuse Directors. (2023). *Implementing the Substance Use Disorder Provisions of the Family First Prevention Services Act: A Toolkit for Child Welfare and Treatment Stakeholders.* Irvine, CA: Children and Family Futures. https://cffutures.org/files/aecf/SUD_Toolkit_Combined_FINAL.pdf

Table of Contents

Acknowledgements

Prepared by the Arizona Substance Abuse Treatment Planning Team:

Casey Family Programs: Meghan Bishop, Christine Calpin, Geoff Cloepfil, Anita Fineday, Monte Fox, Janet Garcia, Jakki Kolzow, Peter J. Pecora, Toni Rozanski, Mike Scholl, Aakanksha Sinha, Joan Smith, and Willeen Whipple.

***Consultants*:** Dan Aune, Melissa Jaacks, and Don Winstead.

***Native Connections*:** Dede Devine, John Godfrey, and Andrea Klimas.

State child welfare experts:

- Deborah Beske-Brown Minnesota Department of Human Services. E-mail: deborah.beske.brown@state.mn.us
- Kyla Clark, Service Continuum Administrator, Utah Division of Child and Family Services, Cell: 801-755-6278, kaclark@utah.gov
- Kevin Jackson, Assistant Director, Utah Division of Child and Family Services, Cell: 801-739-3870, kevinjackson@utah.gov
- Cosette Mills, Federal Operations Administrator, Utah Division of Child and Family Services, Cell: 385-242-5482 E-mail: cwmills@utah.gov
- Maxie Ann Rockymore, MSW, Manager, Foster Care & Title IV-E Program, Minnesota Department of Human Services. (Recently retired.)

Both the Minnesota and Utah state managers graciously sent us a portion of their Title IV-E State Plan that they amended to expand their access to federal funding in support of families and children in residential treatment programs. Note that while Minnesota has created some infrastructure for accessing Title IV-E funds for this service, it has not yet claimed anything for this program.

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For more information about how this planning brief was developed, contact Peter J. Pecora at PPecora@casey.org.

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Introduction

Parent substance abuse is a key reason why many children are separated from their families and placed into foster care, and this dynamic has been present for decades.[1] Early identification of parental substance use and access to assessment, treatment and other services is critical. Substance use disorder treatment is individualized and based on a clinical assessment to determine the appropriate treatment plan, such as the modality of treatment (e.g., outpatient, in-patient) and type of intervention.[2] There are a variety of evidence-based interventions such as medication assisted treatment for opioid and alcohol use disorders; motivational enhancement therapy; and family, individual or group counseling, among others.[3] In some instances, parents/caregivers will need in-patient treatment, as determined by the clinical assessment. Current research has found that when parents can access family-based treatment programs and can enter treatment while able to live with their children, they are much more successful in completing the program and, more importantly, in continuing to improve their capacity to care for their children.[4]

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[1] For example, parental drug or alcohol substance use was one of the reasons why children were placed in out of home care in 42 percent of the children placed in 2021, as reported by 50 state child welfare data systems to the Adoption and Family Care Analysis and Reporting System. But other research studies have found that the percentage of children placed in care because of parental substance use as one of the reasons to be much higher, up to approximately 80%. There is variation in this prevalence among states as well as in the phase and type of child welfare case (e.g., during the assessment of the child maltreatment report, whether the family is receiving in-home or out-of-home care services). These variations are attributed to differences among state child welfare systems in how parental substance use is identified and recorded in data systems. See U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau (2022). *The AFCARS report preliminary FY 2021 estimates as of June 28, 2022. (No. 29).* Washington DC: US Department of Health and Human Services. Retrieved from https://www.acf.hhs.gov/cb/report/afcars-report-29. Seay, K. (2015). How Many families in child welfare services are affected by parental substance use disorders? a common question that remains unanswered. *Child Welfare*, 94(4):19-51.

[2] National Institute on Drug Abuse. (2014). *Principles of drug addiction treatment: A research-based guide (Third Edition).* Accessed January 5, 2024 from https://nida.nih.gov/sites/default/files/podat-3rdEd-508.pdf

[3] In addition, synthetic opioids are being used as treatment strategies because they reduce cravings for more dangerous drugs, which significantly reduces the fatal overdose rate among those who take them. See Shapiro, N. (2023) What most people think about opioid treatment is wrong. *Seattle Times.* https://www.seattletimes.com/seattle-news/what-most-people-think-about-opioid-treatment-is-wrong-wa-researcher-says/

[4] See for example:

- Grella, C. E., Needell, B., Shi, Y., & Hser, Y. I. (2009). Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of Substance Abuse Treatment*, 36(3), 278-293.

The Family First Prevention Services Act, Public Law (P.L.) 115-123 (FFPSA), enacted February 9, 2018, amends Title IV-E of the Social Security Act to provide reimbursement to states, territories, and eligible tribal nations for a portion of the foster care maintenance payments for children placed with a parent receiving services in a licensed residential substance use disorder (SUD) treatment program. This Act allows states, territories, and eligible tribal nations to claim Tittle IV-E foster care reimbursement for services for three groups of children regardless of parental income: (1) children in foster care whose care plan specifies their placement with a parent in a residential family-centered SUD treatment setting; (2) children not in foster care who are deemed at imminent risk of entering foster care for whom evidence based SUD services are needed to prevent placement; and (3) youth already in foster care who are pregnant or parenting and whose case plan includes evidence-based SUD services.

