Why It’s Not Just One More Thing: Making A Stronger Case for Building the Bridges

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www.ncsacw.samhsa.gov

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A Program of the
Substance Abuse and Mental Health Services
Administration
Center for Substance Abuse Treatment
&
the Administration on Children, Youth and Families
Children’s Bureau
Office on Child Abuse and Neglect

NCSACW Mission:
To develop knowledge and provide technical assistance to Federal, State, local agencies and Tribes to improve outcomes for families with substance use disorders in the child welfare and family court systems
The Hard Questions

How widespread is substance abuse in the child welfare caseload?

Why should substance abusing parents in the child welfare system be given priority in access to treatment?

Why must substance abuse be combined with mental health, family violence, poverty and other influences on child abuse and neglect?

Is treatment effective for parents who are at risk or involved with the child welfare system? What are the issues about the quality of treatment for parents in the child welfare system?

Do positive treatment outcomes assure positive reunification outcomes?

What services and supports should be given to infants, children and youth of substance-abusing parents in the child welfare system?
How widespread is substance abuse in the child welfare caseload?
How Many Children?

- 8,300,000 children living with alcohol or drug-dependent parents
- 450,000 children in the child welfare system affected by substance abuse (more in-home than removed)
- 500,000 prenatally exposed infants each year
- 9,000,000 prenatally exposed 0-18 year olds
Children Living With One or More Substance Abusing Parent

- Used Illicit Drug in Past Year: 10.6%
- Used Illicit Drug in Past Month: 8.4%
- Dependent on Alcohol and/or Needs Treatment for Illicit Drugs: 8.3%
- Dependent on AOD: 7.5%
- Dependent on Alcohol: 6.2%
- Dependent on Illicit Drugs: 2.8%
- Need Treatment for Illicit Drug Abuse: 4.5%
<table>
<thead>
<tr>
<th>Age Group of Victims</th>
<th>Number</th>
<th>Percent</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 0-3</td>
<td>273,082</td>
<td>30.9%</td>
<td>2,372</td>
<td>29.4%</td>
</tr>
<tr>
<td>Age 4-7</td>
<td>213,194</td>
<td>24.1%</td>
<td>2,038</td>
<td>25.3%</td>
</tr>
<tr>
<td>Age 8-11</td>
<td>170,944</td>
<td>19.3%</td>
<td>1,594</td>
<td>19.8%</td>
</tr>
<tr>
<td>Age 12-15</td>
<td>170,635</td>
<td>19.3%</td>
<td>1,584</td>
<td>19.6%</td>
</tr>
<tr>
<td>Age 16-17</td>
<td>54,029</td>
<td>6.1%</td>
<td>478</td>
<td>5.9%</td>
</tr>
<tr>
<td>Unknown</td>
<td>3,110</td>
<td>.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>884,994</td>
<td></td>
<td>8,066</td>
<td></td>
</tr>
</tbody>
</table>
Parents Entering Publicly-Funded Substance Abuse Treatment

- **59%**
  - Had a child under age 18

- **22%**
  - Had a child removed by CPS

- **10%**
  - If a child was removed, lost parental rights

Based on CSAT TOPPS-II Project
Risks to Children: Different Situations for Children

- Parent uses or abuses a substance
- Parent is dependent on a substance
- Special considerations when Methamphetamine production is involved
  - Parent involved in a home lab or super lab
- Parent involved in trafficking
- Mother uses a substance while pregnant

Source: Nancy Young, Ph.D., Testimony before the U.S. House of Representatives Government Reform Subcommittee on Criminal Justice, Drug Policy, and Human Resources, July 26, 2005
Past Year Substance Use by Youth Age 12 to 17

Compared to African-American Youth, Caucasian Youth were more likely to use alcohol (41.4% versus 29.8%) and illicit drugs (36.2% versus 26.7%).

