Therapeutic Services for Children: A Review of the Responses to the SAPT Block Grant Application

The Substance Abuse Prevention and Treatment (SAPT) Block Grant Interim Final Rule, Title 42 U.S.C. 300x-22 and 300x-24(b), requires that States allocate a percentage of their block grant dollars to fund services for pregnant women and women with dependent children. These services must include “therapeutic interventions for children in custody of women in treatment which may among other things address their developmental needs and their issues of sexual abuse, physical abuse, and neglect” (45 CFR 96.124 [1993]). All States report that they comply with these requirements, in Goal 3 and Attachment B of the SAPT Block Grant Application.

“Therapeutic services” are not further defined in SAPT Block Grant statute or regulation. Though States must fund such services, the Block Grant statutes and regulations do not describe which children should receive such services, or when they should be delivered. In addition, the Block Grant statute and regulation do not define which levels of care should provide therapeutic services to children. These services can be provided either directly by the program staff, or by referral to another agency.

This report is a first step in learning about how States ensure that children receive therapeutic services as part of their parent’s SUD treatment program and how States define therapeutic services for children. It examines the States’ narrative responses in the 2009 Substance Abuse Prevention and Treatment (SAPT) Block Grant (Goal 3: Pregnant Women’s Services and Attachment B: Programs for Women). This document is not meant to catalogue the responses of each State, but rather to describe themes found across the States, and identify advanced States.

State Block Grant responses include varying levels of detail and specificity in describing therapeutic services for children whose parents receive SUD treatment. Many States use vague or imprecise language to describe the services that children have access to in their Block Grant responses. In this report, much of this language is cited verbatim. In addition, some States provide additional services for children (e.g., by referral) that are funded through other sources which may not be detailed in their Block Grant responses. The next stage of this project, the nine case studies, should clarify exactly what services are provided, how it is determined what services are appropriate for each child, and whether services are provided directly or through a referral.

Therapeutic Services for Children

Relatively few States define what services are provided as therapeutic child care (TCC) services in their Block Grant Applications. However, it is clear that creating linkages across systems has been essential in ensuring that children receive appropriate, therapeutic services while their parents receive SUD treatment.
Eleven States (CO, CT, KS, MA, MI, MN, MO, MT, NY, OK, TX) report that providers are required to assess children’s mental health, and their developmental needs. The SSA in Colorado reported that one provider utilizes the Ages and Stages Developmental Worksheets to screen the children, and will refer them for further assessment (if needed) and services. In Missouri, providers are required to employ a “child therapist...to assess infants/children and either provide the necessary services or make appropriate referrals for infants/children with special needs.” In Montana, the SSA ensures that a neuropsychologist evaluates children whose mothers enroll in SUD treatment. This evaluation is followed by “program interventions addressing developmental delays in children and other developmental issues.” Most States do not describe whether they have specific instruments or protocols that providers are expected to use.

Ten States (CO, GA, ID, NY, NC, OK, RI, SD, TX, UT) also indicate that providers are expected to offer substance abuse prevention education and early interventions for the children of clients receiving SUD treatment.

Four States report that they have implemented special services for children who are diagnosed with, or are suspected to suffer from, Fetal Alcohol Spectrum Disorder (FASD) whose parents enroll in SUD treatment services. In Alaska, the FASD coordinator ensures appropriate diagnostic referrals are made for children who may have FASD. In Minnesota, all grant funded programs are encouraged to develop linkages with the Minnesota Organization for Fetal Alcohol Syndrome (MOFAS) to address FASD and to collaborate with them on any training and technical assistance needs. Programs in Minnesota also provide case management for children who are diagnosed with FASD. In Montana, the SSA participates in the FASD state project “to explore education, identification and treatment response to this population.” In Oklahoma, the Oklahoma University (OU) Department of Pediatrics provides screening, assessment, and treatment planning for children suspected of having FAS whose parents are receiving SUD treatment services.

In Colorado, providers that serve women with dependent children offer therapeutic services for children, which include play therapy, tutoring, mental health groups, family bonding and parental attachment activities. In Idaho, children whose parents receive SUD treatment services take part in play therapy while their parent receives other services. In Iowa, children must receive children's counseling as part of their therapeutic services array. In Minnesota, programs that admit women with dependent children are required to conduct Children of Substance Abusers (COSA) groups.

