

Family-Centered Treatment for Parents with Substance Use Disorders

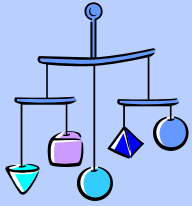
Presented By

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Historical Perspective

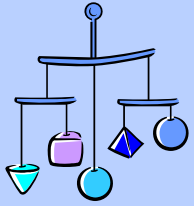
- Alcoholism and addiction have been recognized as a “family disease” since the 1930s, **BUT:**
- As treatment for substance use disorders developed, the treatment systems focused on helping *individuals* to overcome their abuse/ dependence with minimal family involvement.
- Family-centered treatment for parents with substance use disorders evolved as a way of improving individual services for women. Original purpose of involving family was to improve access and outcomes for women.

Treatment Block Grants to States and Women and Children's Set-Asides

1984: 1st ADMS women's set-aside = 5%

1988: 2nd ADMS women's set-aside = 10%

1992: 1st SAPTBG set-aside with emphasis on pregnant women and women with children and more definition of services. Used 5% formula.



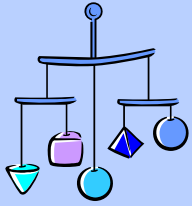
“Family Treatment” Services Defined in 1992 SAPTBG

- **For mothers**

- Comprehensive gender specific treatment
- Primary medical care for mothers
- Parenting
- Case management
- Transportation

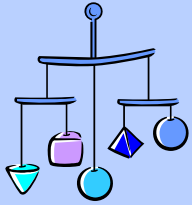
- **For children**

- Pediatric care for children
- Child care
- Therapeutic interventions



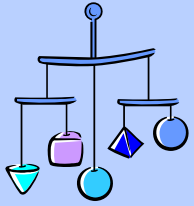
Other Discretionary Funding for Women and Children

- 1980s** Research on impacts of substance use on women and families initiated
- 1989-1990** NIDA funds the Perinatal 20 research demonstration grants.
- 1989-1995** Anti-Drug Abuse Act 1988--Pregnant Post-Partum Women and their Infants Demonstration Project (PPWI) results in 147 grants
- 1993-1995** ADAMHA Reorganization--Comprehensive, long-term (5 year), residential treatment for Pregnant Post-Partum Women (PPW) and Residential Women with Children (RWC) Demonstration Programs results in 70 programs.
- 1994** Developed and disseminated the “Comprehensive Treatment Model for Alcohol and Other Drug-Abusing Women and Their Children”
- 1995** National PPW/RWC Cross-Site Demonstration study begins
- 1998- 2003** Women, Co-occurring Disorders and Violence Study. 2000, Children’s subset study
- 2006-2007** Funding for women in 8 different CSAT grant programs (30% of budget) including 23 PPW programs



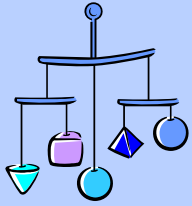
RWC/PPW Cross-Site Evaluation

- Study encompassed 50 5-year demonstration projects
- Cross-site data collection: October 1, 1996 - March 31, 2001
- Projects submitted standardized set of quantitative data quarterly: admission, treatment services, discharge and follow-up data.
- Data set includes:
 - 5,110 women admitted into RWC/PPW projects
 - 3,762 women discharged from RWC/PPW projects
- Outcome data set includes 32 projects that had a 50 percent or better follow-up rate
- Outcome data set contains 1,181 women at all four data points.



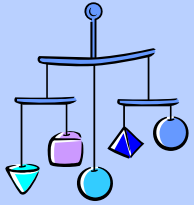
PPW / RWC Required Services

- Gender-specific, culturally appropriate treatment
- On-site residential care for clients' children
- Comprehensive, long-term (6 or 12 month) residential treatment for women and their children that includes:
 - Medical care, including prenatal and pediatric care
 - Mental health services
 - Vocational services
 - Parenting education
 - Nursery/preschool
 - Transportation, legal services and other support services



