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# Using Peer Supports to Foster a Trauma-informed and Recovery-oriented Child Welfare System

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## Introduction

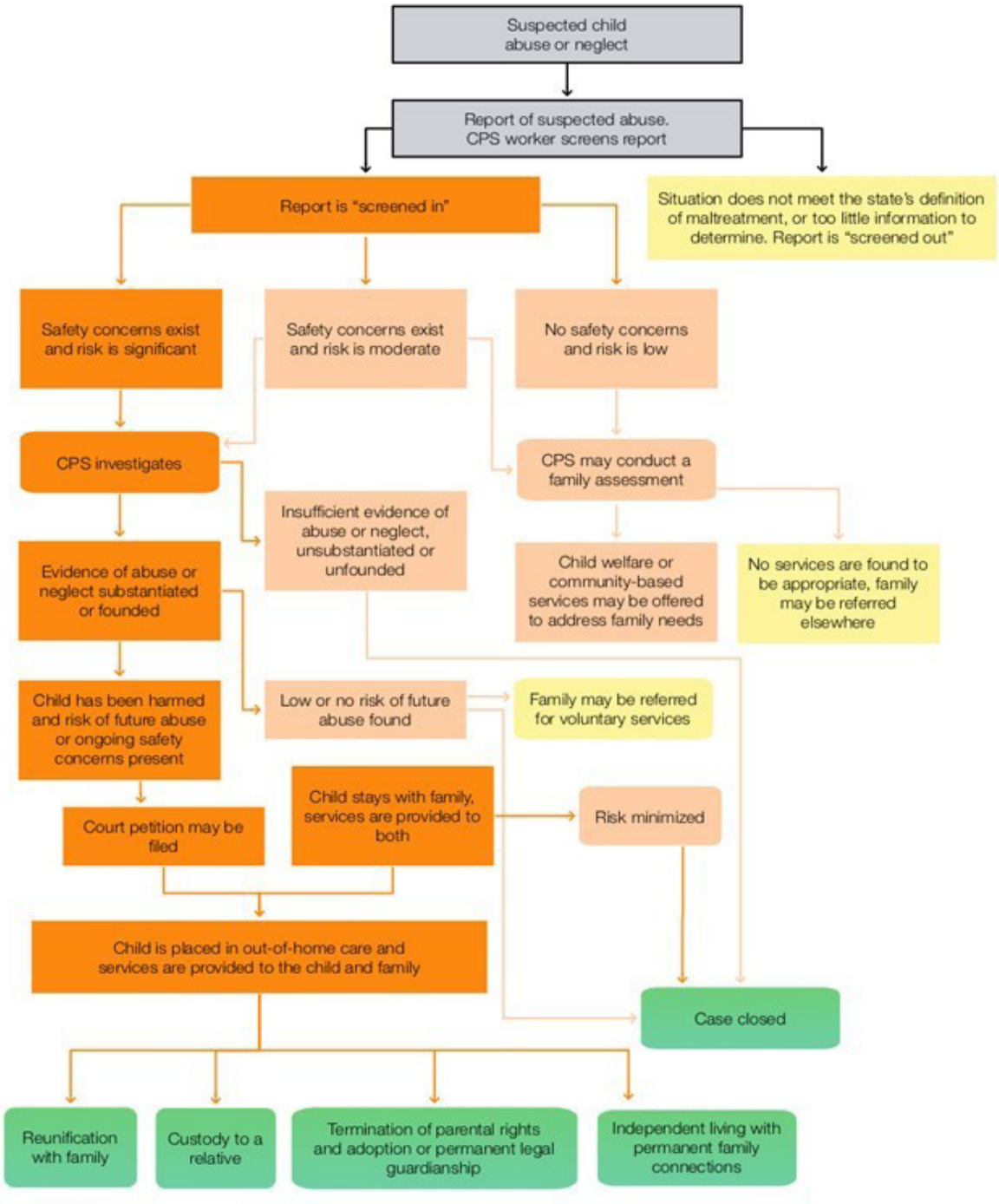
The United States child welfare system affects millions of families each year and often results in consequential changes—both temporary and permanent—to family structures and stability. The experience of navigating the complex and often fragmented child welfare system can lead to trauma and retraumatization for children and adults alike. Further, systemic racism has led to overrepresentation in the system by specific populations, including African American and Native American families (Child Welfare Information Gateway, 2016). Pervasive stigma, discrimination, and the criminalization of substance use disorders (SUDs) have led to a significant number of child removals due to parental substance use. To address the systemic and structural deficiencies of the child welfare system, a transformation toward a trauma-informed and recovery-oriented system needs to take place. The integration of peer recovery support services (PRSS) into the child welfare system, if handled with intention, could serve as an ideal vehicle for that transformation.

PRSS programs within child welfare settings provide support from individuals who have the lived experience of recovery from SUD and child welfare involvement. Peer support workers provide critical emotional, informational, and instrumental support, including engaging parents in SUD treatment and recovery supports; assistance with navigating the child welfare system; liaising between systems and services; accessing resources to housing, social services, transportation, education, and employment; and assisting parents with overcoming multiple challenges to recovery and reunification. Child welfare-specific PRSS programs have demonstrated positive outcomes, including improved treatment completion rates and other positive recovery outcomes, reduced time spent out of the home for children, and improved family reunification rates (National Center on Substance Abuse and Child Welfare, 2018).

To highlight current efforts and identify recommendations to improve child welfare and family outcomes through the implementation of PRSS,

this concept paper (1) provides background on the current systemic and structural issues in the child welfare system that have a disproportionate impact on vulnerable populations; (2) describes PRSS in child welfare settings, identifying the core components of programs, existing challenges, and opportunities for improvement and expansion; (3) highlights existing examples from the field; and (4) offers recommendations for a transformation of the child welfare system toward a trauma-informed, recovery-oriented system.

