

Family-Based Recovery: An Innovative Collaboration between Community Mental Health Agencies and Child Protective Services to Treat Families Impacted by Parental Substance Use

To meet the needs of families who have very young children and are involved with child protective services due to substance use, the State of Connecticut Department of Children and Families, Yale Child Study Center and Johns Hopkins University created an innovative treatment model. This public–private collaboration required a paradigm shift for both child protective services staff and treatment providers. This brief description of the Family-Based Recovery model highlights the family-focused practice elements that allow children to remain safely at home with parents who are in treatment. Outcomes suggest that Family-Based Recovery is a promising practice, and collaborations between child protective services and substance use treatment providers can yield positive results for families with young children. © 2019 John Wiley & Sons, Ltd.

KEY PRACTITIONER MESSAGES:

- Strong collaboration between child protective services and treatment providers can mitigate the risk of out-of-home placement for children impacted by parental substance use.
- In-home treatment that provides concurrent psychotherapy, substance use treatment and parent–child dyadic therapy is an important part of the service array for families involved with child protective services.

KEY WORDS: child protective services; substance use; parents/mothers/fathers; intervention; in-home

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‘Highlights the family-focused practice elements that allow children to remain safely at home with parents who are in treatment’

‘I never had any real reason to quit using before my baby got here. I wasn't worth it, but now that I'm a mom, I see myself as worth it.’ (A Family-Based Recovery mother describing the positive reinforcement of parenting in her recovery process)

Introduction

The needs of parents who use substances and the potential impact on their young children are well documented (Seay and Kohl, 2015; Whitaker *et al.*, 2006). A subset of these parents will come to the attention of child protective services (CPS) due to concerns that substance use is compromising their parenting. A review of all cases accepted in 2014 by the State of Connecticut Department of Children and Families (DCF) revealed that 35 per cent of families with a child under the age of two and 27 per cent of families with a child aged three to five had an indicator of parental substance use (Connecticut DCF Office for Research and Evaluation, 2015). One of the most challenging responsibilities for a CPS social worker is weighing the developmental needs of a child against the risk associated with parental substance use in determining whether the child needs to be removed. Historically, child protection has focused primarily on the physical safety of children, without recognising the need to balance that with psychological safety and wellbeing.

Children removed due to parental substance use typically remain in foster care longer and are less likely to be reunified than children removed for other reasons (Lloyd *et al.*, 2017; Vanderploeg *et al.*, 2007). In fact, for many children, foster care placement has not resulted in positive outcomes (Villodas *et al.*, 2015; Weiler *et al.*, 2016). While placement outside the home may mitigate the risk to the child's safety related to parental substance use, it might have a negative impact on a mother's recovery process and sense of wellbeing. Some mothers may increase substance use to manage their loss and their sense of being judged as less than competent. Diminished motivation to participate in treatment after a child is removed may lead to an increase in adverse life events (Donohue *et al.*, 2014; Nicholson *et al.*, 2006). Mothers with greater stressors, comorbid mental health issues and lower socio-economic status have higher rates of child removal (Canfield *et al.*, 2017; Suchman *et al.*, 2006).

The Adoption and Safe Families Act 1997 shortened the timeline for CPS staff to establish permanency for children removed from parental care. This has highlighted how the timelines of child attachment, development and permanency contrast with that of substance use recovery. In response, the number of treatment programmes addressing the specific needs of mothers involved with CPS has grown, along with recognition of how important integrated support is for families. While CPS and treatment providers may have conflicting treatment goals and philosophies (Marsh *et al.*, 2011; US Department of Health and Human Services *et al.*, 2014), families can benefit from collaboration on their behalf (Neger and Prinz, 2015; Semidei *et al.*, 2001). Many CPS agencies have memoranda of understanding with treatment providers. Nonetheless, collaboration can be difficult (He, 2015). In a culture of risk aversion, one fatality can detrimentally affect these partnerships. Moreover, treatment providers can be reluctant to share information with CPS due to concerns about confidentiality (Green *et al.*, 2008).