Client Characteristics

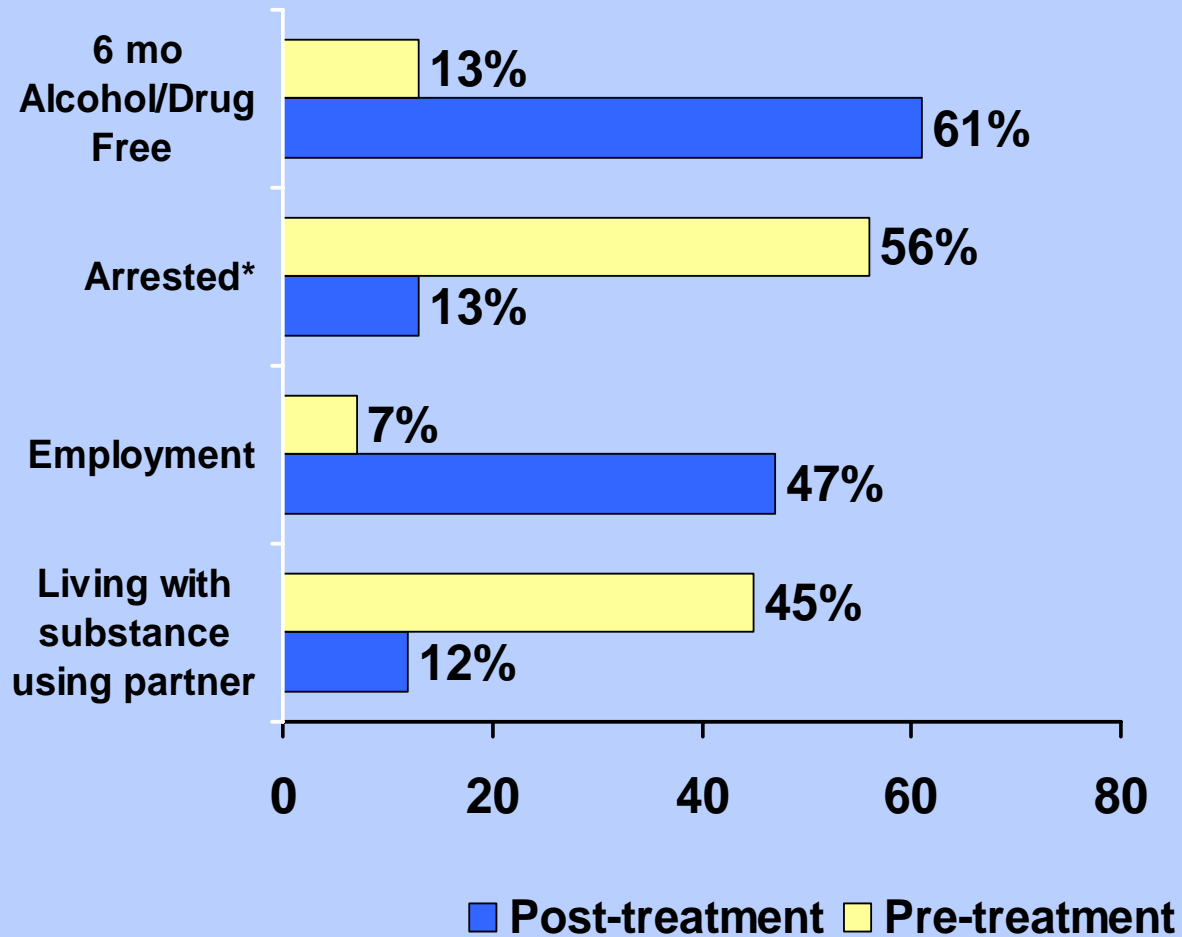
- Average age: 30.4 years
- Average years of drug use: 15.3 years
- 86% had received some previous treatment
- Primary drugs of abuse:
 - 56% crack/cocaine
 - 14.5% alcohol
 - 11.5% heroin
 - 10.6% methamphetamine
- Race/ethnicity:
 - 44.7% African American
 - 30.6% White
 - 11.5% Latina/Hispanic
 - 8.2% Native American/Alaskan Native



Client's Children

- Number of children:
 - 51%: 3 or more children
 - 25%: 2 children
 - 21%: 1 child
 - 3%: child not yet born
- Average age of children: 3.8 years
- 67.1% of children in legal custody of mother; 12.8% of both parents
- Children's living situation in 30 days prior to treatment:
 - 19.3% of children lived with grandparents or other relatives
 - 45.8% with mother alone
 - 9% with both parents
 - 15.9% with State
 - 4.1% with fathers