Based on the experience of Minnesota and Utah, this funding and planning brief outlines some of the planning dimensions that states, territories, and eligible tribal nations could consider to access additional federal fiscal support for the child's care (foster care maintenance) while placed with a parent in family-based substance use residential treatment, using, Title IV-E foster care, Medicaid, and other funds.[5] (Note that while it is possible to use Title IV-E prevention funds for this purpose, MN and UT are not currently doing so.)

The brief also highlights some material from two high quality and comprehensive resources that are essential reading for anyone considering this kind of program:

- ASPE. (2021). *How some states use Title IV-E foster care funding for family-based facilities that treat substance use disorders*. https://aspe.hhs.gov/sites/default/files/2021-09/FFPSA_family_based_facilities.pdf
- Children and Family Futures, ChildFocus, and the National Association of State Alcohol and Drug Abuse Directors. (2023). *Implementing the Substance Use Disorder Provisions of the Family First Prevention Services Act: A Toolkit for Child*

- McComish, J. F., Greenberg, R., Ager, J., Essenmacher, L., Orgain, L. S., & Bacik, W. J. (2003). Family-focused substance abuse treatment: A program evaluation. *Journal of Psychoactive Drugs*, 35(3), 321-331
- Key reports include: ASPE State plan summary and the National Center on Substance Abuse.
- Seattle Times Editorial Board. (2023). To keep WA kids safe, we need more treatment for parents. *Seattle Times,* October 20, Section D3. Seattle: Author. Retrieved from https://www.seattletimes.com/opinion/editorials/to-keep-wa-kids-safe-we-need-more-treatment-for-parents/

[5] Adapted from Minnesota Department of Human Services (2019). *Bulletin: Corrected #18-68-19: Title IV-E foster care maintenance payments for children placed with a parent in residential family-based substance use disorder treatment.* St. Paul, MN: Author.

Welfare and Treatment Stakeholders. Irvine, CA: Children and Family Futures. Retrieved from https://cffutures.org/files/aecf/SUD_Toolkit_Combined_FINAL.pdf

Part 1: Types of Treatment Facilities and Funding Sources

Types of Treatment Facilities

There are some variations in what treatment facilities can be used to help parents in this situation. (See Figure 1.)

Figure 1. What is a Licensed Residential Family-Based Treatment Facility for Substance Abuse?[6]

- A **licensed residential family-based treatment facility for substance abuse** is a placement type in which a child is placed with a parent who is residing in the facility. These placements must meet the requirements in Sections 472(j) and 472(a)(2)(C) of the Social Security Act, such as the facility providing trauma-informed care and particular services (including parenting skills training). While the placement is eligible for Title IV-E foster care maintenance, the facility must be licensed, but is not required to be licensed by the IV-E agency . Also the Title IV-E background screening requirements do not necessarily apply. (See page 4 of ACYF-CB-PI-18-07 [July 9, 2018] for more information on the Title IV-E requirements.)
- Generally, **residential treatment facilities** for substance use disorders provide services in a structured residential setting staffed 24 hours a day. Treatment professionals assess individuals using criteria such as the American Society of Addiction Medicine Criteria to determine whether residential or other levels of care are appropriate.
- Some residential facilities are **family based**, meaning that a child can reside in the facility with a parent who is receiving treatment.[a] Family-based facilities often also provide a range of services for children, such as counseling and therapeutic daycare.
- In this document, we sometimes use the term **family-based facility** to refer more broadly to family-based residential treatment facilities whether or not they meet Title IV-E requirements

[a] In 2020, about 10 percent of residential substance use treatment facilities (397 of 3,825) in the National Survey of Substance Abuse Treatment Services had residential beds for clients' children. For information by state, see Tables 6.13a and 6.5a of the 2020 survey and the related directory of facilities.

Length of Placements

According to the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE), officials in California, Montana, and Utah report that stays in family-based facilities are usually at least three months long. In some facilities,

[6] Weiser, R. & Spielfogel, J. (2021). *How some states use Title IV-E foster care funding for family-based facilities that treat substance use disorders.* Washington, D.C.: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/2021-09/FFPSA_family_based_facilities.pdf

parents are often in residential treatment on their own for one to two weeks before their children join them, allowing time for parents to stabilize in treatment before children arrive. After parents complete residential treatment, families often move to transitional housing and receive outpatient substance use disorder treatment. National stakeholders and providers noted that stays in some family-based facilities are often shorter (for example, about 30 days), though officials in states featured in the ASPE brief did not note this. When a stay is relatively short, it can be difficult to align the timing for beginning and ending treatment and foster care placement in the facility, and the placement can be less stable for the family.[7]

Funding Sources

The Family First Prevention Services Act of 2018 provides a new opportunity to claim federal reimbursement through Title IV-E that may be applicable to states, territories, and tribal nations for reimbursement of foster care provided through family-based substance abuse treatment agencies, including those administered by American Indian/Alaska Natives.