‘For many children, foster care placement has not resulted in positive outcomes’

A strong collaboration is not sufficient to ensure positive outcomes. Advances in research on how substance use affects the maternal brain and behaviour must inform practice. Rutherford *et al.* (2011) propose that changes in the neural circuitry of the stress and reward systems impact perception of infant cues which leads to high stress/low reward responses to parenting, increasing substance cravings and risk of relapse. Suchman *et al.* (2012, 2017) found that many mothers who use substances are less emotionally available to their children than mothers who do not, and show less sensitivity to their infant's cues. Their clinical research finds that focusing on a mother's experience of parenting results in improvements in reflective functioning and greater reciprocity between mother and child. Suchman *et al.* (2012) express concern that a child's emotional distress during a clinical session may increase a mother's affective state to a level where she cannot focus on mentalisation, possibly triggering relapse. They recommend individual treatment to develop coping strategies to identify and regulate emotions prior to dyadic work.

Other research with mothers diagnosed with substance use disorders or postpartum depression recommends that providers find a balance between the competing needs of the mother for self-exploration and the needs of the parent-child dyad (Paris *et al.*, 2011, 2015). Having the child in sessions naturally directs focus to the child's experience and offers the parent an opportunity to explore their feelings about parenting generated by dynamics in the moment.

While researchers may vary in their approach, the family-focused CPS service model prioritises meeting the needs of all family members at the time of engagement. This is compatible with attachment-based treatment and embodies the positive reinforcement that parenting can provide in recovery.

Aims and Objectives

Connecticut DCF has a long history of the use and development of evidence-based practice to respond to families' needs with proven interventions. In 2006, DCF initiated the search for an effective treatment option for caregivers with substance use disorders because the service array was not yielding adequate outcomes for families with infants and toddlers. To address this, DCF, Yale Child Study Center (YCSC) and Johns Hopkins University (JHU) developed a new model, Family-Based Recovery (FBR), by combining substance use treatment with attachment-focused therapy. FBR has a twofold goal: positive family outcomes achieved by addressing the intergenerational impact of trauma and substance use; and helping to build an integrated service system with the capacity to meet the complex needs of families involved with CPS. By keeping children at home with clinical supports when feasible, trauma exposure can be reduced, and security and stability can increase. In 2007, DCF awarded contracts to YCSC and five community-based agencies to implement the model, expanding the number to ten in 2013 to reach families throughout the State of Connecticut. An 11th team joined the FBR network in 2016. YCSC FBR Services provides training and case consultation, monitors model fidelity and awards model accreditation to sites.

'Advances in research on how substance use affects the maternal brain and behaviour must inform practice'

'The family-focused CPS service model prioritises meeting the needs of all family members at the time of engagement'

‘FBR is an in-home treatment programme for parents who are using or have recently used substances and are actively parenting a child under 36 months’

‘The substance use component was adapted from Reinforcement-Based Treatment’

The FBR Model

FBR is an in-home treatment programme for parents who are using or have recently used substances and are actively parenting a child under 36 months (Hanson *et al.*, 2015). Any parent in Connecticut who meets these criteria is eligible to participate. Most are referred by DCF. Two basic tenets of FBR are: parents can achieve recovery while actively parenting; and bonding with a young child and competently parenting reinforce abstinence. FBR simultaneously addresses parents' psychological issues and substance use and focuses on attachment behaviour and the quality of parent–child interactions.

Since the initiation of services in January 2007 through June 2017, FBR has treated 1408 families, representing almost 3000 index clients (mothers, fathers and children). Eighty-five per cent involved a maternal caregiver only, five per cent a paternal caregiver only and ten per cent both parents. The mean monthly income at intake was US \$712 (SD = \$830), with the majority of families receiving cash and non-cash assistance from the government. The mean gestational age of index children was 38.1 weeks (range of 23 to 43 weeks). According to World Health Organization (WHO, 2016) guidelines, 17.5 per cent of index children were considered preterm (less than 37 weeks gestation). The mean birthweight of index children was 2.95 kg (range of 0.64 to 4.54 kg). According to WHO (2016) guidelines, 16.0 per cent were considered low birthweight (less than 2.499 kg). Socio-demographic characteristics of index parents and children are given in Table 1, and risk factor prevalence rates are given in Table 2.