Exhibit 1. Child Welfare System Flow Chart (Child Welfare Information Gateway, 2020)



## Child Welfare: A Brief History

The child welfare system in the United States is composed of numerous agencies and organizations and is funded, monitored, and supported at local, state, and federal levels. This makes it incredibly confusing and complex for families to navigate. Generally, families become involved in the child welfare system after there is a report of suspected child maltreatment by parents or primary caregivers, which can include neglect and physical, sexual, and emotional abuse. Each state has its own laws related to and defining child maltreatment, including reporting requirements (Child Welfare Information Gateway, 2020). Exhibit 1 on the previous page provides a flowchart of the child welfare system and the potential outcomes families can face.

Integrating peer recovery supports early in the process may help families navigate the complex system of government and community-based organizations that make up the child welfare system. PRSS can help bridge fragmentation within the current system and link families to treatment and recovery supports with sensitivity to what families are going through, since peer workers have lived experience and may better understand cultural sensitivities within various communities.

Throughout its history, the child welfare system's main priority has hovered between protecting parental rights and ensuring child safety and permanency. Federal child welfare legislation, known as the Child Abuse Prevention and Treatment Act (CAPTA), was enacted in 1974 and has been amended several times to incorporate needed changes in the system. CAPTA provides federal funding to states in support of prevention, assessment, investigation, prosecution, and treatment activities. In addition, it provides grants to public agencies and organizations, including Native American tribes and tribal organizations for demonstration program and projects (Child Welfare Information Gateway, 2020). CAPTA also identifies the federal role in supporting research, evaluation, and technical assistance and creates a national clearinghouse of information related to child abuse and neglect. Finally, CAPTA sets forth the federal definition of child abuse and neglect (Child Welfare Information Gateway, 2020).

### Other Noteworthy Federal Child Welfare Legislation

**Indian Child Welfare Act (ICWA) in 1978**

Enacted to address the large number of American Indian and Alaska Native children being separated from their families and tribes. The intent of this law was to protect the best interests of the Native children and promote the stability and security of American Indian tribes and families. ICWA sets federal requirements for instances when a Native American child is identified by a child welfare agency and requires that the agency document active efforts to engage the family, identify a placement that fits under the ICWA preference provision, and notify and engage the child's tribe and parents of any court proceedings (National Indian Child Welfare Association, n.d.).

**Safe Families Act (ASFA) in 1997**

Established permanency guidelines in federal legislation, creating a pivotal change for child welfare practice across the United States. The enactment of ASFA marked a shift in priorities away from the rights of birth parents and family reunification and toward the needs of children for safety, health, and permanency (Szilagyi, Rosen, Rubin, and Zlotnik, 2015). It intended to pave the way for states to improve the safety of children, promote adoption, improve services, and support other permanency options through concurrent planning.

## Realities Within the Child Welfare System

In 2017, 4.1 million allegations of child abuse and neglect were made to child protective services agencies. Of those, 2.4 million were referred for an investigation and 674,000 children were determined to be victims of abuse or neglect (Child Welfare League of America, 2019). In 2016, approximately 437,000 children were in the foster care system and 118,000 were awaiting adoption in the United States (U.S. Department of Health and Human Services, 2016). Child welfare outcomes vary widely by state. For example, in 2017, Puerto Rico had the highest family reunification rate (80.6 percent), followed by South Carolina (76.9 percent) and Wyoming (72.9 percent). The states with the lowest reunification rates were Texas (36.8 percent), Delaware (39.2 percent), and Illinois (40 percent) (Administration for Children and Families, n.d.). Because of shifts across the child welfare system, the system has undergone numerous changes in policy, service delivery, and system design so that safety, permanency, and well-being goals can be more broadly met. Many of these changes have been due to the implementation of new federal and state laws, along with the adoption of innovative models to service children and families (Peterson, Joseph, and Feit, 2014). Children in foster care have worse medical and behavioral health outcomes than children in the general population. This is influenced by multiple factors, including a high incidence of chronic medical conditions, incurred by poverty and experiences of trauma (Putnam-Hornstein, Needell, King, and Johnson-Motoyama, 2013).

### Parental Substance Use

Parental substance use is a primary and increasing contributing factor for child removal. In 2016, parental

Exhibit 2. Prevalence of Parental Alcohol and Other Drug Use as a Contributing Factor for Reason for Removal in the United States, 2000 to 2016 (National Center on Substance Abuse and Child Welfare, 2019 and Adoption and Foster Care Analysis and Reporting System [AFCARS] Data, 2000–2016)