Source: Office of Applied Studies, SAMHSA (2005) Substance Use and Need For Treatment among Youths Who Have Been in Foster Care
Percent of Youth Ages 12 to 17 Needing Substance Abuse Treatment by Foster Care Status

Source: Office of Applied Studies, SAMHSA (2005) Substance Use and Need For Treatment among Youths Who Have Been in Foster Care
<table>
<thead>
<tr>
<th>Substance Used (Past Month)</th>
<th>1st Trimester</th>
<th>2nd Trimester</th>
<th>3rd Trimester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Illicit Drug</td>
<td>7.0% women</td>
<td>3.2% women</td>
<td>2.3% women</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>20.6% women</td>
<td>10.2% women</td>
<td>6.7% women</td>
</tr>
<tr>
<td>Binge Alcohol Use</td>
<td>7.5% women</td>
<td>2.6% women</td>
<td>1.6% women</td>
</tr>
</tbody>
</table>

State prevalence studies report 10-12% of infants or mothers test positive for alcohol or illicit drugs at birth.
Number of Children Prenatally Exposed to Substances

- West Virginia total live births = 21,501 (2008)
  - 11% of total live births = 2,365

- Total child victims (2006)
  - 0-3 years old = 2,372
  - Estimated under 1 year old = 600

Where did they all go?
Prenatal Exposure in West Virginia

- 21,000 births (2006)
- 27% prenatal tobacco exposure
- 0.3% alcohol exposure
- 2.8% admitted to substance abuse treatment while pregnant
- Reported on birth score forms?
- CAPTA referrals to CPS?
Most Go Home

80-95% are undetected and go home without assessment and needed services.

- Many doctors and hospitals do not test, or may have inconsistent implementation of state policies
  - Tests detect only very recent use
- Inconsistent follow-up for woman identified as AOD using or at-risk, but with no positive test at birth
- CAPTA legislation raises issues of testing and reporting to CPS
Why should substance-abusing parents in the child welfare system be given priority in access to treatment?
Parental Substance Use Cited as Factor in Child Welfare Case

<table>
<thead>
<tr>
<th>State</th>
<th>Percent</th>
<th>Percent</th>
<th>Percent</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tennessee</td>
<td>8</td>
<td>8</td>
<td>1.0</td>
<td>13.3</td>
</tr>
<tr>
<td>Texas</td>
<td>8</td>
<td>8</td>
<td>11.9</td>
<td>54.2</td>
</tr>
<tr>
<td>Utah</td>
<td>12</td>
<td>14.6</td>
<td>32.8</td>
<td></td>
</tr>
<tr>
<td>Vermont¹</td>
<td>8</td>
<td></td>
<td>2.3</td>
<td>8.2</td>
</tr>
<tr>
<td>Virginia</td>
<td>12</td>
<td>10</td>
<td>6.6</td>
<td>17.6</td>
</tr>
<tr>
<td>Washington</td>
<td>10</td>
<td></td>
<td>8.9</td>
<td>31.1</td>
</tr>
<tr>
<td>West Virginia</td>
<td>10</td>
<td>11</td>
<td>7.6</td>
<td>22.4</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>14</td>
<td></td>
<td>9.3</td>
<td>14.7</td>
</tr>
</tbody>
</table>

In Round 1, these data were not including in the first cohorts of States reviewed, it was an added item in subsequent States.
West Virginia Treatment Admissions: Primary Substance & Child Maltreatment

* Indicates CFSR Round 1 On-Site Review
** Indicates CFSR Round Two On-Site Review
CFSR Round 2 Findings

• West Virginia did not achieve substantial conformity with any of the outcomes
  – The State achieved overall ratings of Strength for three individual items: foster care reentry (item 5), placing children in close proximity to their parents (item 11), and placing children with siblings (item 12).