An FBR team consists of two master's-level clinicians who are cross-trained in substance use and parent–child therapy and a bachelor's-level family support specialist (FSS). The team provides in-home services in order to reach clients with transportation or childcare needs, or who are unlikely to access community-based services for other reasons and to gain a better understanding of the family environment.

The substance use component was adapted from Reinforcement-Based Treatment (RBT) (Tuten *et al.*, 2012), an evidence-based substance use treatment model developed at JHU. The substance use clinician meets with parents twice weekly to address substance use recovery and provide insight-oriented psychotherapy. Using RBT tools, clinicians gather detailed information on parents' substance use history, including positive and adverse outcomes related to their use, motivation for change, confidence in their ability to achieve abstinence, and what will help or hinder their recovery process. It is critical for clinicians to support parents in their efforts to hold the child in mind and explore together how parents' substance use, mental health and environmental stressors impact the child.

The weekly parent–child visit is an opportunity for parents to spend time with the child, reflect on parenting and think about themselves as parents. Parent–child work examines issues that interfere with optimal parenting and validates parents' competence. The clinician uses natural interactions to support reflective functioning, or the parent's understanding of the child's experience. Fundamental parent–child therapy concepts are: (1) attachment is critical to healthy development; (2) reflective functioning is key to parent–child attachment and emotion regulation; and (3) viewing behaviour in the context of development can reduce relational stress and keep children safe.

Table 1. Socio-demographic characteristics: index parents and children

Variable	Maternal/Child characteristics (<i>N</i> = 1339) (%)	Paternal characteristics (<i>N</i> = 209) (%)
<i>Index parents</i>		
Age, years		
< 20	9.4	5.2
21–25	34.1	31.6
26–30	32.1	27.8
31–35	16.0	15.3
36+	8.4	20.1
Total	100.0	100.0
Race/ethnicity		
Caucasian	52.1	57.9
African-American	26.7	19.1
Hispanic	16.4	20.1
Biracial	3.4	2.9
Other	1.4	0.0
Total	100.0	100.0
Marital status		
Single, never married	76.9	64.1
Married	11.1	20.5
Divorced/separated	6.2	5.3
Widow	0.4	0.0
Other/missing	5.4	10.1
Total	100.0	100.0
Educational attainment		
Some high school or less	32.4	27.5
High school/General	34.5	37.2
Educational Development certificate		
Trade/vocational	4.6	3.7
Some college	17.9	12.1
College or greater	2.8	0.9
Missing/unknown	7.8	18.6
Total	100.0	100.0
Socio-demographic characteristics: index children		
Variable	Child characteristics (<i>N</i> = 1406) (%)	
<i>Index children</i>		
Gender		
Male	49.5	
Female	50.5	
Total	100.0	
Age, months		
0–6	57.3	
7–12	12.0	
13–18	11.4	
19+	19.3	
Total	100.0	
Race/ethnicity		
Caucasian	43.9	
African-American	25.5	
Hispanic	15.5	
Biracial	13.9	
Other/missing	1.2	
Total	100.0	

The FSS links families to community resources, especially housing options, working on job readiness skills and compiling information tailored to the family.

An important component of the model is Social Club, a weekly group for parents and children. While not mandatory, all clients are asked to sample the group once they are abstinent from substances. Social Club provides family socialisation, group therapy, peer support and encouragement. FBR staff link the group topic/activity to parenting and/or substance use. At the close of