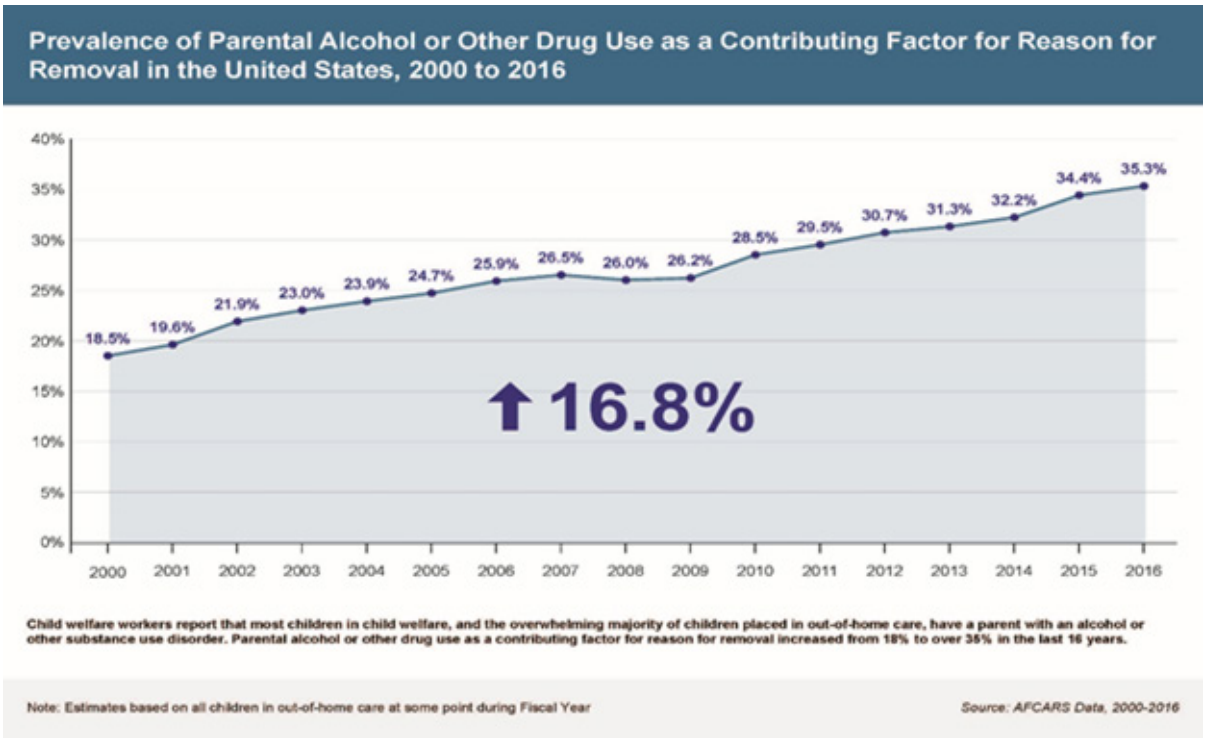
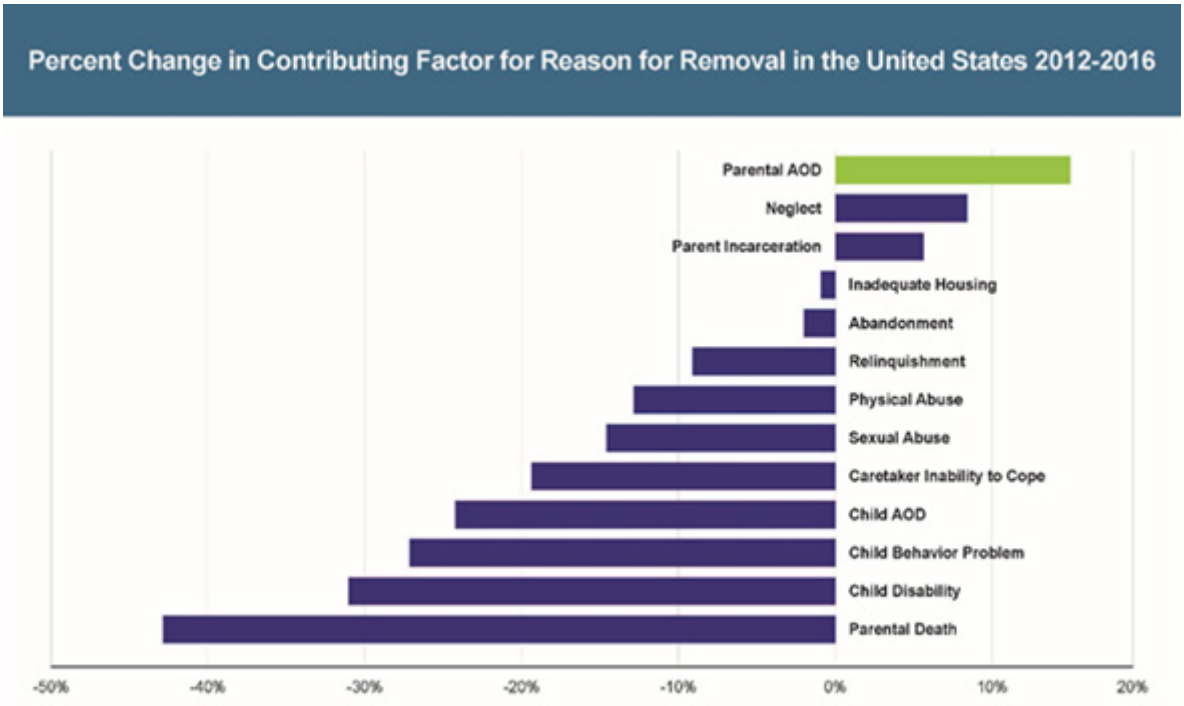


Exhibit 3. Percent Change in Contributing Factor for Reason for Removal in the United States 2012–2016 (National Center on Substance Abuse and Child Welfare, 2019)




substance use was a contributing factor in more than 35 percent of all removal cases nationally, an increase of 16.8 percent since 2000 due to the current opioid epidemic (National Center on Substance Abuse and Child Welfare, 2019). In Alaska, Indiana, Maine, Oregon, Texas, and Utah, parental substance use was a contributing factor in more than 60 percent of all removal cases (National Center on Substance Abuse and Child Welfare, 2019). Between 2000 and 2016, the biggest percentage change in the reasons for suspected abuse or neglect reports came from children being removed because of their caregiver's substance use (National Center on Substance Abuse and Child Welfare, 2019). Exhibits 2 and 3 above highlight the significant increase in child removal cases due to substance use.

## Trauma

Research has shown that adverse childhood experiences (ACEs) can cause lasting physical and emotional harm across the lifespan of an individual (ACEs Connection Network and Interface Children and Family Services, n.d.). The Substance Abuse and Mental Health Services Administration (SAMHSA) states that trauma has three key components: an event, an experience, and subsequent effects. Individual trauma results from an **event**, a series of events or a set of circumstances **experienced** by an individual as physically or emotionally harmful or life-threatening with lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (SAMHSA, 2022).

