A Family-Centered Approach to Serving Vermont Families Affected by Substance Use

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Center for Children and Family Futures
Vermont Statewide Family Treatment Court Event | Sept. 28, 2017
Re-Thinking Family Recovery

What does Family Mean to You?

~85% of children in substantiated abuse and neglect cases either stay home or go home

• Stay Home
• Go Home
• Find Home

Family Recovery is Relationship Based
Recovery occurs in the context of relationships

- Addiction is a brain disease that affects the family
- Adults (who have children) primarily identify themselves as parents
- The parenting role and parent-child relationship cannot be separated from treatment
- Adult recovery should have a parent-child component including prevention for the child
Re-Thinking Family Recovery

**Relationship Based**

- Parents’ recovery must occur in the context of family relationships
- Services that strengthen families and support parent-child relationships helps keep children safe
Continuum of Family-Based Services

Individual Treatment With Family Involvement
- Services for individual with substance use disorders. Treatment plan includes family issues, family involvement
- Goal: improved outcomes for individuals

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 parents

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

Parents Services
- Children accompany women to treatment; women and children have treatment plans. Some services provided to other family members
- Goal: improved outcomes for families, improved parenting

Family-Centered Treatment
- Each family member has a treatment plan and receives individual and family services.
- Goals: improved outcomes for parents, children, and other family members; improved parenting and family functioning
FDC Model as a Collaborative Solution

Judicial Oversight

Drug Court Hearings

Therapeutic Jurisprudence

Comprehensive Services

Access to Quality Treatment and Enhanced Recovery Support

Enhanced Family-Based Services
Parent Recovery
- Parenting skills and competencies
- Family connections and resources
- Parental mental health
- Medication management
- Parental substance use
- Domestic violence

Child Well-being
- Well-being/behavior
- Developmental/health
- School readiness
- Trauma
- Mental health
- Adolescent substance abuse
- At-risk youth prevention

Family Recovery and Well-being
- Basic necessities
- Employment
- Housing
- Child care
- Transportation
- Family counseling
- Specialized Parenting

Family Recovery – Is not Treatment Completion
Is not a Negative Drug Test

Family Centered Treatment for Women with Substance Use Disorders: History, Key Elements and Challenges
» http://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf
Age of Children who Entered Out-of-Home Care, 2015
N=268,790

17.6% Infants

Note: Estimates based on all children who entered foster care during Fiscal Year

Children and Family Futures analyses of the AFCARS Data Set 2000-2015
Number of Children Who Entered Foster Care, By Age in Vermont, 2015

17.4% Infants

N = 958

Note: Estimates based on all children who entered foster care during Fiscal Year

Source: AFCARS Data, 2016
Rates of Children under Age 1 Entering Out of Home Care, 2013

Children Under 1 Entering Foster Care Rate per 1000 Children in Region

- 8.0 - 10.0
- 10.1 - 12.0
- 12.1 - 14.0
- 14.1 - 16.0

Source: AFCARS Data, 2013
### Estimated Number of Infants* Affected by Prenatal Exposure, by Type of Substance and Infant Disorder

<table>
<thead>
<tr>
<th>Substance</th>
<th>NAS</th>
<th>FASD</th>
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</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>600,000 (15%)</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>360,000 (9%)</td>
<td></td>
</tr>
<tr>
<td>Illicit Drugs</td>
<td>200,000 (5%)</td>
<td></td>
</tr>
<tr>
<td>Binge Drinking</td>
<td>80,000 (2%)</td>
<td></td>
</tr>
<tr>
<td>Heavy Drinking</td>
<td>16,000 (0.4%)</td>
<td></td>
</tr>
<tr>
<td>NAS</td>
<td>24,000 (6 per 1,000 births)</td>
<td></td>
</tr>
<tr>
<td>FASD</td>
<td>28,000 (.2-7 per 1,000 births)</td>
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</tbody>
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Windows of Opportunity

• Attention on opioid epidemic
• Comprehensive Addiction and Recovery Act (CARA) Legislation and Plans of Safe Care
• Cures Act Funding
Amended the Child Abuse Prevention and Treatment Act (CAPTA)
Clarified population requiring a Plan of Safe Care:
“Born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder,” specifically removing “illegal”

Required the Plan of Safe Care to include needs of both the infant and family/caregiver:
“the development of a Plan of Safe Care for the infant born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through – (I) addressing the health and substance use disorder treatment needs of the infant and affected family/caregiver”
Comprehensive Addiction and Recovery Act of 2016 (CARA)

- Specified data reported by States, to the extent practical, through National Child Abuse and Neglect Data System (NCANDS)
  - The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder
  - The number of infants for whom a Plan of Safe Care was developed
  - The number of infants for whom referrals were made for appropriate services—including services for the affected family or caregiver