Table 2. Risk factor prevalence: index parents and children

Risk factor	Maternal/Child prevalence (%)	Paternal prevalence (%)
<i>Index parents</i>		
Comorbid mental health disorder	51.1	25.6
Physical abuse	26.3	16.7
Sexual abuse	28.6	9.3
Inter-partner violence	45.4	15.8
Distributed substances	10.8	31.6
Engaged in sexual activities for money	6.1	0.0
Criminal conviction	30.9	45.6
Currently on probation/parole	12.1	18.1
<i>Substance(s) targeted during treatment</i>		
Alcohol	15.2	20.1
Cannabis	57.3	58.9
Cocaine	24.9	23.4
Opiates	27.4	27.3
Phencyclidine	6.7	1.9
Other	6.2	1.0
Poly substance targeted	30.5	27.3
<i>Index children</i>		
<i>Substance exposure in utero</i>		
Alcohol	11.7	
Cocaine	18.6	
Cannabis	43.1	
Opiates	17.9	
Methadone	13.8	
Phencyclidine	3.7	
Tobacco	46.4	
Other	8.6	

Social Club, each client receives a certificate enumerating his/her consecutive days of negative toxicology screens.

FBR works with families for up to 12 months. The FBR team supports the client's efforts toward change in health, education, relationships and employment. Weekly service intensity is three 60-minute home visits (two if the client attends Social Club) for the first six months. The team then assesses the parent's progress toward treatment goals and may reduce service intensity to two visits a week, or once a week if close to discharge.

System Change

Concurrent to the development and implementation of FBR, DCF has shifted its child protection paradigm to focus on a practice model that engages and strengthens families. To accomplish this, DCF has made several policy and practice changes, most notably with racial justice initiatives, trauma-informed system development, family engagement with a targeted focus on fathers, and family teaming. The Strengthening Families Practice Model provides a framework for how the agency will work internally and partner with families, service providers and other stakeholders (Connecticut DCF, 2011). Family-centred assessments are one of seven core strategies outlined in the practice model. An Early Childhood Practice Guide for Children Aged Zero to Five was published by DCF in 2016 to provide staff with a theoretical framework for early childhood development (Connecticut DCF, 2016).

DCF has implemented several other models to provide better services for Connecticut families. A Differential Response System, with the Structured

'The FBR team supports the client's efforts toward change in health, education, relationships and employment'

Decision Making Tool, triages lower-risk families to community services rather than becoming involved with DCF, enabling resources to be focused on higher-risk and higher-need families. DCF practises the full continuum of Family Teaming, commencing with Team Decision Making, followed by Considered Removal Teaming and completed with Permanency Teaming. At each level, families are involved in case planning to mitigate safety concerns. Emphasis is placed on engaging fathers and other relatives as resources to ensure the safety of children.

Cross-training opportunities between FBR and DCF staff have proven helpful in creating a common language, increased knowledge of infant mental health and attachment, and improved understanding of the array of treatment programmes that DCF can access to support families. One joint training opportunity is conducted by the Connecticut Association for Infant Mental Health with financial support from the Connecticut Head Start State Collaboration Office and DCF. The eight-day training in the field of infant mental health is followed by year-long reflective consultation groups.

The DCF and FBR Collaboration

Statewide system changes have made the implementation and expansion of the FBR model possible. One of FBR's foundation principles is that a strong collaboration between DCF and FBR will allow parents to maintain custody of their children while working towards abstinence from substance use. Prior to the development of FBR, many children were removed from their parent's home until the parent engaged in substance use treatment and then maintained a period of sobriety. The developers built structural components into the model to facilitate communication between DCF and FBR staff. The collaboration starts with a joint intake session in which the DCF worker identifies the reason for referral and the department's expectations for the family. The FBR team outlines what information will be shared with DCF: toxicology results, service intensity, general focus of therapy, safety concerns, risk factors and child development. Information not shared includes: details of psychotherapy, relationship status, treatment plans, family planning, and FBR tools and measures. The initial session establishes a mutual understanding of confidentiality and transparency.

An important tool that addresses a shared commitment to mitigate risk is the Safety Plan for Child(ren), which outlines what DCF and FBR expect should a parent choose to use substances. The parent identifies non-substance-using caregivers who could care for the child in that event. The client signs an agreement to not parent children while obtaining, using or being under the influence of a substance. A client who relapses is encouraged to contact his/her DCF worker regarding the use, and FBR also contacts DCF. A positive toxicology screen should not be considered an automatic reason for removal.