Based on a study by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente, ACEs

are defined as 10 specific and possibly traumatizing events experienced by children up to 17 years old. ACEs are correlated with poor health outcomes and premature death; the greater the number of adverse events in childhood, the greater risk for a child to have health complications later in life. The original study included the following ACE categories:

- Family member struggling with substance use or alcohol misuse
- Emotional abuse
- Emotional neglect
- Incarceration of any family member
- Loss of a parent to death or abandonment, including abandonment by divorce
- Mentally ill, depressed, or suicidal person in the home
- Physical abuse
- Physical neglect
- Sexual abuse
- Witnessing domestic violence against a parent

There are many other types of traumatic events that can impact a child's development but may not be labeled as an ACE.

Adverse events, along with prolonged activation of the stress response system resulting in toxic stress, can also negatively affect a child's overall development, especially brain development. The younger a child is when they experience an ACE, the greater the impact on brain development. These effects can include chronic physical and mental health issues, hypervigilance, lower impulse control, a greater vulnerability to addiction, and poorer memory and learning abilities that can potentially affect the course of a child's entire life, leaving them more vulnerable to poor life outcomes (Jackson, 2016).

Rates of trauma exposure and ACEs are disproportionately high among children involved with the child welfare system. Youth placed in foster care are also at a heightened risk for developing post-traumatic stress symptoms. As a result, children in foster care are more likely to experience mental and behavioral health challenges, including concerns related to depression, anxiety, suicidality, risky sexual behavior, and delinquency. Continued mental and behavioral problems also increase the risk for higher restrictive foster care placement and contact with juvenile justice systems.

In addition, parents involved in the child welfare system often have trauma histories and/or struggle with substance use, making child removal more likely. The experiences of child removal can consequently affect parental mental health.

Many families and communities of color have long histories of problematic relationships and distrust of federal and state institutions and policies, including the child welfare system, based on historical evidence of intentional harm. This has contributed to the overrepresentation of families of color in the child welfare system, one of the most pressing issues facing policymakers and practitioners today (Elnekave, Haight, and Jader, 2020). Existing data show that racial and ethnic disparities are pervasive in the child welfare system. Intersectional factors such as racism and discrimination, intergenerational trauma, poverty, mass incarceration, homelessness, and disability contribute to the disproportionate impacts of the child welfare system on people of color.

## Reimagining the Child Welfare System

Historically, the child welfare system was put in place with a primary focus on securing the safety of children. Within the child welfare system, "safety" is a key term that describes a threat of imminent danger of a child,

whereas the term "risk" is a broad concept regarding whether an adverse event might occur if there is not an intervention. Risk levels can be determined through various assessments as low, moderate, or high. The assessment of safety and risk is subjective and ambiguous; staff consider whether there is a threat of danger to a vulnerable child and a lack of protective capacities on behalf of the parent or caregiver. If the answer is yes on both counts, it is determined that there is a reason to intervene within the family.

With safety as the primary driver, a system has been created that privileges separation over rehabilitation, pushes for quick permanency leading to family dissolution, and fails to acknowledge the effects of structural racism and trauma caused by foster care placement (on both children and parents). Further, these attributes of the child welfare system are heightened by attitudes toward substance use that are stigmatizing, discriminatory, and criminalizing.

Considering the many shifts in the child welfare system over time and its increasingly cumbersome bureaucracy, critics have suggested a fundamental shift in priorities that would result in a streamlined system that is more responsive to family strengths and needs. Instead of a system based on punishment, blame, and parent-shaming, imagine a system in which the end goals were healing, resiliency, and recovery. Families who are involved with the child welfare system got there because of a variety of factors, including trauma, poverty, substance and mental health disorders, and structural racism and discrimination. Acknowledgment of the interactive sum of these factors, balanced with strength-based tools to help individuals and families sort them out, will yield far better outcomes than the current system.

## Two Paradigms for Systems Change

The many indicators of flaws in the child welfare system suggest that there is a need for immediate and long-term reform of the system. A system redesign that guarantees a safe, trusting environment with a baseline of sensitivity and transparency will lead to respect and empowerment for everyone in the system and, ultimately, better outcomes. Such an environment, replicated throughout the system, will also serve to avert the retraumatization and harm that is incurred by a system that is ultimately supposed to help, not hurt.

Over the past few decades, there has been tremendous research on, and greater understanding of, the roots of mental illness and SUDs. There has been a concerted movement away from blame and stigma and toward a recognition of contributing factors that include trauma, genetics, poverty, and structural racism. The behavioral health field has incorporated a knowledge base on what it means to be trauma-informed as well as recovery-oriented. These concepts can be a guiding star in moving toward the systemic policy changes that are overdue in the child welfare system.

While the ideas and concepts of trauma-informed and recovery-oriented systems of care were developed separately from one another, there are numerous points of intersection and convergence; they are complementary and serve the same ends. A blended concept of trauma-informed, recovery-oriented systems of care (TI-ROSC), which have peer recovery supports as their core, offers a proactive approach for stakeholders in the child welfare system to engage affected children, adults, families, and communities. Exhibit 4 provides a crosswalk of the characteristics of the two paradigms, which are described in more depth below.

Exhibit 4. Characteristics of Recovery-oriented and Trauma-informed Systems of Care

| Recovery-oriented Systems of Care | Trauma-informed Systems of Care |
|---|---|
| Person-centered | Safety |
| Strength-based | Trustworthiness and transparency |
| Trauma-informed | Peer support and mutual aid |
| Inclusive of family | Collaboration and mutuality |
| Individualized and comprehensive | Empowerment, voice, and choice |
| Connected to the community | Cultural, historical, and gender issues |
| Outcome-driven | |
| Evidence-based | |
| Adequately and flexibly funded | |

## Recovery-oriented System of Care

A recovery-oriented system of care (ROSC) is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems (Substance Abuse and Mental Health Services Administration, 2010).