- Specified increased monitoring and oversight
  - Children’s Bureau through the annual CAPTA report in the State plan
  - States to ensure that Plans of Safe Care are implemented and that families have referrals to and delivery of appropriate services
A Collaborative Approach

- Women with opioid use are identified during pregnancy…
- and, engaged into prenatal care, medical care, substance use treatment, and other needed services…

and, a plan of safe care for the *infant and their family/caregiver* is developed reducing the number of crises at birth for babies, families, and systems.
Plan of Safe Care: Bridging Systems and Services

• Identifies family’s overall needs and engagement into appropriate services

• Identifies lead agency for development and ongoing monitoring to ensure child and family well-being

• Specifies to whom infant will be discharged

• Brings together: Child Welfare Risk, Safety and Strengths Assessment (e.g. investigation), Hospital Discharge Plan, Infant Care Plan, Substance Use Treatment Case Plan, Prenatal Care Plan
Conduct screening and assessment to identify the needs of parents, children, and families
Multiple Needs Require Multiple Partners

**Family Recovery**

**PARENTS**
- Parenting skills and competencies
- Family connections and resources
- Parental mental health; co-occurring
- Medication management
- Parental substance use
- Domestic violence

**FAMILY**
- Basic necessities
- Employment
- Housing
- Child care
- Transportation
- Family counseling

**CHILD**
- Well-being/behavior
- Developmental/health
- School readiness
- Trauma
- Mental health
- Adolescent substance use
- At-risk youth prevention
Parent-Child Key Service Components

- Quality and frequent visitation
- Early and ongoing peer recovery support
- Developmental & behavioral screenings and assessments & presumptive eligibility
- Trauma informed and specific services
- Parent-child relationship-based interventions
- Community and auxiliary support
- Evidence-based parent/child parenting for families with SUDs
Assessment Tools

North Carolina Family Assessment Scale (NCFAS)

North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R) – download a sample scale and definitions
www.nfpn.org/assessment-tools/ncfas-gr-training-package


Structured Decision Making Reunification Reassessment

http://www.cebc4cw.org/program/structured-decision-making/
Ensure Quality Time for Parents and Children
Cases did better when there was frequent, quality visitation.

Cases did better when parents and children were involved in case planning.
Children and youth who have regular, frequent contact with their families are more likely to reunify and less likely to reenter foster care after reunification (Mallon, 2011).

Visits provide an important opportunity to gather information about a parent’s capacity to appropriately address and provide for their child’s needs, as well as the family’s overall readiness for reunification.

Parent-Child Contact (Visitation): Research shows frequent visitation increases the likelihood of reunification, reduces time in out-of-home care (Hess, 2003), and promotes healthy attachment and reduces negative effects of separation (Dougherty, 2004).
Facilitating Quality Visitation

• Rethink language - *Parenting time or Family time*
  • vs. visitation
• Recognize visitations as a right and need
  • vs. privilege, reward, incentive
• Ensure frequency and duration is guided by needs of child and family
  • vs. capacity of CWS, logistics – *best interest of the family or of the system?*
• Provide concrete feedback on parent-child interaction
  • vs. observation, surveillance
Facilitating Quality Visitation

- Affirm permanency as the goal
  - vs. good visits
- Ensure the visitation plan is moving family closer to achieving reunification
  - Are real-life parenting and reasons for removal being addressed?
- Create contingency agreements based on age of child
  - Are reasons to end a session immediate safety concern?
- Can parents join child’s appointments?
- Maintain collaboration and communication with family, treatment providers, service providers, and foster parents
Connect with services that strengthen families and support parent-child relationships
Connecting Families to Evidence-Based Parenting Program

- Knowledge of parenting skills and basic understanding of child development has been identified as a key protective factor against abuse and neglect (Geeraert, 2004; Lundahl, 2006; & Macleod and Nelson, 2000)

- The underlying theory of parent training is that
  - (a) parenting skills can improve with training,
  - (b) child outcomes can be improved, and
  - (c) the risk of child abuse and neglect can be reduced

Johnson, Stone, Lou, Ling, Claassen, & Austin, 2008
Key Components: Infant MH and Parent Training (Birth-3)

- Parents and children are BOTH included in the program
- Optional group format - average of 10 participants
- Homework - tracking child behavior and proximity seeking
- Video feedback on parent/child interaction or observation of stock videos
- Minimum professional requirement of Bachelor’s degree
- Dosage (Weekly, 1 hour, primarily 4-20 weeks)
- Setting (Home-based and community-based)
- Social learning and attachment are foundational theories
- Parent-directed and child-directed play
- Psychoeducation about child development and Mental Health
Generic Parent Training Programs (4-8)