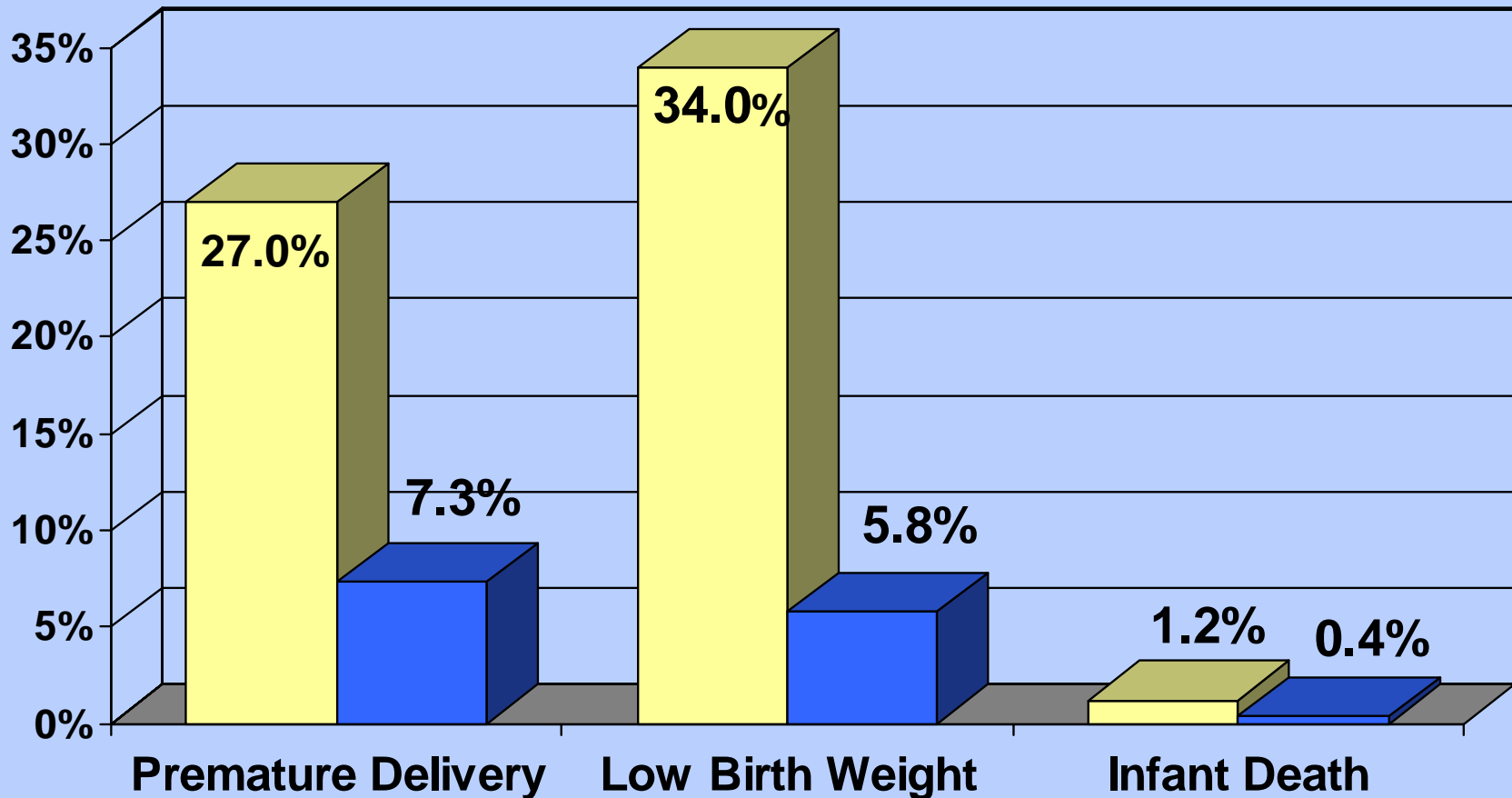
Treatment Works! Outcomes of Participants in RWC/PPW Programs



*Time frame for pre-treatment is within last 12 months;
at post-treatment timeframe is within 6 mo. following discharge

