“Meeting the Needs of Families in the Child Welfare System Affected by Substance Use Disorders”

Trauma-Informed Care for Families Affected by Substance Use Disorders

New England Practice & Policy Webinar #3

March 26, 2015
1:00PM – 2:30PM (Eastern)
Welcome & Opening Remarks

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National Center on Substance Abuse and Child Welfare

- Established in 2002
- A national resource center providing information, expert consultation, training and technical assistance to child welfare, dependency court and substance abuse treatment professionals to improve the safety, permanency, well-being and recovery outcomes for children, parents and families
Established in 1993 by SAMHSA

National network comprised of 10 regional centers, 4 national focus area centers, and a coordinating office.

Network mission is to: raise awareness and skills of the workforce that serves individuals affected by substance use disorders; accelerate the adoption and implementation of evidence-based practices; and foster regional and national alliances among diverse clinicians, researchers, policy makers, funders and the recovery community.
In your region, what are the **top three special topic areas** of greatest training need? Please select three responses. (N=63)

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma-informed approaches to care</td>
<td>70.5%</td>
<td>(N=43)</td>
</tr>
<tr>
<td>Opioid abuse and medication-assisted treatment</td>
<td>59.0%</td>
<td>(N=36)</td>
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<tr>
<td>Transition-age youth; aging out of the system</td>
<td>52.5%</td>
<td>(N=32)</td>
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<tr>
<td>Substance-exposed newborns</td>
<td>37.7%</td>
<td>(23)</td>
</tr>
<tr>
<td>Prescription drug abuse</td>
<td>26.2%</td>
<td>(16)</td>
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<tr>
<td>Minority and underserved populations</td>
<td>17.5%</td>
<td>(10)</td>
</tr>
<tr>
<td>Parental custody rights</td>
<td>13.1%</td>
<td>(8)</td>
</tr>
<tr>
<td>Medicaid/ACA implementation</td>
<td>9.8%</td>
<td>(6)</td>
</tr>
<tr>
<td>Other</td>
<td>8.2%</td>
<td>(5)</td>
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</tbody>
</table>

- How to assess child safety related to substance abuse/reunification
- Training and support for foster parents who are asked to care for children impacted by parental substance abuse.
- CBT skills training for providers
- Diagnosis
- Screening and treatment for adolescents
Today’s Webinar Agenda

• Welcome & Opening Remarks
• NCSACW’s Trauma-Informed Care Assessment Project
• Institute for Health and Recovery
• Q&A and Discussion
• Resources
Background on Substance Abuse, Trauma and Trauma-Informed Care

Vivian Brown, PhD
Amanda Kellerman, MSW
How many children in the child welfare system have a parent in need of substance abuse treatment?

- Between 60–80% of substantiated child abuse and neglect cases involve substance use by a custodial parent or guardian (Young, et al, 2007)
- 61% of infants, 41% of older children who are in out-of-home care (Wulczyn, Ernst and Fisher, 2011)
- 87% of families in foster care with one parent in need; 67% with two (Smith, Johnson, Pears, Fisher, DeGarmo, 2007)
Substance use, trauma and child maltreatment are often multi-generational problems that can only be addressed through a coordinated approach across multiple systems to address needs of both parents and children.
Definition of Trauma

Trauma results from an event or series of events that is experienced by an individual as physically and/or emotionally harmful or threatening and has lasting adverse effects on the individual’s functioning and well-being. It is the individual’s experience of these events that determines whether it is traumatic.