Over the past 15 years, ROSCs have provided a useful framework for transforming the entire SUD treatment system of care. In a ROSC, a comprehensive approach is taken, providing the full continuum of care (prevention, early intervention, treatment, continuing care, and recovery) in conjunction with a range of other stakeholders and sectors. A ROSC encompasses a choice-driven menu of individualized, person-centered, and strength-based supports and services offered through a community-based provider network. By design, a ROSC provides individuals and families with a diverse range of options with which to make informed decisions regarding their care. Services are designed to be accessible, welcoming, and easy to navigate. A fundamental value of a ROSC is the involvement of people in recovery, their families, and the community to continually improve access to and quality of services. Given this value, PRSS are at the center of a ROSC.

## Trauma-informed Care

Trauma-informed care focuses on individual and family strengths, empowerment, and recovery. Being trauma-informed allows people to regard attitudes, behaviors, and responses—that might otherwise be characterized as negative—instead as coping mechanisms adopted to survive traumatic experiences (Clervil and DeCandia, 2013). SAMHSA provides the four Rs that define a trauma-informed program, organization, or system:

- **Realizes** the widespread impact of trauma and understands potential paths for recovery. This means trauma can affect how individuals eat, sleep, and work—all aspects of life.
- **Recognizes** the signs and symptoms of trauma in clients, families, staff members, and others involved with the system. A trauma-informed agency recognizes that anyone could be a trauma survivor and acts accordingly.
- **Resists** retraumatization. The providers have an individual's safety and comfort in mind. They take into consideration what individuals have been through and what could cause them or their child to remember or reexperience a traumatic event.
- **Responds** by fully integrating knowledge about trauma into policies, procedures, practices, and settings. All levels of staff should know about trauma and its effects (Substance Abuse and Mental Health Services Administration, 2022).

Understanding trauma and its impacts on children and families is the first step in maintaining healing, hopeful, honest, and trusting relationships between staff members, between staff members and leadership, and between staff members and the individuals they are serving within the community.

## How Integrating Peer Supports Can Foster a Trauma-informed and Recovery-oriented Child Welfare System

PRSS and peer practice can be powerful vehicles for supporting TI-ROSC in the child welfare system. Integrating peer support workers into programs can improve outcomes for families with complex needs related to substance use or mental health challenges. With their lived experience, peer support workers may earn trust more quickly, which can lead to a deeper and more effective engagement in services. A variety of successful models incorporating peer workers have had positive outcomes by offering onsite support to engagement in treatment and recovery. These models have demonstrated increased success in reunifying families, access to treatment, and engagement and a reduction of out-of-home care time (National Center on Substance Abuse and Child Welfare, 2018).

Peer workers help reduce stigma, serve as liaisons within the system, support families in communicating with and connecting to services, develop recovery capital to help maintain recovery, and offer nonclinical perspectives to the support team (National Center on Substance Abuse and Child Welfare, 2018; Bringing Recovery Supports to Scale Technical Assistance Center Strategy, n.d.).

While adding peer support will not automatically create a trauma-informed, recovery-oriented system, if it is done thoughtfully and with intention, the implementation of PRSS can facilitate system transformation. PRSS does so by incorporating recovery values and recovery-oriented approaches, embracing multiple pathways to recovery, practicing assertive outreach and continued reengagement, supporting people in determining their own recovery goals, and providing community-based services.

The successful use of peer support workers in a variety of settings, including child welfare, has led to tremendous success in recovery outcomes, reduced hospitalizations, reduced arrests, increased citizenship, shorter stays in out of-home care for children, and family reunification (Gregoire and Schultz, 2001; Brook and McDonald, 2009). Overall, peer support workers have been effective in engaging individuals and families in achieving long-term recovery, improving a wide range of outcomes for children and families.

Further, the philosophy behind peer support assumes that all individuals, families, and communities have assets and strengths that can be built upon. This belief alone has created a paradigm shift from how business has traditionally been conducted in the SUD field, which blamed people for having an addiction and then placed a double blame on them if they failed treatment. The potential to create a similar change in the child welfare system is imminent, as peer support workers who have experienced SUDs and been castigated as bad parents are placed in valued positions, charged with engaging and helping others like them.

## Peer Support: Core Philosophies and Values

PRSS core philosophies are centered around recovery principles. SAMHSA has outlined the 10 guiding principles as follows:

1. Recovery emerges from hope.
2. Recovery is person-driven.
3. Recovery occurs via many pathways.
4. Recovery is holistic.
5. Recovery is supported by peer support workers and allies.
6. Recovery is supported through relationships and social networks.
7. Recovery is culturally based and influenced.
8. Recovery is supported by addressing trauma.
9. Recovery involves individual, family, and community strengths and responsibility.
10. Recovery is based on respect.

PRSS are implemented in a variety of settings; programs may look different based on organization or system needs. The core values of peer support are being nonjudgmental, sharing power in non-hierarchical ways, mutuality, and reciprocity. Peer support is based on a unique relationship that is grounded in shared experience, trust, and encouragement.

This paper makes use of the generic term "peer support worker." Depending on the context and the state, a wide variety of terms are in current use, including "peer support specialist," "peer recovery coach," "peer mentor," and "peer advocate."

Adding peer support workers to the workforce engages individuals to actively participate in their own recovery by defining their recovery goals and developing a plan to achieve them. Peer support workers may support treatment professionals and case managers, but their work is not clinical: they do not diagnose or give advice but, rather, act as recovery guides and mentors. And while peer support workers serve often as resource connectors, the peer role should not be confused with or a substitute for the role of the case manager.