• Identified areas of concern in achieving outcomes for children and families.
  – Permanency Outcome 1 (Children have permanency and stability in their living situations)
  – Well-Being Outcome 1 (Families have enhanced capacity to provide for children’s needs)
  – Safety Outcome 2 (Children are safely maintained in their homes when possible and appropriate)
Round 2 Summary Findings

- Need for more sufficient substance abuse treatment services
  - Quality of treatment services
  - Access to treatment
- Lack of substance abuse training for child welfare workers
- Need for identifying needs of the family and providing services that meet those needs
Understanding the “Treatment Gap”

- Total treatment admissions
- Compare to estimated prevalence of substance use disorders among parents in the child welfare system
- Determine how many parents are already entering treatment
- The remainder is the treatment gap
- Compare treatment gap to reunification totals
Intergenerational Effects

Substance use disorders are family diseases

Affected children
- Children we remove
- Children we send back home
- Children we leave at home

What we know

California sample
Family centered treatment works
Developmental Effects

Five levels of impact on younger children

CAPTA amended in 2003

What we know

80-95% of prenatally exposed children are not identified at birth and just go home

Prenatal exposure effects can be reduced through early identification and early intervention
Models of Priority Access

• A few states and jurisdictions have made child welfare parents a priority in accessing treatment.
  – Arizona Executive Order
  – Sacramento
  – Santa Clara
• Federal 48-hr requirement, but not reported or monitored annually
Why must substance abuse be combined with mental health, family violence, poverty or other influences on child abuse and neglect?
• Total 9,818 admissions
• 36% women (3,534)
• Pregnant at admission: 578 (.2%)
• Alcohol only 44.4% (US 22.7%)
• Amphetamines 1.5% (US 7.6%)

Federal TEDS data 2007-08
Research Findings

• Mothers with more employment and psychiatric problems were less likely to be reunified with their children

• Completion of 90 or more days in treatment approximately doubled their likelihood of reunification

• Mothers who were treated in programs providing a “high” level of family-related or education/employment services were approximately twice as likely to reunify with their children as those who were treated in programs with “low” levels of these services

Source: Journal of Substance Abuse Treatment, Volume 36, Issue 3, Pages 278-293 C. Grella, B. Needell, Y. Shi, Y. Hser
Comprehensive Approaches

• Integrated treatment coordinates substance abuse and mental health interventions to treat the whole person more effectively

• Recognizes the importance of ensuring that entry into any one system can provide access to all needed systems

• Colorado and California have developed models of links between family income support programs and child welfare
Is treatment effective for parents who are at risk or involved with the child welfare system? What are the issues about the quality of treatment for parents in the child welfare system?
Key Questions

- Are family treatment services provided?
- Is treatment the right dose and duration?
- Does comprehensive treatment include treatment for co-occurring disorders?
- Are recovery support services available for the family?
- Are children of substance-abusing parents screened for developmental delays?
Family Treatment Works

• 70% of women entering treatment have children
• Women recover in relationship with others, and family and kinship supports are a critical ingredient to effective treatment
• The Rebecca Project, Washington D.C.
In 2003, a cross-site evaluation of 24 residential family-based treatment programs 6 months after post-treatment revealed successful outcomes for mothers and their children:

- 60% of the mothers remained completely clean and sober 6 months after discharge.
- Criminal arrests declined by 43%.
- 44% of the children were returned to their mothers from foster care.
- Enrollment in educational and vocational training increased from 2% prior to treatment to 19% post-treatment.
## Compliance with Medical Treatment

### Insulin Dependent Diabetics
- Compliant with medication: < 50%
- Compliant with diet and foot care: < 30%
- Retreated in 12 months: 30% - 50%

### Hypertensives
- Compliant with medication: < 30%
- Compliant with diet: < 30%
- Retreated in 12 months: 50% - 60%

Compliance with Medical Treatment

• > 50% of “re-occurrence” was due to lack of compliance

• > 50% of medical patients lie about compliance

Do positive treatment outcomes assure positive reunification outcomes?
Understanding the Outcomes