-Substance Abuse and Mental Health Services Administration, 2012
Major Studies Defining Trauma and Trauma-Informed Practice

- The Adverse Childhood Events (ACE) Study
- Women with Co-Occurring Disorders and Violence Study (WCDVS)
Major Studies Defining Trauma and Trauma-Informed Practice

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Adverse Childhood Events (ACE) Study

- Kaiser Permanente (Felitti) & CDC (Anda)
- Large-scale epidemiological study of influence of stressful/traumatic childhood experiences
- Interviewed more than 17,000 people
- Investigating adverse childhood experiences and adult health status

ACE Study Findings

Recurrent & severe physical abuse - 11%
Recurrent & severe emotional abuse - 11%
Contact sexual abuse - 22%
Growing up in a household with:

- **Substance abuse** – 25%
- Member being imprisoned – 3%
- Mentally ill, chronically depressed, or institutionalized member – 19%
- The mother being treated violently – 12%
- Both biological parents NOT present – 22%

Compared to persons with ACE score of 0, those with ACE score of 4 or more were:

- 2x more likely to be smokers
- 12x more likely to have attempted suicide
- 2x more likely to be alcoholic
- 10x more likely to have injected street drugs


Women with Co-occurring Disorders and Violence Study (WCDVS)

- 5 year National Study funded by SAMHSA – 9 sites in the country
- 2,729 women enrolled in the study
- 54% White, 18% Latina, 29% African American
- Each site had Intervention and Comparison programs
- 4 sites also studied their children

At 6 months Follow-Up:
- On 2 of 4 measures (post-traumatic symptoms and drug use severity), women in the intervention group showed significantly greater improvement than those in usual care
- On mental health status, differences almost reached significance
- Integrated counseling was positively related to outcomes.
Key Lessons from WCDVS

1. **Integrated** counseling on mental health, substance abuse, and violence issues in a trauma-informed context appears to be more effective and no more costly than services as usual.

2. Collaborations between those with **lived experience** and researchers/providers increases the quality of services and research.

3. “Trauma-Informed Practice” versus “Trauma-Specific Services”
Responses To Traumatic Events

- **FIGHT** – Individual in court acts in an angry/hostile way.
- **FLIGHT** – Individual does not follow court plan or does not return to court.
- **FREEZE** – Individual may be unable to communicate (mostly seen in children).

All of these responses affect an individual’s response to program requirements.
Failure to Identify and Address Trauma

May lead to:
- Withdrawal from services;
- Inadequate or inappropriate services;
- Re-traumatization;
- Increase in relapse events;
- Increase in management problems; and
- Poor treatment outcomes.

Before assuming a client is being “non-compliant,” think trauma first
Importance of Trauma-Informed Care

- High prevalence of trauma, substance abuse, & mental health disorders in our populations
- Traumatic events shatter trust; the experiences a client has from the moment s/he arrives will impact her/his ability to engage in a healing process
- Need to maximize safety and reduce possible re-traumatization of clients
- T-I services improve retention in services and improve outcomes
6 Principles of Trauma-Informed Care

1. **Safety** – ensure the physical and emotional safety of clients and staff

2. **Trustworthiness and Transparency** – provide clear information about what the client may expect in the program, ensure consistency in practice and maintain boundaries

3. **Peer Support** – provide peer support from persons with lived experiences of trauma to establish safety and hope and build trust

6 Principles of Trauma-Informed Care

4. **Collaboration and Mutuality** – Maximize collaboration and the sharing of power with consumers to level the power differences between staff and clients.

5. **Empowerment, Voice and Control** – empower clients and staff to have a voice, share in decision making and goal setting to cultivate self-advocacy.

6. **Cultural, Historical and Gender Issues** – as an organization, move past cultural stereotypes and biases, offer gender- and culturally-responsive, and recognize and address historical trauma.

Organizational Trauma Assessment
Background of the Organizational Trauma Assessment

Fallot & Harris (2004) developed an Agency Self-Assessment, involving 5 core elements:

- Safety
- Trustworthiness
- Collaboration
- Choice
- Empowerment

Brown (2008) adapted the Assessment into a System “Walk-Through” that allows staff and administrators to move through system processes *through the eyes of the client.*

Trauma Walk-Through Goals

- Better understand the experience of care through the clients’ eyes
- Assist staff members to understand how they may inadvertently re-enact trauma dynamics
- Uncover assumptions, inconsistencies, and limitations of systems
- Generate ideas for improving system processes