FBR staff maintain regular phone and email contact with DCF staff. Joint home visits are held to talk about a client's progress, discuss specific concerns and, when needed, establish a safety plan. Bi-monthly or monthly case reviews are also held between DCF and FBR staff. The primary focus of these meetings is to share clinical progress as it relates to parenting, child safety and wellbeing, and substance use. Additionally, the reviews serve to further effective communication built on trust.

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‘In 2013, FBR developed and piloted an adherence measure that merged an RBT adherence tool with FBR components’

Methods

Data Sources

FBR providers enter data into a web-based data collection system that is maintained by FBR Services at YCSC. The system is not designed for research purposes but rather to monitor clients' characteristics, programmatic adherence and outcomes, and to support quality assurance and quality improvement activities. For this study, all data were analysed using SPSS version 21.

Measures

FBR uses tools and measures to guide the intervention, identify and track symptoms, and measure treatment effectiveness. A rapid toxicology screen is conducted during each session. Observed screens occur when the staff member is the same gender as the client. Testing supplies are approved by the Clinical Laboratory Improvement Amendments-waived test system for home use. Breathalysers are conducted at each visit for clients whose target substance is alcohol and randomly with other clients.

Standardised measures are completed at intake, 90-day intervals and discharge. Since 2007, all sites have used the Edinburgh Depression Scale (EDS) (Cox *et al.*, 1987); the Parenting Stress Index-Short Form (PSI-SF) (Abidin, 1995); and the Postpartum Bonding Questionnaire (PBQ) (Brockington *et al.*, 2001). An analysis of intake measures reveals that 37 per cent of mothers and 23 per cent of fathers scored in the Distress or Need-to-Evaluate range in the EDS. Twelve per cent of mothers and ten per cent of fathers scored above the 85th percentile in the Total Score on the PSI-SF. A greater percentage of parents had elevated scores on the sub-scale of Parental Distress: 25 per cent of mothers and 33 per cent of fathers. One per cent of mothers and fathers scored in the elevated range in the PBQ Total Score. The Impaired Bonding sub-scale had the highest percentage of elevated scores at two per cent for mothers and three per cent for fathers.

In 2013, FBR developed and piloted an adherence measure that merged an RBT adherence tool with FBR components. All clients have been asked to participate in the measure since 2016. After the site obtains a client's consent, a YCSC research assistant completes the tool in a brief phone interview with the parent.

Statistical Procedures

Socio-demographic characteristics were examined by calculating means and frequencies for index parents and children. Urine toxicology screens submitted by parents were examined to summarise the number of toxicology screens conducted and the percentage of negative and positive results. Kaplan–Meier analysis was used to estimate a median length of stay by fitting a survival curve using all available data from open and discharged cases. Changes in a parent's clinical functioning were examined for parents with valid scores at intake and discharge. Pre-test and post-test scores were compared using *t*-tests, and Cohen's (1977) *d* statistic for single samples was used to calculate the effect size of change scores for each measure and its sub-scales.

Results

The critical outcomes for FBR families are parental abstinence, placement of the index child at discharge and parental wellbeing. Toxicology screens provide one important source of data. Clients have provided 67 144 toxicology screens to date. Results were examined for all clients in active sites who were in treatment for at least 20 weeks ($n = 745$ caregivers, representing 55% of all caregivers). Figure 1 summarises the results, which reveals a decrease in positive screens obtained over a five-month period.