Source: Caliber Associates, 2003

Treatment Resulted in More Positive Birth Outcomes for RWC/PPW Clients



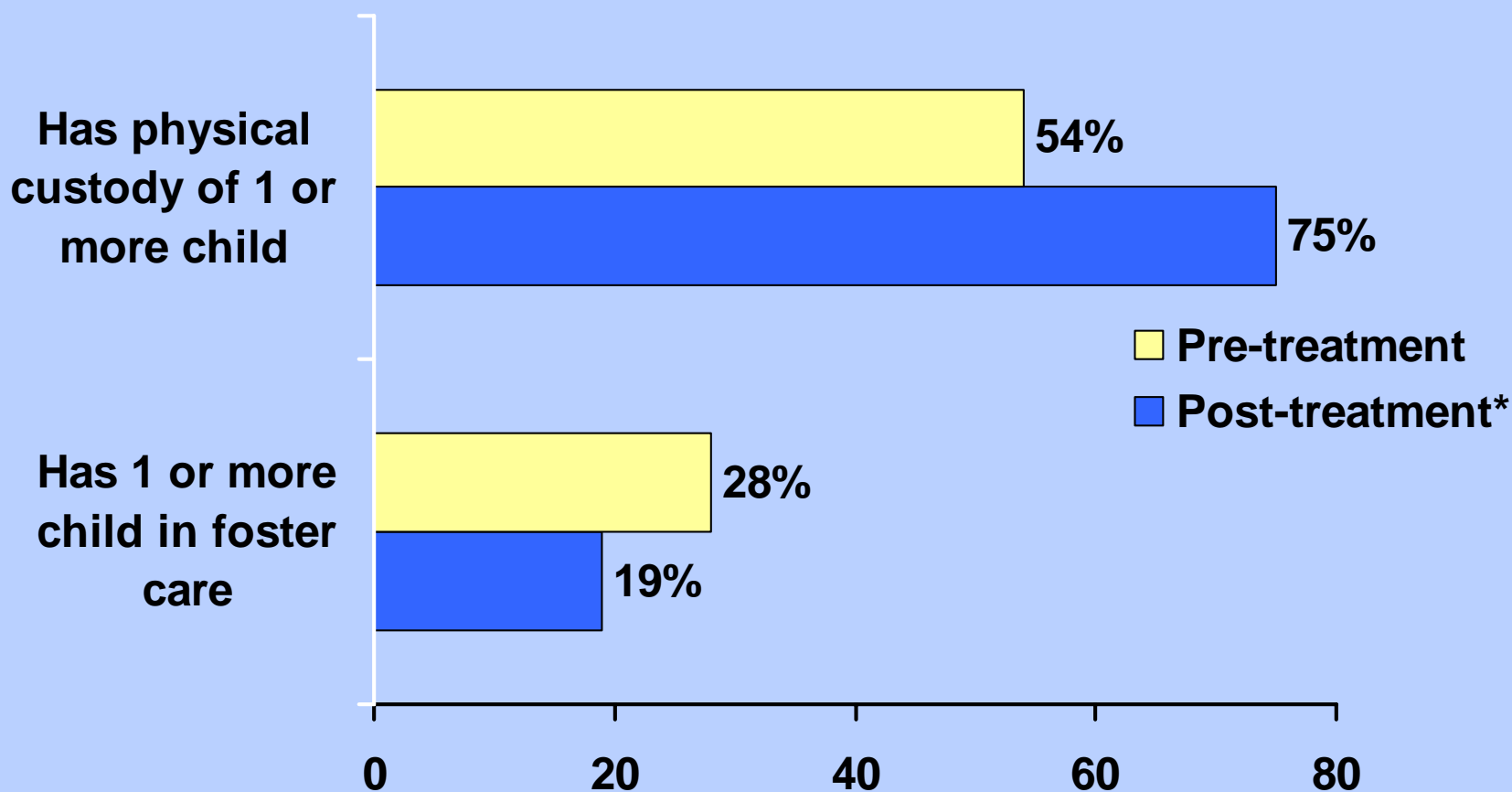
■ Substance Abuser Comparisons (n varies*)

■ RWC/PPW Clients In-Tx Deliveries (n=739)