Conducting a walk-through and implementing changes leads staff to better address issues of safety for clients and staff members, reduce re-traumatization, improve consistency in practice, and increase client empowerment.
Trauma Walk-Through Process

- A mutual information-gathering strategy that does not feel like a judgment – when we look through the “trauma lens,” we understand that we may be unintentionally re-traumatizing clients

- Trainings and technical assistance (TA) grow directly from the Assessment and Action Plan

The core question of the Walk-Through is: Could this practice or procedure upset or trigger the participant?
Identifying Trauma Triggers

- At each step of the walk-through, identify possible triggers
- For each trigger, brainstorm what possible changes could be made
- The team can begin to rate priority (greatest risks) and feasibility (how “doable”)
- The team then discusses how these possible solutions fit into an Action Plan, including who might be responsible and dates to be completed
- Discuss the Action Plan with managers and staff
Key Findings and Lessons Learned from the NCSACW Trauma-Informed Care Assessment Project
Background of the Project

- Funded through NCSACW as a component of its technical assistance project
- To participate in the project, selected sites applied and met the following criteria:
  1. Had already begun some discussions and activities on being trauma-informed
  2. Had an established collaborative partnership that unites child welfare, substance abuse treatment providers, and a family drug court to serve families in the child welfare system who are affected by parental substance use disorders
  3. Had a steering committee or executive committee available to participate in the walk-through and planning efforts, with policy-makers or administrators from each system (i.e. Court, Substance Abuse Treatment, Child Welfare)
  4. Committed to developing an action plan following the walk-through and implementing site-specific solutions to become more trauma informed
- NCSACW selected five sites from across the country, representing both rural and urban areas
Trauma Walkthrough Preparation

- Planning call to convene the team, including substance abuse treatment agency, child welfare agency, court and others
- Agenda development for the 2-day visit – ensure the team can physically walk through each key agency
- Sites complete baseline survey
Pre-Assessment Baseline Survey

Each site completed a brief survey across agencies to gather baseline information on:

- Respondents’ understanding of trauma-informed/trauma-specific services
- Training and staff development on the topic of trauma
- Available funding for families who may have experienced trauma
- Implementation of trauma-specific screening, assessment and intervention
- Organizational policy and practice relating to provision of trauma-informed/trauma-specific services

Figure 1. Agency Representation, N=146

- Child Welfare Services, n=73
- County Government, n=1
- Court, n=24
- Mental Health Services, n=5
- Substance Abuse Tx Services, n=36
- Other, n=7
Understanding of Trauma

- 92.4% of respondents indicated that they understand how trauma can impact a person.
- 87.9% indicated that they have an understanding of how trauma affects a family.
- Only 50% of respondents agreed that they have an understanding of how to provide trauma-informed services.
- 59.9% indicated that they knew the difference between trauma-informed care and trauma-specific services and 28.8% responded “Don’t Know” to this question.

Training

- 68.2% of respondents have received training on the topic of trauma.
- 42.4% or respondents have received training in trauma-specific interventions.
Baseline Survey Findings

Screening and Assessment

- 40.9% indicated that their agency conducts trauma screening and assessments
- Approximately 10% indicated that trauma screening and assessment is not applicable to their role and/or agency.

Trauma-Specific Interventions

- 39.4% of respondents agreed that their agency currently implements one or more evidence-based intervention(s) to address the service needs of trauma survivors; 23.5% disagreed; 22.0% didn’t know and 15.2% indicated that it was N/A to their agency.