Ten common components:

1. Strong engagement and alliance development with parent
2. Demonstration of skills to be learned
3. Relentless focus on increasing positive behavior of parent and child with praise and other rewards
4. Require completion of behaviorally specific homework each week with child
5. Psychoeducation about child development and Mental Health
6. Monitoring of: (a) parent’s progress and (b) child’s progress
7. Methods to maintain engagement in the group
8. Require frequent behavioral practice in session (preferably with live feedback)
9. At least 15 hours (individual), 25 hours (group)
10. Supervision of group leader based on observation (or listening)

Parenting Programs for Children Birth-8: What is the Evidence and What Seem to be the Common Components?; Barth, Richard P., University of Maryland
Parenting Programs Specific to Families Affected by Substance Use Disorders

- Celebrating Families - http://www.celebratingfamilies.net/

Please visit:

- California Evidence-Based Clearing House - www.cebc4cw.org
- National Registry of Evidence-Based Programs and Practices - www.nrepp.samhsa.gov
When Should We Offer Parent Education?

Sequencing of Parent Education

• Key considerations include cognitive functioning
• *Participation in parenting programs can enhance parent motivation and engagement in treatment* because it affirms their primary role and identity as a parent and focuses on their most important need
• Increase self-confidence as parents and equip them with needed skills
• *There is no time to lose when it comes to parent-child bond*
Support Strategy — Reunification Group

- Participation begins during unsupervised/overnight visitations through 3 months post-reunification
- Staffed by an outside treatment provider and recovery support specialist (or other mentor role)
- Focus on supporting parents through reunification process
- Group process provides guidance and encouragement; opportunity to express concerns about parenting without repercussion
Aftercare and Ongoing Support

Ensure aftercare and long-term recovery success beyond FDC and CWS participation:

- Personal recovery plan – relapse prevention, relapse
- Peer-to-peer – alumni groups, recovery groups, youth groups
- Other relationships – family, friends, caregivers, significant others
- Self-sufficiency – employment, educational, and training opportunities
- Community-based support and services – basic needs (childcare, housing, and transportation), mental health, physical health, medical care, and spiritual support
Rethinking Readiness

How will we know?

• Attendance vs. behaviors
• Compliance vs. adherence
• Safe vs. perfect
• Relapse vs. lapse
Sacramento County, CAM Project
Children in Focus (CIF)

Key Service Components

• Implementation of Celebrating Families
  • 16-week curriculum for families affected by parental substance use and child maltreatment and/or neglect

• Linkage to local Family Resource Center

• Warm-hand offs and case management support provided by Recovery Resource Specialists
Sacramento County
Family Drug Court Programming

- Dependency Drug Court (DDC)
  - Post-File
- Early Intervention Family Drug Court (EIFDC)
  - Pre-File

Parent-child parenting intervention
Connections to community supports
Improved outcomes

DDC has served over 4,200 parents & 6,300 children
EIFDC has served over 1,140 parents & 2,042 children
CIF has served over 540 parents and 860 children
Sacramento County, CAM Project, Children in Focus (CIF)

Treatment Completion Rates

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<tr>
<th>Program</th>
<th>Completion Rate</th>
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<tr>
<td>DDC</td>
<td>49.2</td>
</tr>
<tr>
<td>CIF</td>
<td>64.3</td>
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<tr>
<td>EIFDC</td>
<td>44.0</td>
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<tr>
<td>CIF</td>
<td>53.7</td>
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Sacramento County, CAM Project, Children in Focus (CIF)

Rate of Positive Court Discharge/Graduate

- DDC: 41.8
- CIF: 64.4
- EIFDC: 50.3
- CIF: 34.0
Sacramento County, CAM Project, Children in Focus (CIF)

Remained at Home

89.9

95.1

EIFDC

CIF
Sacramento County, CAM Project, Children in Focus (CIF)

Reunification Rates

<table>
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<tr>
<th>COUNTY</th>
<th>DDC</th>
<th>CIF</th>
<th>EIFDC</th>
<th>EIFDC</th>
<th>CIF</th>
<th>SAC COUNTY</th>
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<tr>
<td></td>
<td>87.8</td>
<td>97.0</td>
<td>85.1</td>
<td>94.9</td>
<td></td>
<td>53.1</td>
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</table>
Sacramento County, CAM Project, Children in Focus (CIF)

No Recurrence of Maltreatment at 12 Months
Sacramento County, CAM Project, Children in Focus (CIF)

No Re-Entry at 12 Months

- DDC: 89.6%
- CIF: 91.8%
- EIFDC: 100.0%
- CIF: 100.0%

SAC COUNTY
Ensure cross-system communication and information sharing for effective coordinated service delivery.