* n=4,095 for premature delivery and n=11,561 for LBW, from 18 recent hospital-based outcome studies for cocaine-using women; n=10,816 for infant death, from previous pregnancies of RWC/PPW clients

Source: Caliber Associates (2003)

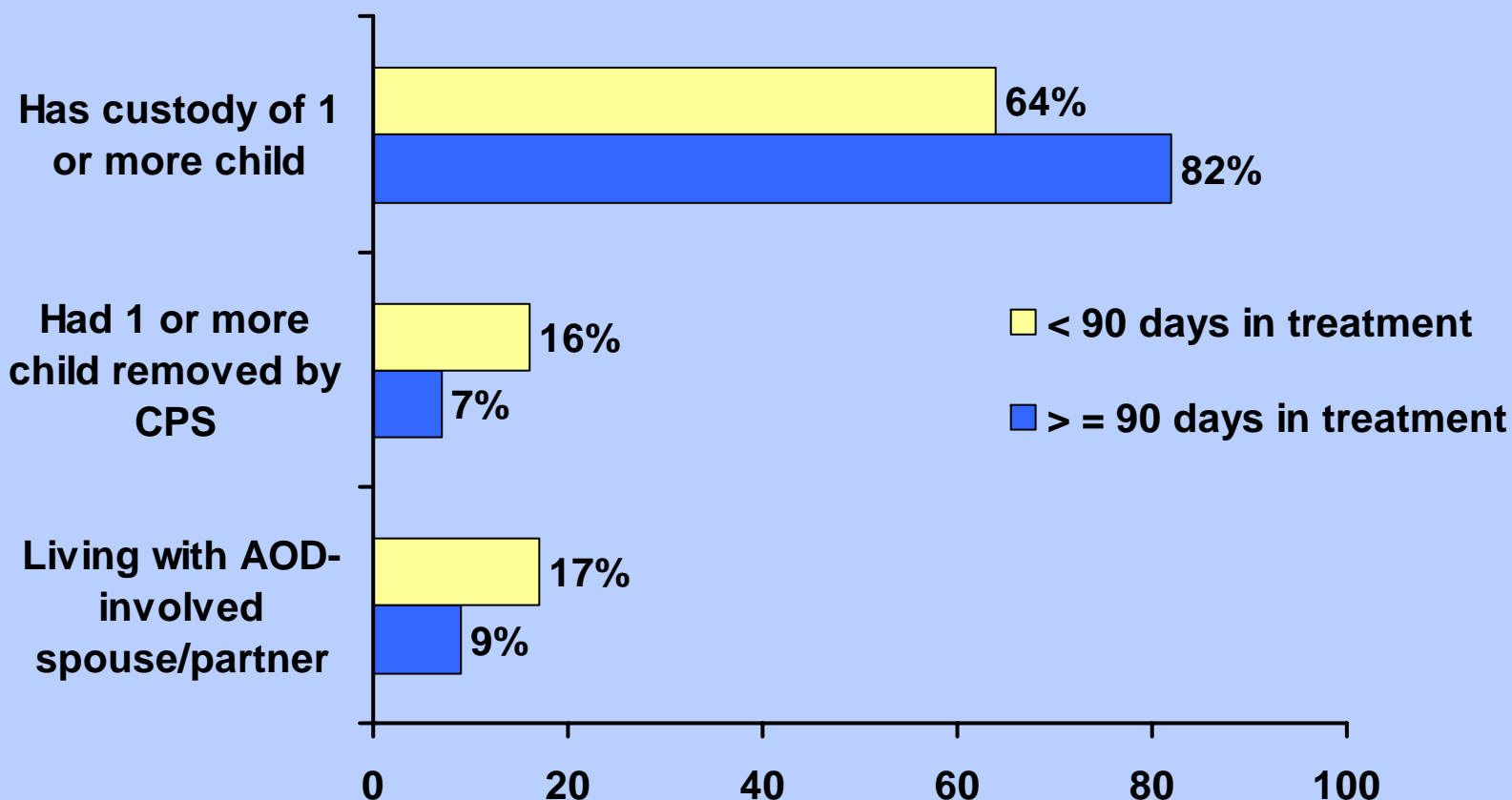
Changes in Child Custody Status Among Participants in RWC/PPW Programs