Minnesota requires that Chemical Dependency programs use the SAMHSA/ evidence based manual *The Children’s Program Kit* with dependent children of parents who receive SUD treatment.

Funded by a SAMHSA Addictions and Mental Health Early Childhood State Incentive Cooperative agreement, Oregon developed the Starting Early Starting Smart model. This model focuses on prevention and early intervention services to children 0-8, whose parents are
receiving SUD treatment services and who have or are at risk for developing, mental health or drug and alcohol problems. The service array includes child and family therapeutic approaches, consultation to providers in child-serving agencies including child care providers, and improved access to mental health services. Based on the experiences of four pilot sites, a document *Principles to Practice: Guidelines for Oregon’s State Incentive Grant Project* was created to guide the implementation of the model throughout Oregon. The document describes each of the Key Principles, which are evidence-based, with a specific focus on the three levels of implementation: system level, the agency level, and the direct service levels. Providers in Oregon have also implemented the evidence-based practice *The Incredible Years*, an evidence-based program which has been successful in reducing children's aggression and behavior problems, and increasing social competence.

Programs in Texas provide the *Strengthening Families* curriculum to children ages 6-10 whose mothers are receiving SUD treatment services.

**Importance of Referrals**

To meet the Block Grant requirement of providing pediatric care, therapeutic services for children and child care, States have been successful in helping their providers to make referrals to existing initiatives, programs and funding streams. Providers in Idaho, Montana, Rhode Island and Virginia helped eligible clients to access Medicaid services for their children. Connecticut, Kansas and Oregon require that programs establish linkages with local HeadStart programs and other community supports for children.

SSA staff in Georgia compile and maintain a current listing of all existing TCC providers, including addresses, staff members, phone numbers, and email addresses.

SUD treatment providers in Idaho have accessed therapeutic services for children that are provided by the Department of Health and Welfare’s children's mental health and developmental disabilities program services. In addition, programs have received funding from Medicaid, the Social Services Block Grant emergency assistance monies, and community indigence funding to pay for therapeutic services for children. Finally, providers have networked with other community agencies to ensure that children receive the required services.

In Oregon, the legislation was implemented to create the Intensive Treatment and Recovery Services (ITRS) initiative, “emphasizes the need for addiction providers to connect with local partners in the early childhood system of care, including prenatal care providers, early childhood education, mental health therapists, and Head Start to ensure parents and their young children have adequate resources and support.” The SSA also “supports the Oregon Children’s Plan, which focuses on prevention and early intervention services to children 0-8 and their families,” who have or are at risk for developing, mental health or drug and alcohol problems. The service array includes child and family therapeutic approaches, consultation to
providers in child-serving agencies including child care providers, and improved access to mental health services.

In Texas, providers are required to coordinate with WIC to receive pediatric care and other services for children.

The SSA in Vermont “collaborated” with the Department of Children and Families to ensure that women receiving SUD treatment services can access either licensed day care services (for women enrolled in outpatient services and in residential programs that accept children) and the services of licensed foster care homes (for women in residential treatment programs that do not accept children).

In Virginia, children whose parents are in SUD treatment receive services through Project LINK (one program of Virginia’s Home Visiting Consortium), which offers state-funded early childhood programs and services. This program also links families to needed community services and support them through a variety of education, preventive and intervention efforts.

The SSA in Washington has worked “to establish links” between SUD treatment providers who serve pregnant women and women with dependent children and Washington’s First Steps program, which provides free childcare, infant case management and pediatric care for babies 0-2.

In West Virginia, all providers must have on record Memorandums of Understanding with child care agencies, primary care services, and OBN/GYN hospital clinics for pediatric medical care for infants and children, and follow-up services within the community. This requirement has improved patients’ access to such services, and has reduced the time that clients must spend trying to arrange such services. The West Virginia Women and Children’s Treatment Coordinator has worked with the State offices of the Bureau for Children and Families (BCF) to resolve problems between child care agencies and substance use disorder treatment centers. This has decreased the time spent on gaining approval for the payment of day care fees (which is a part of the "WV Works" TANF program). Residents’ time in treatment is considered acceptable to qualify for WV Works. Providers have continued to obtain Memoranda of Understanding with child care agencies to provide care to children whose mothers enroll in SUD treatment regardless of TANF eligibility.