Table 3 displays an analysis of pre-post paired scores on the EDS, PSI-SF and PBQ. The data reveal improvements in parental wellbeing throughout FBR participation. Parents' self-report of depressive symptoms on the EDS, and the Total Score and Parental Distress sub-scale on the PSI-SF show the greatest improvement. Modest changes were observed on the parents' PBQ scores. Although nearly all of the effect sizes are considered small, the largest

'The data reveal improvements in parental wellbeing throughout FBR participation'

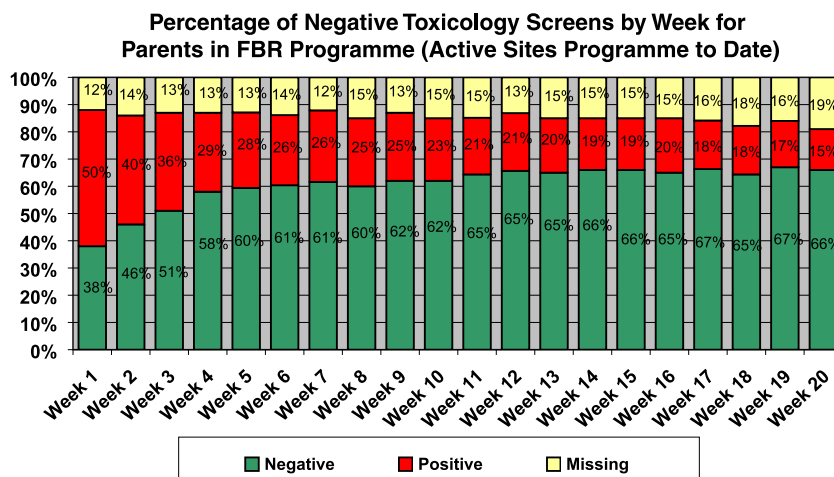


Figure 1. Urine toxicology screens of parents who received the in-home treatment programme Family-Based Recovery by week (active sites programme to date). [Colour figure can be viewed at wileyonlinelibrary.com]

Table 3. Pre-post change in caregiver measures of clinical functioning

Pre-post change (paired scores)	N	Baseline	Discharge	t-Values and significance	Effect size
Edinburgh Depression Scale Total Score	600	7.27	5.53	$t = 3.60, p < .001$	.29
Parenting-Stress Index-Short Form	576				
Total Score		63.8	58.2	$t = 8.94, p < .001$	.31
Parental Distress		26.8	23.3	$t = 9.89, p < .001$	.36
Parent-Child		20.1	18.1	$t = 6.21, p < .001$	.22
Difficult child		22.9	21.6	$t = 4.05, p < .001$	.15
Postpartum Bonding Questionnaire	537				
Total Score		5.39	4.35	$t = 4.50, p < .001$	.18
Impaired Bonding		3.13	2.49	$t = 4.33, p < .001$	.18
Rejection-Anger		0.84	0.74	$t = 1.24, p = .217$	.06
Infant-focused Anxiety		1.36	1.10	$t = 3.11, p = .002$	.15
Risk of Abuse		0.54	0.17	$t = 1.74, p = .082$	.09

‘Seventy-seven per cent of [FBR] families had no report of abuse or neglect filed against them during the course of the treatment’

‘FBR and DCF work together to identify and address conflicting viewpoints at a variety of levels’

effect sizes were observed for the PSI-SF measures of Total Score ($d = 0.31$) and Parental Distress ($d = 0.36$), as well as the Total Score on the EDS measure of depression ($d = 0.29$). Adherence measure results were aggregated across sites and administration time periods, and reported for the programme to date. The results indicate strong agreement among caregivers that FBR is delivered according to model specifications.

Kaplan–Meier analysis was used to examine the duration of FBR treatment. Length of stay was calculated for 1408 cases, revealing a median treatment duration of 5.59 months. Only 94 (7%) of the discharged cases were discharged in less than one month. Among the 1309 discharged cases, 81 per cent of the index children were living with at least one biological parent, nine per cent were with a relative, five per cent were in foster care, four per cent were in kinship foster care and one per cent were missing data.

Since July 2009, DCF has required FBR sites to enter data into its Provider Information Exchange. By July 2017, data on 1155 FBR families had been entered. Seventy-seven per cent of these families had no report of abuse or neglect filed against them during the course of treatment, a key indicator of positive child protection outcomes. In addition, 90 per cent of FBR children were up to date on their medical care.