The Foundation of the BEST Communication Protocol is Trust.
What Information Should Be Shared?

• Strong communication and information sharing are a cornerstone of effective coordinated service delivery

• Information should include:
  - **Case level data** – to assess participant progress and case management (*How are families doing?*)
  - **Administrative data** – for program performance (*How is our program doing?*)

• **Protocols for communication pathways** - *who needs to know what and when*
How do you know..... How will you.....

- How are families doing?
- Doing good vs. harm?
- What’s needed for families?
- Monitor and improve performance?
- Demonstrate effectiveness?
- Secure needed resources?

What’s the Scorecard on Your Wall?
What do you Care Enough about to Count?
Take the Four Next Steps
1. Examine Data to Agree on Desired Outcomes
2. Conduct a Needs Assessment to identify what families need
Family Recovery

Needs

PARENTS
- Parenting skills and competencies
- Family connections and resources
- Parental substance use
- Parental mental health/co-occurring disorders
- Medication management
- Domestic violence

FAMILY
- Basic necessities
- Employment
- Housing
- Child care
- Transportation
- Family counseling

CHILD
- Well-being/behavior
- Developmental/health
- School readiness
- Trauma
- Mental health
- Adolescent substance use
- At-risk youth prevention
Things to Consider

- Review publicly available information
- Need to have a structure for comparing potential programs
- Pairing the curriculum to the needs and realities of target population
- How will it help achieve desired outcomes?
3. Conduct Community Map of existing services
Things to Consider

• What resources already exist in the community to serve children and families?
• Have you identified shared outcomes to make the case for shared resources?
• What steps can be taken to develop community partnerships to expand comprehensive services to meet the needs of the entire family?
4. Develop a plan for cross-system training
Things to Consider

• How can we provide cross-system training to ensure that partners understand the needs of parents, children, and families affected by substance use disorders?

• How do we get various disciplines into the same room for training?

• What topics are the most needed?
Ways to do It

• Require NCSACW training for child welfare, SUD treatment agency staff, attorneys, judges & court administrative staff
• Create a certification/fellowship to develop internal expertise
• Develop SUD treatment agency certification in child welfare practice
• Lawyers for lunch
• Specialized cross training days in conjunction with other trainings
Highlighted Resources
New Publication!

**Purpose:** Support the efforts of states, tribes and local communities in addressing the needs of pregnant women with opioid use disorders and their infants and families

**Audience**
- Child Welfare
- Substance Use Treatment
- Medication Assisted Treatment Providers
- OB/GYN
- Pediatricians
- Neonatologists

**National Workgroup**
- 40 professionals across disciplines
- Provided promising and best practices; input; and feedback over 24 months.

https://www.ncsacw.samhsa.gov/
Children Affected by Methamphetamine Brief

- Overview Children Affected by Methamphetamine (CAM) grant program (funded by SAMHSA from October 2010 – September 2014)
- Key implementation lessons learned
- Highlights safety, permanency, recovery, and well-being outcomes for the 1,850 families served during the first three years of the grant
Transitioning to a Family Centered Approach: Best Practices and Lessons Learned from Three Adult Drugs Courts

To download a copy:

Implementation Lessons for Family-Centered Approaches

3 Year Grant
Round 1 Apr. 2014 - May 2017

4 Family Drug Courts

• San Francisco, CA
• Pima County, AZ
• Robeson County, NC
• Tompkins County, NY

Read!

Case Studies (All Four Grantees)

Learn!

Overview of PFR
Key Lessons for Implementing a Family-Centered Approach
Cross-Systems Collaboration, Governance and Leadership:
Evidence-Based Program Implementation
Building Evaluation and Performance Monitoring Capacity of FDCs

The Prevention and Family Recovery initiative is generously supported by the Doris Duke Charitable Foundation and The Duke Endowment.
Additional Resources on Opioids

Web-Based Resource Directory
Webinar Series

Information on Treatment of Opioid Use Disorders in Pregnancy; Neonatal Abstinence Syndrome

Site Examples

Contact Information

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nkyoung@cffutures.org
www.cffutures.org
Putting Knowledge into Practice: Breakout Sessions

**Breakout 1 – Leadership Discussion and Q&A**
Legislators, Commissioners, Agency Directors and higher-level decision makers

**Breakout 2 – Next Steps to Plan Your FTC**
Local practitioners interested in learning more about the necessary next steps in planning an FTC

**Breakout 3 - Chittenden Family Treatment Court**
The planning committee for the Chittenden Family Treatment Court