Children Placed with a Parent Residing in a Licensed Residential Family-Based Treatment Facility for Substance Abuse. States can claim federal Title IV-E foster care reimbursement on behalf of children who are currently under the placement and care of the Title IV-E agency and placed in a residential family-based treatment facility. Unlike traditional IV-E eligibility for foster care maintenance payment reimbursement, the financial eligibility requirements do not apply (although financial eligibility does apply to potential Medicaid eligibility). [8]

There are requirements related to provision of parenting skills, parent education, and individual and family counseling. This funding is available for up to 12 months under these specific circumstances: (a) if the child's case plan goal supports this placement; (b) the treatment services are trauma informed; and (c) the facility provides the parent with skills training and individual counseling. Services may also be available more than once if children re-enter foster care at a later date.[9]

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[7] ASPE. (2021). *How some states use Title IV-E foster care funding for family-based facilities that treat substance use disorders*. p.4. https://aspe.hhs.gov/sites/default/files/2021-09/FFPSA_family_based_facilities.pdf For a discussion of this challenge, see "Implementing the Substance Use Disorder Provisions of the Family First Prevention Services Act: Challenges and Opportunities" (November 2020).

[8] Children and Family Futures, NASADAD, & ChildFocus. (2023). *Implementing the Substance Use Disorder Provisions of the Family First Prevention Services Act: A Toolkit for Child Welfare and Treatment Stakeholders.* https://cffutures.org/files/aecf/SUD_Toolkit_Combined_FINAL.pdf

[9] Candidates for foster care cannot receive this funding. The child must be under the care and responsibility of the state (i.e., in state custody). Children's Defense Fund. (2018). *The Family First Prevention Services Act: Historic reforms to child welfare system will improve outcomes for vulnerable children.* https://www.childrensdefense.org/wp-content/uploads/2018/08/family-first-detailed-summary.pdf

Fortunately, substance use treatment programs can be supported by drawing upon multiple federal and state funding sources, details of which are included in Appendix A, from an excellent toolkit published by Children and Family Futures, Childfocus, and the National Association of State Alcohol and Drug Abuse Directors in 2023.[10]

With the passage of the Family First Prevention Services Act, a portion of the foster care maintenance payment for a child in a family-oriented substance use treatment facility can be paid for by claiming Title IV-E foster care funds. This is a new allowable use of Title IV-E foster care maintenance funds in that the child is in foster care (under the placement and care of the Title IV-E agency) but is placed with the parent.

The other opportunity is the allowable use of Title IV-E Prevention funds for children, their parents and/or caregiver, for children who are not under the placement and care of the Title IV-E agency but who are candidates (at imminent risk of foster care) for evidence-based interventions included in the Title IV-E Prevention Services Clearinghouse. In other words, these funds would be used for interventions approved by the Prevention Clearinghouse, but these funds would not be used for maintenance because the children, by definition, are not in foster care. Note these are separate applications of Title IV-E funding, and the new statutory provisions on children placed with a parent residing in a licensed residential-based treatment facility for substance use cover maintenance payments and the provisions related to prevention services are for a different group of children (candidates) and a different type of service.

The most relevant funding sources are also highlighted below:

1. **Federal Medicaid**: Medicaid can be an important funding source for these kinds of facilities. See a separate section on Medicaid below.
2. **Federal Child Abuse Prevention and Treatment Act (CAPTA) funds**
3. **State Health Care Authority and Substance Abuse treatment general and other funds:** Room and board for *parents* can be funded by state funds like Health Care authority funds and other state programs.
4. **State Health Care Authority and Substance Abuse treatment funds general and other:** Room and board for *infants and children* can be funded by state funds like Health Care authority funds and other state programs.
5. **Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) funds.**

[10] Children and Family Futures, Childfocus, and the National Association of State Alcohol and Drug Abuse Directors. (2023). *Implementing the Substance Use Disorder Provisions of the Family First Prevention Services Act: A Toolkit for Child Welfare and Treatment Stakeholders.* Irvine, CA: Children and Family Futures. https://cffutures.org/files/aecf/SUD_Toolkit_Combined_FINAL.pdf

6. **Title IV-E Foster Care Maintenance funds:** If the infant or child is placed in out-of-home care but is living with the mother or father in the substance abuse treatment facility, then Title IV-E Foster Care Maintenance funds can be used to pay for infant/child room and board.
7. **Title IV-E Prevention Services Funds:** If the child is a candidate (that is, not in foster care but at risk of foster care based on the state's definition of candidacy), and the prevention service is listed on the Prevention Clearinghouse, and that intervention is in the state's approved FFPSA prevention plan and in the child-specific prevention plan….the intervention could be covered - assuming the prevention service is not already being paid for by another funding source like Medicaid or health insurance.

   There are many intervention choices here, including Methadone Maintenance Therapy, Motivational Interviewing, Parent Child Interaction Therapy, Functional Family Therapy, and Trauma-Focused Cognitive Behavioral Therapy.