*Time frame is 6 months following treatment discharge

Source: Grella, 2003

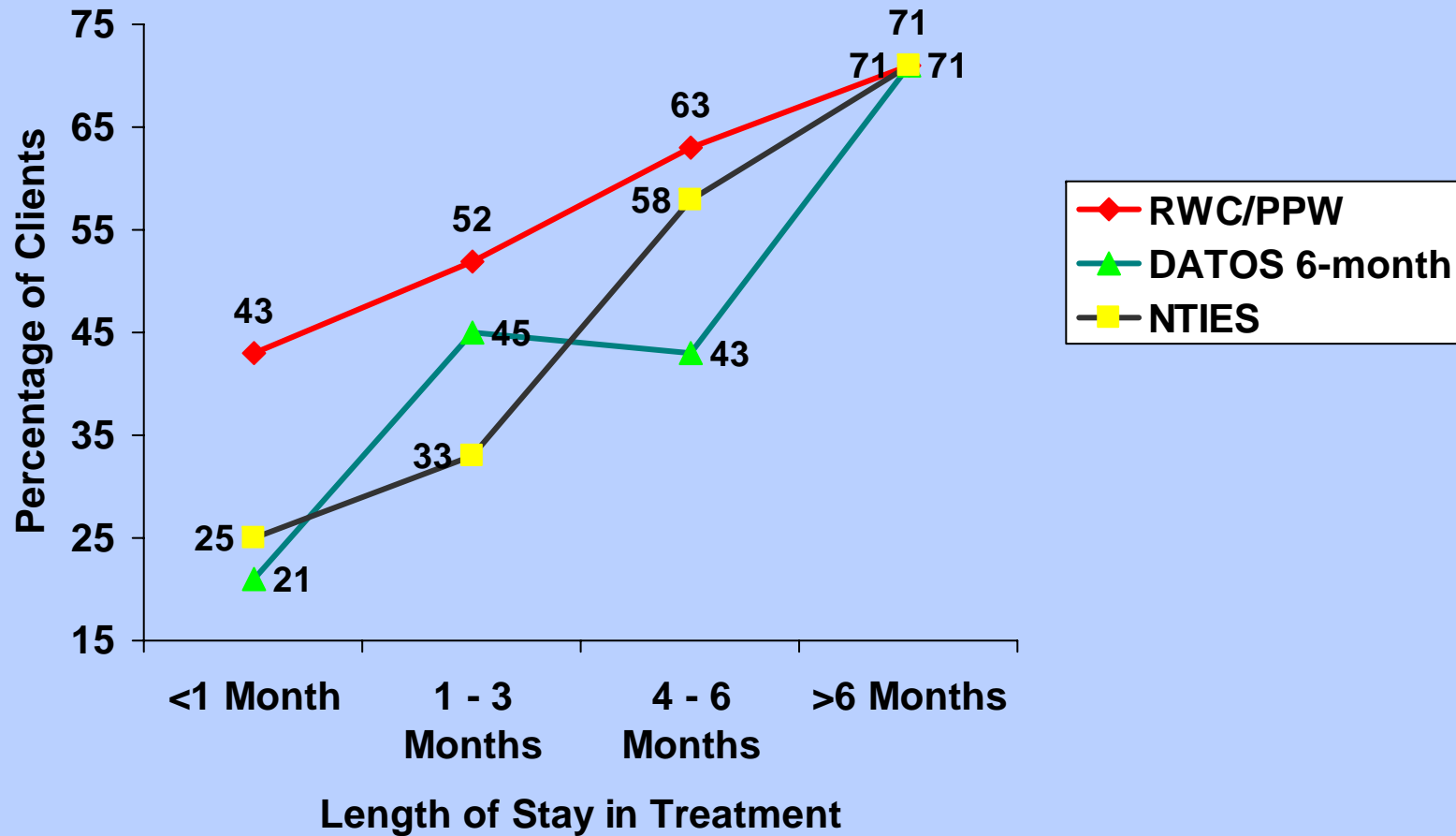
Longer Treatment Retention Associated with Better Outcomes in RWC/PPW Programs*