### Peer Worker Core Competencies

There are existing core competencies for peer support workers across different settings. In addition, there are unique skills, responsibilities, and roles that apply to child welfare settings. The Oregon Regional Facilitation Center identified a set of 10 best practices for peer support workers specific to child welfare settings (Smith and Debban, 2017):

1. Establishing a connection with parents
2. Supporting positive engagement in services
3. Supporting compliance with the child welfare system
4. Promoting self-efficacy
5. Inspiring hope and serving as reunification role models
6. Providing person-centered, trauma-informed services that evoke individual needs, objectives, and goals
7. Advocating for parents within the child welfare system
8. Guiding the development of supportive relationships
9. Guiding and teaching system navigation
10. Enforcing regulations, ethical conduct, and peer boundaries

These core competencies provide guidance for developing the knowledge and skills needed to best support families in key areas. Peer support workers bring valuable experience to the team; core competencies describe how to apply that experience as well as the knowledge and skills. Developing training based on the core competencies ensures consistency in roles, responsibilities, and expectations across systems.

Equally important are training opportunities for other staff members, and participating agencies, to learn about peer support workers' roles, value, and scope within the child welfare system. Other staff members need to have a thorough understanding of what it is that peer workers do (and do not do) and how their roles complement those of other staff members. Other staff members also may need to be assured that peer workers are not taking their jobs (because they are not junior counselors or social workers), are not more fragile than any other staff members, and are not clients but coworkers.

### Peer Supervision, Hiring, and Retention

As organizations decide to incorporate PRSS, it is critical to understand the supervision, hiring, and retention of staff members. The supervision of PRSS staff members is an essential element to any successful program to ensure that staff members feel supported, to reduce secondary trauma and burnout, and to promote self-care.

When integrating PRSS into organizations, it is critical to be clear on who will be supervising peer staff members and how to incorporate peer support workers into various care teams. The SAMHSA Bringing Recovery Supports to Scale Technical Assistance Center Strategy provides the Supervision of Peer Workers Toolkit to help supervisors learn how to supervise peer support staff members in agencies that serve persons with SUDs or severe mental illness (National Center on Substance Abuse and Child Welfare, 2018). The toolkit has several components to support agencies and supervisors. It also allows agencies to infuse the information into their own curricula or for staff members to participate in a self-guided course (Bringing Recovery Supports to Scale Technical Assistance Center Strategy, n.d.).

As far as the individual(s) designated to hire or oversee peer support workers, it varies across agencies and states. In some cases, child welfare agencies may contract with housing organizations or case management or treatment agencies within their communities to provide recovery support to parents involved with the child welfare system. In other cases, staff members may be hired and overseen by the child welfare agency. Like other work settings, competitive pay and employee benefits support the recruitment of quality peer support workers. Recruitment and retention of staff members may be challenging; strategies may include posting flyers in the community, outreach to past program participants or graduates, posting to employment websites, and ensuring sufficient supervision after hiring.

## Thoughtful Integration of Peer Support: Opportunities and Challenges

Since parental substance use is a primary contributing factor leading to child removal, it is imperative that child welfare agencies approach designing a PRSS program through trauma-informed, recovery-oriented lenses. Without acknowledging and accounting for the roles that generational trauma, poverty, and structural racism play in the child welfare system, it will be difficult for agencies to truly achieve desired outcomes through PRSS. There is no one-size-fits-all

## COVID-19 Implications for Child Welfare

Since the beginning of the pandemic, child welfare agencies have experienced increased pressure on an already vulnerable system. Agencies have had to quickly shift how they deliver services and ensure the safety of children in their system and within/across their communities. The pandemic has highlighted the many shortcomings across the system that call for both immediate and long-term action (Welch and Haskins, 2020).

The isolation of families and other institutions, coupled with the reactionary nature of the system, has deprived agencies of the proper tools to identify, investigate, and support children who may be victims of maltreatment. This pandemic may be the push needed for stakeholders and local and federal leaders to examine and rebuild a child welfare system that is able to recognize and address the risk factors that lead to child maltreatment and support families while ensuring the safety of all children. However, we are now living in a "new normal" and must evaluate and address the current issues, even while being constrained by the flawed system design and limited resources. The system must quickly find new ways of adapting to the social distancing restrictions and accompanying financial hardships as the current economic and public health crises threaten to take a heavy toll on our nation's most vulnerable population of children and youth (Masand, n.d.).

PRSS program, so agencies must be intentional when crafting the vision, structure, and goals (short-term and long-term) of their programs. Furthermore, PRSS models must be distinct from the agencies' typical case management work to preserve and protect the intent of the peer programs given the inherent tensions between child welfare (child-centered) and PRSS (parent- and family-centered) priorities. Done correctly, PRSS can be a catalyst for change and can provide substance-using parents with an opportunity to overcome barriers to treatment and recovery, leading to increased rates of family preservation and/or reunification. Done incorrectly, peer support workers will become entrenched in the minutiae and bureaucracy of child welfare case management, pulling them away from the unique role they should play and creating a further strain on families and government resources.

There are four key areas on which to focus when planning and implementing a PRSS program: (1) essential (core) elements, (2) design factors, (3) drivers of success, and (4) integration processes. Below are some guiding questions for agencies to consider in each focus area.

### Essential Elements

- Who are the key stakeholders, and what is their role in the success of this program?
- Whom will the peer support workers report to? Will they be integrated into the existing case manager/social work teams, operate as a stand-alone team/unit, or be staff members of a partnering agency?

- What is the peer support workers' level of autonomy?
- For a program to align with peer recovery values, it must offer choice. How will the organization ensure family/client buy-in for peer support services?
- What support systems will be in place to support the continued recovery of peer support workers?

### Design Factors

- At what point in the child welfare continuum will PRSS be offered?
  - At the screening and assessment level?
  - At the in-home services/family preservation level?
  - At the out-of-home/foster care level?
- Where/how will the organization recruit peer support workers?
- How recent can the peer support workers' child welfare involvement have been?