   Note that, currently, no state, territory or tribal nation can use Title IV-E prevention services funds for *room and board* for parents or their children in these facilities because we do not have any ***whole cloth*** Family-Centered Substance Abuse treatment programs approved by the Title IV-E Prevention Services Clearinghouse – only some of the individual interventions -- like those listed above.
8. **American Indian/Alaskan Native Substance Abuse Treatment funds**. In addition to the opportunities outlined above, a local tribal nation could set up an agreement with a local family-centered substance abuse treatment program to treat some of their tribal members and pay for some of those costs with the funds that the Tribal Nation receives from the Federal Government.

   IHS/Tribal facilities may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent (SHO022616 (medicaid.gov)). For example, in the state of Washington this is referenced as the Affiliated Tribal Medicaid FQHC Agreement (Tribal roundtable-Washington Apple Health (Medicaid) as Tribal Federally Qualified Health Center (March 1, 2019).[11]

[11] Personal Communication, Dan Aune, June 3, 2024.

Note that this is a very complex funding area because Tribal Nations vary in how they approach this. A tribe could receive funds from IHS under a Public Law 93-638 Indian Self-Determination and Education Assistance Act in the form of a Title I Contract or Title V Compact. A tribe could also receive numerous and varied grant awards through the federal system to provide healthcare services. In addition, some direct service tribes rely 100% on IHS delivering all their healthcare, others rely on tribal enterprise revenue to support their healthcare funding. Each tribe is different.[12]

Medicaid Additional Funding Notes

Medicaid can cover Family-Centered Substance Abuse treatment programs, depending on the individual state Medicaid plan. Vermont, Massachusetts, and California are among the most innovative states in this area. Listed below are some key points to consider:

- *State-Specific Coverage:* Medicaid is jointly funded by the federal government and individual states, and coverage can vary significantly from one state to another. Each state has its own Medicaid program, with different rules and covered services.
- *Types of Services Covered:* Many state Medicaid programs cover a range of substance abuse treatment services, including outpatient and inpatient treatment, medication-assisted treatment (MAT), counseling, and behavioral therapy. Family-centered treatment, which involves the participation of family members in the treatment process, may also be covered if it falls within these service categories.
- *Medicaid Expansion:* States that have expanded Medicaid under the Affordable Care Act (ACA) generally offer more comprehensive coverage for substance use disorder (SUD) services. In these states, individuals with incomes up to 138% of the federal poverty level are eligible for Medicaid, increasing access to treatment. (CA, MA, NY, VT, WA)[13]
- *Integrated Care Models:* Some state Medicaid programs promote integrated care models that include family-centered approaches. These models recognize the importance of involving family in the treatment process to improve outcomes for individuals with substance use disorders. (CA, CO, MA, NY, VT)
- *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT):* For Medicaid-eligible children and adolescents, the EPSDT benefit ensures coverage for a broad range of health services, including substance abuse treatment.

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[12] Personal Communication, John Godfrey, May 30, 2024.

[13] Guth. M. & Ammula, M. (2021). *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion*, KFF. https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/

Family-centered approaches may be included as part of comprehensive care for young patients.[14]

- *Waivers and Special Programs:* Some states have obtained waivers from the federal government to implement innovative approaches to substance abuse treatment, including family-centered programs. These waivers allow states to tailor their Medicaid programs to better meet the needs of their population (e.g., CA, MA, NJ, VA, VT).[15]

Implementation Mechanisms

A recent toolkit highlights several best practices for states to create new collaborations utilizing funds and flexibilities in Title IV-E created through the Family First Act, as strong partnerships are needed to maximize success and to ensure that families have access to family-centered treatment in the long-term. These best practices include:

1. Clarifying missions, underlying values, and principles of collaboration.
2. Screening and assessment to match families to appropriate services.
3. Engagement and retention in care using support and encouragement.
4. Services to children of parents with SUDS, such as specialized prevention and early intervention services.
5. Working with community-based treatment organizations.
6. Efficient communication and information systems.
7. Budgeting and program sustainability.
8. Training and staff development, such as cross-training for personnel at all levels.
9. Working with related agencies.
10. Joint accountability and shared outcomes.[16]

The *Toolkit* also provides a helpful table of Title IV-E prevention services and foster care implementation ***challenges and strategies related to substance abuse treatment*** that we have reprinted in Appendix B. One additional way to possibly mitigate some implementation challenges is by working with the *Building Bridges Family-Based Residential Substance Abuse Treatment Technical Assistance Project (BBI)*, which involves program experts from around the country who are already providing effective

[14] Federal law requires that children under age 21 who are enrolled in Medicaid be entitled to EPSDT benefits, and that States must cover a broad array of prevention and treatment services.

[15] Personal Communication, Toni Rozanski, May 22, 2024.