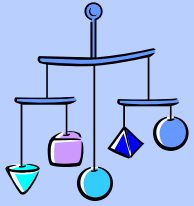


*Time frame is 6 months following treatment discharge

Source: Grella, 2003

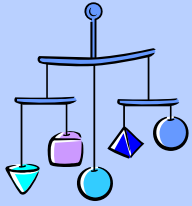
Percentage Abstinent Post-Discharge, by Length of Stay and Select Study





Selected PPW/RWC Lessons

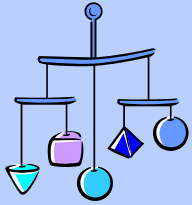
- Programs often limited number and age of children, which can be a treatment barrier.
- Children coming to programs with their mothers have their own developmental and treatment needs.
- Relationships with family members (positive and negative) impact treatment retention and outcomes for women.
- Families are dynamic and changing. Addressing complex needs requires flexibility and ability to respond to multiple priorities.



What Is a Family?

Edith Schaeffer provides an analogy between a family and a mobile:

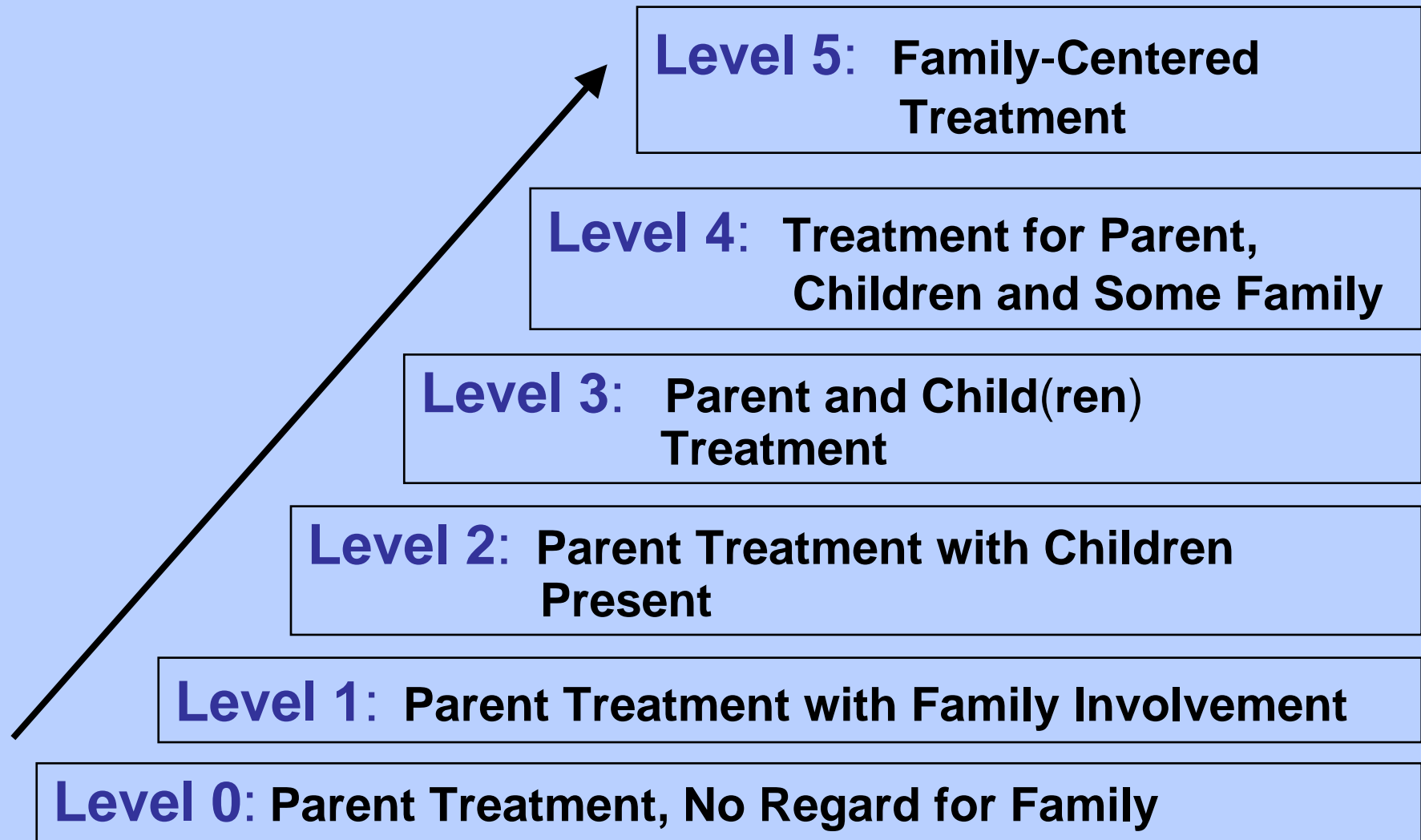
“Each member is connected to the others through invisible strings. When the wind blows, all parts move individually and harmoniously. Mobiles are delicate. If one piece breaks, if a string is severed or becomes knotted, the whole mobile is affected. Similarly, the actions of one family member affect the entire family.”