### Drivers of Success

- What policies will be put in place to structure and shape the role of the peer support worker in the agency?
- How will the organization measure success?

### Essential Integration Processes

- Is there a specific population or demographic your agency plans to roll PRSS out with? If so, why this demographic?
- How will the perspectives and ideas of peer support workers be incorporated into the case plan?
- What is the vision for how peer support workers will engage and interact with families?
- How will the peer support workers' engagement be different from that of family case/social workers? How will it overlap?
- What resources will be made available to the peer support workers to perform their role?
- Are they mandated reporters?

## Current Practices of PRSS in Child Welfare Settings

Family services organizations and family court programs have integrated PRSS into their staffs—through partnerships with community-based organizations—to improve outcomes for families within the child welfare system that are affected by SUDs. PRSS were introduced within child welfare agencies to give additional support to families and parents with SUDs and to overcome barriers to treatment and other recovery support services. These barriers include those that are exacerbated by child welfare system involvement. PRSS are deeply appreciated by both parents and staff, as they are so instrumental to successful outcomes in child welfare cases that involve parents with SUDs (Abrahams, Ali, Davidson, Evans, King, Poplawski, and White, 2015).

In addition, a growing number of child welfare agencies and family court programs have directly integrated peer support workers into their service delivery models. Child welfare staff have cited the positive impact that peer support workers have in engaging other parents and helping to navigate the system, providing the hope and motivation often needed by parents who are in or seeking recovery and in the child welfare system.

Regardless of whether provided through partnership or peer workers on staff, PRSS programs in child welfare agencies connect a parent in the system with a person in SUD recovery who may also have had previous involvement with the child welfare system.

Peer support workers serve as a positive example and provide hope that unification and recovery are not only possible, but the expectation. In addition, peer support workers can reduce negative attitudes and stigma toward parents with SUDs among agencies and community partners. Finally, research suggests that the implementation of peer support workers within child welfare programs increases positive outcomes for families, improves treatment completion and recovery rates for parents, reduces the length of time children spend in out-of-home care, and increases family reunification rates (National Center on Substance Abuse and Child Welfare, n.d.).

## Financing PRSS in Child Welfare

As agencies begin to integrate PRSS across their programs, it is important to think about the financing of this role. A variety of funding streams are available to agencies. Through the National Center on Substance Use and Child Welfare, agencies in four states were interviewed on their use of PRSS—California, Connecticut, Illinois, and Kentucky—to support the development of the technical assistance tool (National Center on Substance Abuse and Child Welfare, 2018). The agencies that supported the technical assistance tool along with programs surveyed highlighted several ways that they were able to leverage existing funds, partnerships, and federal funds to ensure that peer support worker roles were available to child welfare agencies and programs. All the organizations indicated that they initially tapped into existing state and county/city funds—for example, from the states' departments of alcohol and drug programs, mental health services, child welfare services, and the county board of supervisors—to create this role.

Santa Clara County, **California's** child welfare system identified the need for mentor parents, who are individuals with lived experience of SUDs and child welfare involvement. Over the years, the funding for the mentor parent program has evolved. Initially, the county's Department of Alcohol and Drug Services (DADS) funded the program; however, in 2007, the program was expanded by the SAMHSA Children Affected by Methamphetamine (CAM) grant and then expanded again in 2009 with funding from Santa Clara County Mental Health. Once the CAM funding ended, the Santa Clara County Board of Supervisors sustained the CAM-funded portion of the mentor parent program largely because of the positive outcomes reflected in the CAM evaluation report. Ultimately, the county's Substance Use Treatment Services absorbed this cost into its own base budget. Currently, 76 percent of the program funding is from Substance Use Treatment Services and 24 percent is from Santa Clara County Mental Health (National Center on Substance Abuse and Child Welfare, 2018).

**Connecticut** implemented the Recovery Specialist Voluntary Program (RSVP) as a joint initiative of the Connecticut Department of Mental Health and Addiction Services (DMHAS); the Connecticut Department of Children and Families (DCF), Judicial Branch; and Advanced Behavioral Health (ABH), an administrative services organization that manages mental health and SUD services. From the beginning, RSVP was jointly funded by DMHAS and DCF through the reallocation of existing state dollars to ABH. RSVP staff members are employed by ABH and partner with the child welfare staff at DCF. To make the case to maintain RSVP, stakeholders compared spending

on RSVP to various drug testing programs. From the review, it was determined that the state was paying less for RSVP with better outcomes than on drug testing; therefore, additional funds were moved to RSVP. This allowed ABH to hire more staff members, which expanded the program and allowed more families to get the support of a recovery specialist (National Center on Substance Abuse and Child Welfare, 2018).

**Illinois** implemented the Sobriety Treatment and Recovery Teams (START) in 2006 to support integrated services between the child welfare system and substance use treatment providers. The Illinois Department of Children and Family Services (DCFS) contracted with Treatment Alternatives for Safe Communities (TASC) to provide the recovery specialists as well as the supervision of staff members. Funding was explored through federal funds as DCFS applied for a Title IV-E waiver project in June 1999 through the Title IV-E Foster Care and Adoption Assistance Program. The U.S. Administration for Children and Families (ACF), Children's Bureau, approved the application for a 5-year demonstration on September 29, 1999, and implementation began on April 28, 2000. Through subsequent extensions of the Illinois Waiver Demonstration, the most recent approval extended through September 30, 2019 (National Center on Substance Abuse and Child Welfare, 2018).

**Kentucky's** child welfare system employed family members who are individuals in long-term recovery from SUDs and have lived experience of the child welfare system. Family mentors are paired with child protection workers to implement a system for care for families. To fund this new role, Kentucky leveraged two regional partnership grants funded by ACF as well as leveraged Temporary Assistance to Needy Families (TANF) as a funding source. Kentucky was able to expand the program through the Title IV-E waiver program (National Center on Substance Abuse and Child Welfare, 2018).