[16] Children and Family Futures, Childfocus, and the National Association of State Alcohol and Drug Abuse Directors. (2023). *Implementing the Substance Use Disorder Provisions of the Family First Prevention Services Act: A Toolkit for Child Welfare and Treatment Stakeholders.* Irvine, CA: Children and Family Futures. https://cffutures.org/files/aecf/SUD_Toolkit_Combined_FINAL.pdf

family-based substance abuse treatment programming to families involved in child welfare. This project can help in several capacities:

- When there is a gap of Family-Based Residential Substance Abuse Treatment programs in a geographical area, BBI can help fill the gap with TA to develop effective quality family-based residential substance abuse treatment programs for families involved with child welfare.
- BBI consultants can support existing child welfare residential providers who may no longer be able to meet the new standards for congregate care because of the state's implementation of Family First. These programs may have an interest in implementing a family-based residential substance abuse treatment program to address organization fiscal losses, and more importantly, to support their oversight agency in successfully addressing the needs of families and children.
- BBI consultants can support current child welfare related providers who want to expand their service array by adding this service to their service and support offerings. [17]

Part 2: Planning Dimensions and Lessons Learned

Overall Planning Dimensions

Before presenting some implementation strategies and lessons learned by some pioneering states, in Table 2 we present some fundamental planning components that need to be considered.

[17] Building Bridges Initiative (2019). *BBI Family-Based Residential Substance Abuse Treatment (FBRSAT) Technical Assistance (TA) Project. Milwaukee, WI: Author, p. 1.* https://familyfirstact.org/sites/default/files/BBI%20FBRSAT%20Technical%20Assistance%20Program%20Flyer%20(1).pdf Also see https://buildingbridges4youth.org/

Table 2. Key Planning Dimensions with a Column for Your State

(Note that Minnesota and Utah do not draw down FFPSA prevention funds to support their family-centered substance abuse treatment program, so these elements focus on Title IV-E maintenance payments for children placed with their parents. And while Minnesota has created some infrastructure for accessing Title IV-E funds for this service, it has not yet claimed anything for this program.)

Planning Dimension	Minnesota	Utah	Your State
Eligibility for Reimbursement for Title IV-E Maintenance Payments for a child placed in a residential substance use treatment facility	A child must either be eligible for Title IV-E foster care maintenance payments or meet all eligibility requirements for Title IV-E foster care maintenance payments ***except*** the Aid to Families with Dependent Children (AFDC) eligibility requirements. A child is not required to meet Title IV-E AFDC eligibility requirements for foster care maintenance payments to be claimed when placed in a residential substance use treatment facility.[18]	The Child and Family Team will determine if placement of the child with the parent in a licensed family-based residential substance use treatment program is appropriate. The child's formal foster placement will be at the facility. If legal custody is returned to the parent no payment can be made.[19] Eligibility requirements specified by MN also apply for Utah. .	
Child Age (any child under the age of 18 is acceptable)[20]	Most are 0-9 but one facility allows teens.	Most are 0-5 but some facilities will allow children up to age 10.	
Childcare and Services: How are children cared for on a day-to-day basis?	Served during the day onsite or off-site at a day care center or other facility – paid for by title IV-E or other funds.	Parents and children live in the same facility. Care for children while the parent is in treatment varies by program, either being provided within the facility or by arranging for childcare or school	

[18] Note that in Minnesota a child eligible for Title IV-E foster care maintenance payments for placement with their parent in a SUD program who does not meet AFDC eligibility requirements is not categorically eligible for Medicaid. [Section 472 (j)(2) of the Social Security Act] Case plans need to address how a child's medical needs will be met through existing health insurance coverage, or parents may apply for Medical Assistance for their child.

[19] Utah Department of Human Services. (2018). *Licensed Family-Based Residential Substance Use Treatment* (Utah Legal Partner Handout). Salt Lake City: Author.

[20] The federal statute (sec. 472(j) of the Social Security Ace says, "...a child who is eligible for foster care maintenance payments..."). Note that child programming in the facility will differ significantly across developmental age ranges.

Planning Dimension	Minnesota	Utah	Your State
		attendance outside of the facility.	
Child Custody and Case Management (Child is in foster care for the Title IV-E funds to be used)	Mostly Voluntary Placement Agreements (VPA) (The MN Bulletin contains a sample Voluntary Out-of-home Placement Agreement.)	Custody of children is most often court-ordered, though voluntary placements are also allowable using existing foster care VPA policies.	
Discharge/Transition Planning	The caseworker helps parent to access community-based treatment services and works with the parent to find housing	Along with other transition services, housing is a huge issue because it is such a large expense.[21]	
Facility Licensure and Numbers	Licensed by MN DHHS.[22] *Agencies:* 3 (used to be 5 but 2 dropped out– plans to expand the number)	Licensed by the Utah Department of Health and Human Services as residential treatment or residential support, which are allowable categories for foster care placement. *Agencies:* 7 (5 organizations, with two agencies having 2 sites)	
Father Eligibility	The state does not have any facilities currently that can serve fathers.	One facility in the state serves fathers.	Do your eligible agencies serve moms, dads, and couples?
Payment for the child's cost in the residential facility	Title IV-E allows for reimbursement for a portion of the foster care maintenance payments for eligible children. Day care costs are covered by	Title IV-E allows for reimbursement for a portion of the foster care maintenance payments for eligible children. Day care	

[21] This delays discharge so some facilities want the parents to be employed or to save up their TANF funds for housing.