Discussion

The successful development and implementation of FBR services throughout Connecticut have required the ability to collaborate and communicate across multiple systems, primarily DCF and social service agencies providing the model. The CPS social worker looks at the family through the lens of child safety, wellbeing and timely permanency planning, all of which a young child needs immediately. Alternatively, the clinician approaches recovery from a substance use disorder lens with the patience needed to treat a chronic health condition. These two perspectives can often conflict with one another, leading to misperceptions of behaviour: seeing clinicians as naïve, over-aligned with the parent and too trusting, and DCF workers as unrealistic and lacking empathy for the parent. To address these potential tensions, FBR and DCF work together to identify and address conflicting viewpoints at a variety of levels. FBR and DCF supervisors are encouraged to resolve differences at the case level to avoid misunderstandings that can impact the family. While DCF holds the legal mandate to ensure child safety and make the final decision on a child's placement, through this partnership, FBR has an opportunity to have a voice at the table to share clinical expertise and knowledge of the family. When concerns about model implementation arise, the FBR Services director and the DCF Central Office contract manager meet with all parties to address concerns in a transparent manner and develop a plan of action.

Additionally, the definitions of risk and safety can vary across systems. The initial FBR staff training includes a section on risk and safety, highlighting factors that CPS weighs when assessing risk in the home. Some DCF social workers may be slower to change practice and accept the idea of managing risk in the home. This can lead to shifts in case direction that do not reflect the underlying principle of the collaboration and FBR approach to substance use

treatment. The greatest influence on DCF's acceptance of the model has been the development of relationships with FBR staff and shared successful case outcomes.

Constant attention to the adherence of the principles of the collaboration and treatment model will always be necessary for both DCF and FBR teams. FBR Services and DCF outcome data strongly suggest that this joint focus yields benefits for many families. Many parents have been able to utilise the opportunity to parent a child as a motivator for change. Outcome data support the belief that concurrent treatment for the parent and the parent–child dyad can mitigate risk and maintain family cohesion. Home-based work allows for greater opportunities to observe parent–child interactions. The clinician reflects with the parent on the meaning of child behaviour and supports appropriate parenting responses.

Limitations and Future Directions

FBR has focused on model development, service delivery and quality assurance analysis. However, there has been limited capacity to conduct a thorough analysis of the data to better understand key aspects of the model, including which clients are best served and what dosage of treatment is optimal. The Connecticut Family Stability Project (FSP), a Pay for Success (PFS) project, combines non-profit expertise, private funding and independent evaluation to expand the capacity of FBR, support a randomised control trial and pilot an adaptation of the FBR model for parents with a child aged three to six years. The PFS model afforded the state an opportunity to engage philanthropic and commercial investors in developing a public–private partnership that mobilised US \$11.2 million to expand FBR services to an additional 500 families across the state. This is Connecticut's first PFS project, and the first one introduced with a focus on family stability in the context of substance use disorders. The FSP was launched at a time when the state's budget crisis prohibited the addition or expansion of services in spite of acute needs stemming from an opioid epidemic. Moreover, the FSP may be able to advance understanding of how human service systems can fund 'preventative' programming. The theory is that by preventing the removal of children from families experiencing substance use disorders, other outcomes can be averted, including: housing instability, criminal justice involvement, unemployment and long-term reliance on assistance programmes. These findings will provide some baseline information on children who avoid foster care and whether they experience any long-term benefits compared to those who enter foster care.

Conclusions

FBR is an example of a public–private partnership that is changing how parents with a substance use disorder and CPS involvement are treated. Families experience an integrated system intervention in which all entities – the family, DCF and FBR – share the same goal: success in achieving positive outcomes for families. FBR data on child placement at discharge suggest that children can remain safely in the home while parents work to achieve recovery, decreasing unnecessary removals and promoting positive attachment and

'Concurrent treatment for the parent and the parent–child dyad can mitigate risk and maintain family cohesion'

'Children can remain safely in the home while parents work to achieve recovery'

family stability. It is important to ensure that there are effective services to address the dual challenges of parenting and recovery that this intervention was designed to address.

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