Monitored by CFSR process

Need to prove that treatment works for child welfare cases

What we know

Reunifications linked to substance abuse

Baselines for reunification vs. baselines for substance-affected children
Sacramento Family Dependency Drug Court

Critical components of DDC:

• Immediate identification of alcohol and drug problems by early intervention specialist workers

• Prompt assessment and placement in treatment services, usually within 2-5 working days;

• A full continuum of alcohol and drug treatment services; Intensive recovery management provided by the STARS program;

• Drug Court hearings at 30, 60, and 90 day intervals to monitor compliance and ensure accountability for all parents with alcohol and drug problems (Phase I - mandatory);

• More frequent drug court hearings for parents who are in need of additional support and monitoring in order to succeed (Phase II and III - voluntary); and,

• Timely use of incentives and progressive sanctions.
Child Placement Outcomes at 36 Months

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Comparison</th>
<th>Court-Ordered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reunification***</td>
<td>26</td>
<td>45.7</td>
</tr>
<tr>
<td>Adoption</td>
<td>33.5</td>
<td>26.7</td>
</tr>
<tr>
<td>Guardianship**</td>
<td>12.7</td>
<td>7.3</td>
</tr>
<tr>
<td>FR Services</td>
<td>1.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Long-Term Placement***</td>
<td>17.3</td>
<td>5.1</td>
</tr>
</tbody>
</table>

**p<.01; ***p<.001

Comp n=173; DDC n=2086

Source: CWS/CMS
Arizona’s Family First Program

- Provides family-centered substance abuse and recovery support services to parents or caregivers whose substance abuse is a significant barrier to maintaining or reunifying the family or achieving self-sufficiency

- Focuses on improving two outcomes:
  - Engagement
  - Continuation (retaining clients in treatment)

- Various strategies were implemented:
  - Contingency management
  - Participation in TDM meetings
  - Availability of assessments within 5 days
  - Providing transportation
Performance Outcomes

Reduction in:

• Recurrence of child abuse and neglect – 98% of the clients in the AFF program did not have a substantiated recurrence of child maltreatment after six months of enrollment.

• Substance abuse – 53% of AFF clients who completed their participation in the program demonstrated no drug use during their participation.

Increase in:

• Number of children achieving permanency – Of the 581 children who left CPS, 80% were reunified with their parents or placed with other relatives.

What services and support should be given to infants and children of substance-abusing parents in the child welfare system?
The effects of prenatal exposure and family violence on prefrontal cortex/ executive functions and impulsivity mean these children are more likely to have behavioral problems and to live in families in which maternal depression, family violence, and other conditions impair their development.

They often process information differently and have trouble behaving in accord with preschool and school expectations.

Early identification and early intervention make a difference.
The Importance of Identifying Infants Prenatally Exposed to Substances

- Though a small percentage of child welfare services cases, these children are disproportionately affected by many lifelong conditions.
- Prenatal exposure to alcohol is the leading cause of mental retardation.
- Special education classrooms contain a disproportionate number of children who were prenatally exposed to drugs.
Prenatal Exposure Belongs to No One Agency

• Prenatal Exposure is:
  – a school readiness issue
  – a maternal and child health issue
  – a developmental disability issue
  – a substance abuse prevention issue
  – a child welfare issue
  – a family support issue

• Therefore, taking this problem seriously requires uncommon interagency efforts and accountability for annually reported results
The effects of substance use disorders on children and families are significant and well documented.

Research shows that children of parents who abuse drugs are more at risk than their peers for delinquency, depression, poor school performance, and alcohol and drug use.