[22] In MN, Residential programs must be licensed by the Minnesota Department of Human Services under Minnesota Statutes, Chapters 245A, 245G.01-245G.16, 245G.19, and 245G.21, as a Residential Substance Use Disorder Treatment Program specializing in treatment of clients with children under Minnesota Statutes, Chapter 245G, or approved or licensed by a tribe to provide residential family-based substance use disorder treatment services. (Note that there is no requirement that a SUD program meet children's residential facility licensing requirements under Minnesota Rules, Chapter 2960.) To be eligible, SUD programs must provide:

- Parenting skills training, parent education, and individual and family counseling
- Trauma-informed services under an organizational structure and treatment framework that involves understanding, recognizing and responding to the effects of all types of trauma, in accordance with principles of a trauma-informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing.

Planning Dimension	Minnesota	Utah	Your State
	other financial assistance programs.	costs are either covered under that payment or by the parent qualifying for day care assistance based on employment while in the program.	
Length of Stay	1 month is typical but a child can be co-located with a parent in a SUD program up to 12 months.	3-6 months is typical.[23]	
Outcomes (What does completion look like? Positive outcomes?)	Parent substance abuse behavior is ended. The intention is that parents and children stay together.	Has some preliminary data that reunification outcomes are better, and treatment is more successful in terms of abstinence.	
Parent Room and Board	Each program establishes its own processes for paying for the parents' room and board, utilizing local funds or in some cases Medicaid funds under an adult bundled rate for SA treatment.	Each program establishes its own processes for paying for the parents' room and board, utilizing local funds or in some cases Medicaid funds under an adult bundled rate for SA treatment.	
Parent Caregiving Roles	The parent provides all direct care for their children, except when in treatment or child in daycare or school off site.	The parent provides all direct care for their children, except when in treatment, but with 24-hour staff support and oversight for safety. Programs vary in the extent to which parents assist with specific chores such as grocery shopping or meal preparation.	
Parent Treatment	Paid for by Medicaid.	Paid for by Medicaid for eligible parents (which is nearly everyone). If not Medicaid eligible, programs have arranged for local funding.	Some states have different care plans, and various programs may have different lengths of stay. It would be good to have more standardization.

[23] The Utah SUD providers recommend 8 months but that is not possible due to Medicaid restrictions.

Planning Dimension	Minnesota	Utah	Your State
Provider Issues: Anything special to note?			
Rate (maintenance cost for the child)	Pegged to the maintenance they pay for foster family homes: $22.09 - $30.94 per day.	Pegged to the maintenance they pay for group care at more of a base daily rate: $127.	
State Statute (Does any modification need to be made to any state statute?)	MN made a change that FC can include this kind of placement in a SUD treatment facility.	No state law change was needed.[24]	

Table Notes:

- Title IV-E can pay for childcare if it is built into the state plan.
- Child Candidacy: Could apply to any state in a state with an approved Title IV-E prevention plan.
- TANF may be a support as well for some of these children, depending on the child's circumstances.
- Provider congruence: it is important that everyone is working in the same direction and with dedication/compassion for the parents.

Lessons Learned

The white paper titled *Implementing the Substance Use Disorder Provisions of the Family First Prevention Services Act: Challenges and Opportunities* highlights key challenges that were discovered as part of implementing the SUD-related provisions of the law over a two-and-a-half-year period. These challenges are informed by the perspectives of stakeholders working to connect SUD treatment services to families in their states, and include the following:

- ***Challenge 1:*** For states to draw down Title IV-E foster care maintenance payments for a child placed with a parent in a family-based residential treatment facility for SUDs, the child must be under the placement and care of the child welfare agency.
- ***Challenge 2:*** Multiple funding streams are needed to support families affected by substance use, each with its own complex rules and eligibility require.[25]

[24] Utah did not change state law to implement this requirement. They designated the allowability of this placement in practice guidelines for child welfare staff.

[25] Adapted from Children and Family Futures, ChildFocus, & NASADAD. (2020). *Implementing the Substance Use Disorder Provisions of the Family First Prevention Services Act: Challenges and Opportunities.* Irvine, CA: Children and Family Futures, p. 1. https://www.cffutures.org/files/QIC_Webinar_Resources/FFPSA%20Implementation%20Challenges%20and%20Strategies_FINAL.pdf

We highly recommend review of the Toolkit discussion of these challenges. Additional lessons from Minnesota and Utah can help inform a plan for other states. Utah, like Arizona, implemented whole family substance abuse treatment ***prior to*** passage of the Family First Act. Don Winstead recommends that an agency begin by identifying the family treatment needs and other family support needs, and then craft rules that can support the services that families need – rather than starting with a set of rules.

Because of the change in federal law the California and Minnesota child welfare agency leaders felt they needed to change the state laws. California added family-based facilities as an allowable foster care placement, and Minnesota's new statute includes details about case planning, court review, and permanency proceedings for children in family-based facility placements.[26] Utah did not make changes to how their state law defines foster care to implement this substance abuse treatment service.

Each state approached placement authorization and foster care maintenance and other payment aspects in family-based facilities a little differently. For example, Minnesota uses (and California plans to use) foster care basic rates to pay the facilities. In Minnesota, the children accompany a parent into treatment primarily under a ***voluntary placement agreement*** (VPA) but some are court-ordered. In Minnesota they pay a base foster care rate placement to help pay for the needs of the children ($22-31 per day, depending on child age). This was done to make it as easy as possible for the state to launch the program. (See Table 3.)