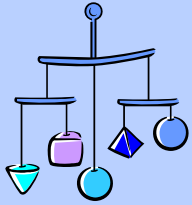


Moving Toward Family Services

- In July 2005, CSAT in conjunction with the Rebecca Project for Human Rights held a Symposium to discuss family based services. Thirty leaders in family based treatment attended. This symposium informed current thinking.
- Development of a **Continuum of Family-Based Services**. Treatment providers are at various stages along this continuum.
- The treatment framework is evolving from an individual care model toward a **family-centered treatment approach**.

Family-Based Services Continuum



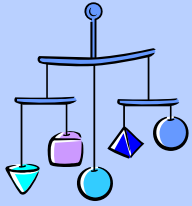


Available Services

- 6 million children under the age of 18 live with at least one alcohol or drug dependent parent (OAS, 2003)
- 69.2% of women and 52.5% of men entering treatment report having children (Brady & Ashley, 2005).

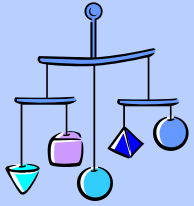
BUT:

- Most community treatment services are in the lower levels of the continuum. The National Survey of Substance Abuse Treatment Services for 2005 indicates that
 - 4% of residential programs have beds available for client children
 - 9% of all treatment facilities offer child care
 - 14% have a specialized program or group for pregnant women
 - 76% report offering family counseling (often consisting of a voluntary weekly education group) (OAS, 2006)



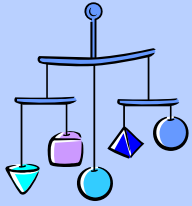
Outcomes

- **Individual outcomes for parent, child and other family members.** (e.g., changes in substance use, employment, health or mental health status, developmental progress, educational performance, improved resiliency)
- **Relational outcomes for whole families and between members.** (e.g., parent-child relationship, family stability, attachment, relationship satisfaction, reunification, reduced violence, communication and parenting improvement)
- **System or societal outcomes for the community.** (cost savings from improved employment, reduced criminal recidivism, improved prenatal and birth outcomes, reduced school problems, future health costs.)



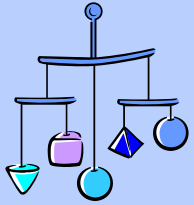
Challenges

- **Funding** – cost-savings occur in future and multiple systems. Cost sharing between systems is complex.
- **Programmatic Challenges** – families are dynamic, children come with their own needs, family violence, when reunification is not the best option.
- **Building Capacity** – Treatment provider readiness, appropriate sites, multi-disciplinary staffing, collaborative partnerships, system (e.g., assessment, placement, outcome criteria) based on individuals.



Opportunities

- CSAT and other stakeholders are working to expand availability of family-centered services within communities.
- The Child and Family Improvement Act of 2006 provides funding for regional partnerships to increase the well-being of and improve the permanency options for children affected by methamphetamine or other substance abuse (\$40 million in 2007).
- Increased use of family-based models in an array of collaborating agencies increase all of our ability to work inter-dependently to improve outcomes for children and families.



Charge to Move Forward

- Where on the continuum of family centered services are the programs in your community?
- Looking through the eyes of clients. How do families with substance use disorders experience your system? Young children? Older children? Parents with substance use disorders? Other family members?
- What do you want your community continuum to include in 2010? What actions can you take today to move this direction?
- What are the funding, capacity and program challenges to overcome?
- What community assets and resources can help?
- What internal and external changes can you influence?

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