Research has found that maltreated children were also at increased risk of other interrelated problems in adolescence including drug use, poor academic performance, teen pregnancy, serious and violent delinquency, and emotional and mental health disorders.
Research Findings-
Linkage with Juvenile Justice

- A 2006 New York study found youth in the high-offending groups were more likely than their less frequently offending peers to have experienced childhood maltreatment and out-of-home placement and to come from homes characterized by some type of family dysfunction, such as parental substance abuse and family criminality (Colman, R.A., Kim, D., Mitchell-Herzfeld, S., Shady, T. 2009).

- A 2004 study in Arizona showed that
  - Youth with histories of court involvement on dependency matters are twice as likely to recidivate if referred on a delinquency offense as juveniles with no history of dependency court involvement (62% vs. 30%).
  - Of youth ages 14–17 with an active dependency 73% had at least one delinquency referral, 49% were on probation, and 51% were detained at some point (Halemba, Siegel, Lord, & Zawacki, 2004).
Continuum of Family-Based Services

- **Women's Treatment With Family Involvement**
  - Services for women with substance use disorders. Treatment plan includes family issues, family involvement.
  - Goal: improved outcomes for women

- **Women's Treatment With Children Present**
  - Children accompany women to treatment. Children participate in child care but receive no therapeutic services. Only women have treatment plans.
  - Goal: improved outcomes for women

- **Women's and Children's Services**
  - Children accompany women to treatment. Women and attending children have treatment plans and receive appropriate services.
  - Goal: improved outcomes for women and children, better parenting

- **Family Services**
  - Children accompany women to treatment; women and children have treatment plans. Some services provided to other family members.
  - Goals: improved outcomes for women and children, better parenting

- **Family-Centered Treatment**
  - Each family member has a treatment plan and receives individual and family services.
  - Goals: improved outcomes for women, children, and other family members; better parenting and family functioning
Clinical Treatment and Support Services for Children

### Clinical Treatment Services
- Screening
- Intake
- Assessment
- Medical care and services
- Mental health
- Residential care (in residential settings)
- Case management

### Clinical Support Services
- Onsite or nearby child care
- Mental health and remediation services
- Prevention services
- Recreational services
- Educational services
- Advocacy
- Recovery community support services

- Case planning
- Substance abuse education and prevention
- Mental health and trauma services
- Therapeutic child care and development
Where are We Heading?

Progress and Challenges
Elements of System Linkages
The Ten Key Bridges

Mission

1. Underlying Values and Priorities

Children, Family, Tribal, and Community Services

2. Screening and Assessment
3. Engagement and Retention
4. Services for Children
5. Community and Family Support

System Elements

6. Information Systems
7. Training and System Tools
8. Budget and Sustainability
9. Working with Other Agencies

Outcomes

10. Shared Outcomes and Systems Reforms
## 10 Element Framework

### Underlying Values

<table>
<thead>
<tr>
<th>Collaborative Capacity Instrument (CCI)</th>
<th>Collaborative Values Inventory (CVI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Anonymous way to assess strengths and challenges in working across systems</td>
<td>• Anonymous way to discuss common values and beliefs that can act as barriers between systems</td>
</tr>
<tr>
<td>• Matrix of Progress provides a description of the characteristics in communities with basic and advanced collaborative practice</td>
<td>• Results used to develop common principles of collaborative work</td>
</tr>
</tbody>
</table>
10 Element Framework
Underlying Values

- What do we agree on? What do we disagree about?
  - Treatment effectiveness, parenting capacity, child removal, drug testing, abstinence and harm reduction, confidentiality issues

- What measures do we agree we will use to assess our progress in working together?: shared outcomes

- For child welfare, a core values question: can we achieve our goals working within the child welfare system with its resources alone?
  - If not, you’re in the collaboration business

- Who are the clients? Which are our priorities?
  - Treatment: Do we serve children as well as adults?
UNCOPE – Washington and Maine

- In the past year, have you ever drunk or **used** drugs more than you meant to?
- Have you ever **neglected** some of your usual responsibilities because of using alcohol or drugs?
- Have you felt you wanted or needed to **cut down** on your drinking or drug use in the last year?
- Has anyone **objected** to your drinking or drug use?
- Have you ever found yourself **preoccupied** with wanting to use alcohol or drugs?
- Have you ever used alcohol or drugs to relieve **emotional** discomfort, such as sadness, anger, or boredom?