Training, Compliance and Effectiveness Monitoring

Three States (GA, MI, VA) report that the SSA provides technical assistance (TA) to providers to help them to provide, or refer clients to appropriate therapeutic services for children whose parents enroll in their programs. In Georgia, the SSA offers TA via phone, mail and email, or site visits, as requested by the providers. The goal of the TA is to aid the development and expansion of existing services with a foundation of supporting best prevention, intervention and treatment for children from families of addiction. The SSA also worked with Wingspan to offer two two-day training opportunities, Al’s Pal’s and Here, Now and Down the Road.
trainings, to provide TCC staff with information on new research, best practices, and research-based prevention. Finally, the TCC consultant provides best practices information in a two-day training which includes updated research and knowledge regarding Fetal Alcohol Syndrome and practices for working with children of addicted parents.

It is likely that other States also offer TA and trainings to providers on both a formal and informal basis. States may have reported this data in their responses to Goal 11: An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services. It will be important to discuss training opportunities with the nine case study States.

All States ensure that their providers are offering the required services. All States are required to report how often they conduct compliance monitoring in Attachment D: Program Compliance Monitoring. In their narrative responses to Goal 3 and Attachment B, many States note that they also write these requirements into contracts. In Georgia, the SSA employs a consultant to conduct annual compliance site visits for all of the Therapeutic Child Care providers. Based on these visits, the consultant completed site visit reports, which were distributed to a variety of stakeholders at the state, regional and provider levels.

The SSA in Georgia also developed an evaluation plan and consequent ongoing reporting system for therapeutic services for children to ensure appropriate reporting of data to the SSA. In addition, the SSA has begun to “evaluate the current service array for effectiveness.”

Conclusions

All States report in their Block Grant Applications that they provide therapeutic services to children whose parents are receiving SUD treatment services. A review of the States’ responses to Goal 3 and Attachment B of the SAPT Block Grant cannot provide a complete picture of what services children whose parents are enrolled in SUD treatment receive. It also cannot provide a detailed picture about the ways that States provide oversight to ensure that children receive therapeutic services when their parents enroll in SUD treatment services, or how SSAs define therapeutic services for children.

However, this review has yielded some themes that should be further explored in the nine case studies. Though States do not thoroughly define exactly what therapeutic services are provided to children whose parents receive SUD treatment services in their Block Grant responses, it is clear that screening and early intervention/prevention are common components of the service array for children whose parents enroll in SUD treatment services. It will be important to learn how States define therapeutic services for children in more detail, and how these services are delivered. It will also be important to learn if States have identified particular developmental screenings/assessments instruments that they encourage or require providers to use. In particular, many States have initiatives around identifying FASD. Learning about assessments and services for children who are suspected to have FASD, and whose parents are enrolled in SUD treatment, should be another focus for the case studies.
This review has also shown that many States encourage their providers to refer clients to outside therapeutic child care programs, rather than offering these services in-house. It will be important to explore what lessons States have learned as they help providers to make appropriate referrals. West Virginia has overcome many obstacles while helping SUD treatment providers effectively refer children for pediatric care and child care. The lessons learned from their experiences may help other States. In addition, Oregon’s SSA has worked to create systemic links between SUD treatment programs and children’s services that are offered by other State agencies. As part of the case studies, NASADAD will explore the ways that system linkages can help to increase efficiency and help providers access therapeutic services for children. In addition, the SSA in Oregon has implemented a Statewide model to provide such services. Understanding the challenges and opportunities created by implementing a model on a large scale can help other States. Finally, Virginia’s SSA has worked with the Governor’s Home Visiting Consortium Initiative (Project LINK), which now offers in-home services to children whose parents enroll in SUD treatment services. Many States identify transportation as a major barrier to services.

There is a focus among SSAs on using evidence based practices (the use of evidence based practices is a National Outcome Measure). Georgia focuses heavily on implementing evidence-based therapeutic services for children. Identifying such practices that have been successfully implemented in the States should be a focus of the case studies. The case studies should also focus on how States have ensured that their providers have been trained in, and faithfully implemented evidence-based therapeutic services for children.