In Utah, children in these placements are most often court ordered into foster care. Utah calculated a rate based on Title IV-E allowable costs in the family-based facilities. Utah pays each facility a base rate for care of the children that is more akin to the lowest tier of the residential treatment rate of $127 per day. Medicaid pays for the parent and child treatment.

Table 3. Minnesota Payment Rate for Children Placed in SUD Facilities as of June 30, 2020

Child's Age	Monthly Basic Rate	Daily Basic Rate
Birth – 5	**$672**	**$22.09**
6-12	**$797**	**$26.20**
13-17	**$941**	**$30.94**

Note that this is the Northstar Care for Children basic rate, effective July 1, 2019 – June 30, 2020.

In terms of implementation, Maxie Ann Rockymore helped launch this effort in Minnesota a few years ago, but then had to focus on other QRTP and FFPSA planning areas. But Maxie and her team developed a detailed Bulletin to support the implementation process. Initially Maxie and the child welfare agency Deputy Director, Marvin Davis, reached out to

[26] See California Welfare and Institutions Code §11402 and Minnesota Statutes, section 260C.190.

a variety of people to publicize the program, including (a) American Indian tribes and substance use treatment agencies/programs; (b) African American substance use treatment agencies; and (c) other stakeholders.

In Utah, the Department of Health and Human Services had existing contracts with the local mental health authorities to provide SUD treatment, with Medicaid paying for treatment for eligible parents or children in the residential program. So, Utah was able to move quickly to implement this program by adding a supplemental contract for these programs to cover the child's foster care maintenance payment and to address parenting provisions after passage of the Family First Act. For trial home visits, Utah used TANF funds to pay for some of the expenses. In an initial CQI study, Utah found that in comparison with other families served in child welfare, families served by the whole family treatment programs had higher rates of family reunification, and lower rates of repeat maltreatment and foster care reentry.[27]

Experts from each state mentioned the importance of educating their legal partners (e.g., judges, guardians ad litem) so they are aware of this treatment and foster child placement option and its benefits. ASPE in their report highlighted two other key planning areas:

- **Modifying information technology.** States have modified their information systems to support billing, tracking children and placements, and collecting data. For example, California created a new code in its system that identifies children in these placements, which will help ensure that facilities' claims are paid properly, and children's Medicaid benefits are not inadvertently impacted.
- **Developing guidance and disseminating information.** States have developed various informational resources such as provider bulletins, practice guidelines, one-page fact sheets for caseworkers and legal stakeholders, and staff training about the placements. State officials noted that stakeholders are interested in information on topics such as the impact of placements on reunification timelines.[28]

Successful Outcomes Can Be Achieved

Utah has seen positive reunification outcomes among children in foster care placed with their parents in family-based facilities. As of January 2021, of the children who were in these placements from October 2018 to December 2020:

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[27] Utah the Department of Human Services. (2021). *CQI Report: Parent Child SUD Residential*. Salt Lake City: Author.

[28] ASPE. (2021). *How some states use Title IV-E foster care funding for family-based facilities that treat substance use disorders*. Washington, D.C. Author, p. 5. https://aspe.hhs.gov/sites/default/files/2021-09/FFPSA_family_based_facilities.pdf

- 62 of 97 (64%) children who had exited foster care placement remained with their parent in the family-based substance abuse treatment facility.

  48 of 57 (84%) children of parents who had completed the treatment program who had subsequently exited foster care were reunified with their parent at case closure. For context, among all children in foster care in Utah for all abuse and neglect allegation types, 45% were reunified with their parent at case closure.[29]

> "The parents are stabilized enough that we can place the child there and let that placement help motivate the parent and be able to have the parent practice parenting skills with the children, with the staff at the facility helping support that."
>
> *— Utah child welfare official*[30]

Part 3: How Title IV-E Prevention Services Funds Can Be Used to Support Family-Centered Substance Abuse Treatment Programs

If jurisdictions utilize evidence-based substance use programs that have been rated as Promising or higher by the Title IV-E Prevention Clearinghouse, and if those interventions are in the state's approved Title IV-E prevention plan, the state could draw down Title IV-E prevention dollars to support those interventions provided to these parents, kin and children.

For tribes who directly administer Title IV-E foster care programs, the Tribal Title IV-E agency may determine the practice criteria for services that are adapted to the culture and the context of the Tribal communities served and may include these programs in their Title IV-E prevention plans and receive federal reimbursement.[31] For families under the care of a Tribal direct Title IV-E program, it is possible that services and administration would

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[29] ASPE. (September, 2021). p.3

[30] ASPE. (September, 2021). p. 3

[31] Note: As of April 4, 2023, there are 19 Tribes or Alaskan Native Communities approved to directly receive Title IV-E funding, although some have chosen to not implement Title IV-E services at this time. (See https://www.acf.hhs.gov/cb/grant-funding/tribes-approved-title-iv-e-plans) Of these, three are in Arizona: Navajo Nation, Pascua Yaqui Tribe, and Salt River Pima-Maricopa Indian Community. As of January 4, 2024 a total of four American Indian tribal nations have approved Family First plans: Cherokee Nation (Talhlequah, Oklahoma); Eastern Band of Cherokee Indians (Cherokee, North Carolina); Port Gamble S'Klallam Tribe (Washington); and Salt River Pima-Maricopa Indian Community (Arizona) See https://www.acf.hhs.gov/cb/data/status-submitted-title-iv-e-prevention-program-five-year-plans

also be eligible for reimbursement for these culturally-adapted programs when they are included in the tribe's approved title IV-E prevention services programs.