None of the programs had Medicaid funding; however, it should be noted that in some states, peer services are billable to Medicaid. In 2007, the Centers for Medicare and Medicaid Services indicated to state Medicaid directors that peer support services are a comprehensive mental health and substance use service delivery system that could be reimbursed under Medicaid. However, to incorporate peer support in the state Medicaid plan, peer support workers must be supervised by a mental health professional, as defined by the state; must coordinate peer support with an individualized recovery plan with measurable goals; and must complete training and certification, as defined by the state (National Center on Substance Abuse and Child Welfare, 2018). Therefore, agencies should consider this avenue to fund this vital role as a part of other funding streams or along with their programs or create partnerships with organizations that understand the child welfare system and are integrating peer support as part of their programs.

## Conclusion

The current child welfare system is outdated, punitive, and oftentimes traumatizes, or retraumatizes, children, youth, families, and child welfare staff members. There is a need for a complete transformation of the system into a trauma-informed, recovery-oriented one that assists parents with substance use or mental health challenges to achieve improved health, wellness, and quality of life. The integration of PRSS can help with this transformation, providing community-based services and supports to families that are person-

centered and build on their strengths and resiliencies. If all child welfare organizations were staffed with peer support workers, families would have opportunities to receive support and guidance from someone who has been in a similar situation and to feel understood, supported, and more motivated to change, thus improving outcomes and increasing pathways to recovery. Thoughtful integration of peer support workers is crucial.

Moving forward, the test of peer support programs will be in the intention of their implementation. If they are used as an adjunct to the existing system and workforce, nothing will change. If they are used in a way that engages individuals and families in new and innovative ways, works to create an environment that is trauma-informed and recovery-oriented, and authentically helps people in putting back together their lives and families, they can serve as a vehicle to transform the child welfare system.

## Additional Tools and Resources

| Tool | Description |
|---|---|
| The Benefits of Family Peer Support Services: Let's Examine the Evidence<br>SAMHSA<br><br>(Recorded webinar) | This foundational webinar covers topics related to family peer support:<br><br>• What is family peer support?<br>• Qualifications of those providing family peer support<br>• How family peer supports are utilized<br>• Identified benefits of family peer support<br>• General research and literature review for family peer support services |
| Child Welfare Training Toolkit<br>National Center on Substance Abuse and Child Welfare<br>(PDF) | The National Center on Substance Abuse and Child Welfare developed this toolkit to educate child welfare workers about substance use and co-occurring disorders among families involved in the child welfare system. |
| Coronavirus: What Child Welfare Systems Need to Think About<br>*The Imprint*<br><br>(Research article) | This article discusses how COVID-19 is affecting the foster care system. |
| Family Involvement in the Improving Child Welfare Outcomes Through Systems of Care Initiative<br>ACF<br><br>(Longitudinal study) | This report is based on the 5-year cross-site evaluation of the implementation of the Improving Child Welfare Outcomes Through Systems of Care demonstration initiative in 9 grant sites representing 18 communities. The report study concludes by identifying lessons learned and recommendations to enhance the implementation of future family involvement efforts within the child welfare system. |

| | |
|---|---|
| How Do Parent Partner Programs Instill Hope And Support Prevention and Reunification?<br>Casey Family Programs<br>(Issue brief) | This issue brief describes the use of peer mentors, or "parent partners," who serve to bridge the gap between birth parents and a complex, often challenging, and overwhelming system. |
| Parent Partner Job Description<br>Child Welfare Information Gateway<br>(PDF) | The Child Welfare Information Gateway provides the job description for parent partners—parents who have firsthand experience with the child welfare system and who have exhibited exceptional qualities in their own efforts to develop viable permanency plans for their children, an understanding of how the child welfare system works, an appreciation of what it takes to be successful, and personal qualities that lend themselves to collaboration on various levels. |
| Child Welfare Practice to Address Racial Disproportionality and Disparity<br>Child Welfare Information Gateway<br>(PDF) | This issue brief from April 2021 discusses racial disproportionality and disparity within the child welfare system. |
| Substance Use Disorder Peer Delivered Services Child Welfare Best Practices Curriculum<br>Bay Area First Step<br>(PowerPoint presentation) | This presentation provides a broad overview of best practices for peer mentors within child welfare systems. |

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## About Altarum

Altarum is a nonprofit organization that works with federal and state agencies and foundations to design and implement solutions to improve the health of individuals with fewer financial resources and populations disenfranchised by the health care system. We achieve measurable results by combining our expertise in public health and health care delivery with technology, workforce training and continuing education, applied research, and technical assistance. Our innovative solutions lead to better health for beneficiaries and better value for payers. Under a grant from the Bureau of Justice Assistance (BJA), Altarum provides nationwide training and technical assistance to COSSUP grantees, states, and communities to build, enhance, and sustain peer recovery support services programs as part of multidisciplinary criminal justice responses to the opioid epidemic. To learn more about peer recovery training and support, visit https://altarum.org/services/solution/coap-bja. To learn more about Altarum, visit www.altarum.org.

Visit the Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) Resource Center at **www.cossup.org**.

## About COSSUP

COSSUP has transitioned from the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP). This change in title for the program is indicative of efforts to reduce the stigma related to substance use and to support impacted people in their recovery journey.

## About BJA

BJA provides leadership and services in grant administration and criminal justice policy development to support local, state, and tribal law enforcement in achieving safer communities. To learn more about BJA, visit www.bja.gov and follow us on Facebook (www.facebook.com/DOJBJA) and X (formerly known as Twitter) (@DOJBJA). BJA is part of the U.S. Department of Justice's Office of Justice Programs.

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