Source: Norm Hoffman, Ph.D. - Evince
10 Element Framework
Daily Practice – Engagement and Retention

- Out-stationing staff
- Use motivational enhancement
- Ensure AOD treatment and CPS practice is responsive to clients’ individualized needs
- Strengths-based, supportive relationships, trauma-informed, culturally competent, accessible
- Parent Partners
- Recovery management approaches
  - STARS
  - SARMS
Dropoff Points

1,000 Children – 720 Parents in Substantiated Cases

27.8% of Parents Need SA treatment
200

50% Enroll in treatment
100

36.1% Achieve Positive Treatment Outcomes
36

Actual Reunifications

Payoff
Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR)

- Provides screening and assessment tools
- Includes guidelines for communication and collaboration across the systems responsible for helping families
- Available at: www.ncsacw.samhsa.gov

It’s the Team not the Tool
10 Element Framework
Daily Practice – Services to Children

- Screening project for FASD among the children of the Santa Clara County Family Drug Treatment Court (California)
- OASAS FASD Task Force – Buffalo Home Visiting Program
- Use of Celebrating Families! or Strengthening Families curricula to educate families about the impact of substance dependence on families
This document provides an assessment of State policy from the broadest perspective: prevention, intervention, identification, and treatment of prenatal substance exposure, including immediate and ongoing services for the infant, the mother, and the family.

Order Free Copies

This publication may be downloaded or ordered at www.samhsa.gov/shin. Or, please call SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español). In addition, this publication can be ordered from the Child Welfare Information Gateway at 1-800-394-3366.

Policy and Practice Framework: Five Points of Intervention

1. Pre-pregnancy awareness of substance use effects

2. Prenatal screening and assessment

3. Identification at Birth

4. Ensure infant’s safety and respond to infant’s needs

5. Identify and respond to the needs of
   - Infant
   - Child
   - Preschooler
   - Adolescent

Initiate enhanced prenatal services

Respond to parents’ needs

Identify and respond to parents’ needs

System Linkages
- Filling in “missing boxes” for prevalence of
  - Substance abuse in child welfare cases
  - Prevalence of effects among children of substance abusers (abuse, neglect, developmental delays)
  - Extent of newborn prenatal substance exposure
- Michigan revised SACWIS to prioritize case planning for families with substance use disorders
- Developing communication protocols
- CFSR (SIP) and NOMS processes
10 Element Framework
Training and Staff Development

• FREE! On-Line Training (CEUs available!)
  http://www.ncsacw.samhsa.gov
    – Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Legal Professionals
• Funding and Program Sustainability
  – Two types of sustainability:
    • Financial
    • Political and Community Support
• So an inventory of existing and potential funding streams is a critical need
Financial Sustainability

- Project funding
- The Real Money

Categories:
- TANF
- Libraries
- Hospitals
- Schools
- Parks
- Police
- Mental Health
- Medicaid
- Housing
Cross-System Funding Inventory

• Maps all sources in the community that fund services
  – At what levels
  – On what types of programs
  – For which populations

• Includes information such as
  – Total funds by Federal, State, and local funding sources
  – Program descriptions, including program objectives, services, and effectiveness
  – Target populations served and client demographics by age, gender, and race/ethnicity

• Publication: Funding Comprehensive Family Treatment
The Road Remaining

Opportunities and Challenges
Filling the data holes: treatment gaps, dropoff analysis

Home visiting as an opportunity for early identification and early intervention

Taking CAPTA seriously: what are your numbers?

Family treatment and chronic care management

Health care reform: integration with physical health services

Veterans

Family Drug Courts

Parity: expanded private insurance coverage