Currently, few SUD prevention and treatment programs are rated as promising, supported, or well-supported programs by the Title IV-E Prevention Services Clearinghouse which would allow states to claim reimbursement for these programs under Title IV-E prevention services. [Note this challenge is not relevant to the use of Title IV-E foster care maintenance funds for children already in foster care who are placed in family-based substance use residential treatment with a parent.]

Staff at Casey Family Programs are trying to better understand this part of the law and how to help states and tribes develop these programs and use Title IV-E prevention services funds to support this intervention – with much more to learn as states and substance abuse treatment organizations draw down Title IV-E prevention services funding.

Conclusions

Based on the experience of Minnesota, Utah and other states, this funding and planning brief outlined some of the planning dimensions that states, territories, and tribal nations could consider as part of providing more fiscal support for these kinds of treatment centers, using Title IV-E foster care maintenance, Title IV-E prevention services funds, and other funds. It also highlights material from three comprehensive resources that are essential reading for anyone considering this kind of program. While not all parents need inpatient residential treatment for a substance abuse disorder, many parents and their children would benefit from this family-centered approach. Fortunately, there is much wisdom being accumulated by the field in how to design, fund and implement these strategies. Thus, this intervention strategy can and should be scaled up in every state and for every tribal nation.

Appendix A: Major Funding Sources for Family-Centered Substance Abuse Treatment from a Report by Children and Family Futures, ChildFocus, and the National Association of State Alcohol and Drug Abuse Directors

TITLE IV-E FOSTER CARE MAINTENANCE

New funding for family-based residential treatment is available with the passage of the Family First Act through Title IV-E for children already in foster care.

ELIGIBLE USES	OTHER USES
Title IV-E can reimburse for 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 reimburse 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 Title 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 services 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. 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.[32]

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

TITLE IV-E PREVENTION SERVICES

New funding available with the passage of the Family First Act through Title IV-E for "candidates" for foster care and pregnant and parenting youth in foster care.

ELIGIBLE USES	OTHER USES
Title IV-E can reimburse for evidence-based SUD prevention and treatment services on behalf of children and youth at risk of entering foster care with no income eligibility requirement. 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 evidence-based 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 reimburse 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. Programs eligible for reimbursement must be included in 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, as well as their parents or kinship caregivers, on behalf of children defined as candidates foster care. The definition of candidacy is determined by each state. [Note that states can be reimbursed for up to 12 months; if extended not clear they can receive reimbursement. States could however allow families and children to remain together as long as they like and use other funding beyond the 12 months.] 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

MEDICAID

Federal health insurance program for low-income families.

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 to. Does not pay for room and board. Children and families in family-based residential treatment are not categorically eligible for Medicaid, but most are likely eligible. Some states may opt to pay for 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.

SUBSTANCE USE PREVENTION, TREATMENT, AND RECOVERY SERVICES BLOCK GRANT (SUPTRS BG)

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. SUPTBG 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.

Source: Adapted with permission from Children and Family Futures, ChildFocus, and the National Association of State Alcohol and Drug Abuse Directors. (2023). *Implementing the Substance Use Disorder Provisions of the Family First Prevention Services Act: A Toolkit for Child Welfare and Treatment Stakeholders.* Irvine, CA: Children and Family Futures. https://cffutures.org/files/aecf/SUD_Toolkit_Combined_FINAL.pdf Pages 20-23.

Appendix B: Family First Implementation Challenges and Strategies Related to Substance Abuse Treatment

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.

PITFALLS	STRATEGIES FOR SUCCESS
Treating medications used in MAT [medically assisted treatment] 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. [Note that Family First prevention services also could be provided without the need for placement in care.]
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.

Source: Children and Family Futures, NASADAD, & ChildFocus. (2023). *Implementing the Substance Use Disorder Provisions of the Family First Prevention Services Act: A Toolkit for Child Welfare and Treatment Stakeholders.* (pp. 27-28) https://cffutures.org/files/aecf/SUD_Toolkit_Combined_FINAL.pdf Reprinted with permission.

Casey Family Programs

Casey Family Programs is the nation's largest operating foundation focused on safely reducing the need for foster care and building Communities of Hope for children and families in the United States. By working together, we can create a nation where Communities of Hope provide the support and opportunities that children and families need to thrive. Founded in 1966, we work in all 50 states, Washington, D.C., Puerto Rico, the U.S. Virgin Islands and with tribal nations across North America to influence long-lasting improvements to the well-being of children, families and the communities where they live.

P 800.228.3559
P 206.282.7300
F 206.282.3555

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