- 64.4% agreed that their agency collaborates with other community agencies or providers to offer trauma-specific services

- Top three interventions most frequently selected by respondents:
  - Seeking Safety (26.4%)
  - Trauma-Focused Cognitive Behavioral Therapy (15.4%)
  - Parent-Child Interaction Therapy (12.1%)
Trauma Walkthrough Process

- All sites completed a 2-day trauma walkthrough with Dr. Brown and NCSACW staff during the summer of 2014
- Each visit began with a briefing session and concluded with a debriefing session, during which findings were shared with the team
- NCSACW delivered a Preliminary Action Plan in follow up, with identified trauma triggers and proposed solutions
- NCSACW provided technical assistance as needed and follow-up conference calls with each site
Commonly Identified Trauma Triggers — Safety and Physical Space

- Unwelcoming buildings – dark, cold, unsafe, rooms felt like a closet and rooms filled with trash
- Armed security guards and triggering security screens
- Loud/echoes in rooms, flickering lights
- Lack of artwork or trauma-triggering artwork
- Staff desks – clients backs to door or clinician blocked in
- Not enough space for clients to sit in courtroom, chaotic environment upon entering courtroom
- Court rooms that feel like a “tribunal” – “us versus them”
Commonly Identified Trauma Triggers —
Intake and Assessment Process

- Repetition of the same assessment forms at every agency — client must repeat sensitive information many times and therefore feels unheard and loses trust in the agency
- Lengthy intake procedures with no breaks — client feels overwhelmed
- Lack of screening/assessment questions for trauma and lack of trauma-specific services to which to refer clients
- Lack of clarity, unexpected or inconsistent processes — client doesn’t know what to expect during the program
Commonly Identified Trauma Triggers — Trauma-Specific Interventions

- Lack of trauma-specific services for children and/or parents
- Lack of partnership with mental health services — client doesn’t have access to mental health services and trauma treatment needs are not met
- Lack of widespread knowledge of trauma-specific interventions
Commonly Identified Trauma Triggers — Court Responses to Behavior

- Lack of consistency in responses or no clear messaging about responses — client loses trust in the team
- Triggering sanctions (i.e. jail time) — client is re-traumatized by a sanction
- Need for sanctions to take into account behaviors that were precipitated by trauma (i.e. drug testing)
Commonly Identified Trauma Triggers — Drug Testing Space and Procedures

- Lack of privacy — testing done in high-traffic areas
- Uncomfortable bathrooms — too small, lack of comfort, lack of space
- Limited testing times
Commonly Identified Trauma Triggers — Client Choice and Empowerment

- Challenges with the balance between accountability and choice
- Staff concern over clients “taking advantage”
- Clients do not have choice over therapists or treatment groups
Commonly Identified Trauma Triggers — *Secondary Trauma*

- Lack of support for staff — staff feels overwhelmed and loses trust in the agency
- Staff physical space is triggering — no “safe space” for staff to decompress after a difficult meeting
- Staff burden and wellness
- Front office and security staff who don’t have an understanding of trauma and feel very anxious
Site Reported Changes After 6 Months

Safety

- Two sites reported rearranging staff offices to ensure no one feels “blocked in” or is distracted by noise.
- Two sites reported changing drug testing bathroom spaces by moving to more private and comforting bathrooms.
- All sites noted that they were working on adding artwork to walls.
- One site is creating a safe space or “Zen room” for staff in the child welfare office.
- Two sites are implementing a training for front office staff and security guards on trauma.
- One site noted they are now using peer specialists greeting individuals and helping them through security and sitting in crowded waiting rooms with the clients.
Site Reported Changes After 6 Months

Trustworthiness and Transparency

- One site has made it a priority to develop information-sharing agreements across agencies to minimize duplication of assessments and intake questions.
- All sites noted making changes to their incentives and sanctions in family drug court, including implementing a tiered list of rewards and sanctions and ensuring consistency.

Peer Support

- Two sites are working on securing paid positions for peer mentors to support families.
- One site implemented a support group for peer mentors and is encouraging more frequent supervision meetings for peer mentors. The site reports already seeing the benefits of this increased support, including increase in morale and decrease in feeling of burnout.
Site Reported Changes After 6 Months

Collaboration and Mutuality Empowerment, Voice and Control

- One site created a liaison position between mental health services and alcohol and drug services.
- All sites noted offering clients a choice of therapist.
- All sites reported changes in how they interact and talk with clients, such as asking clients, “What can I do to make you feel more comfortable during this process?” during drug screens.
- All sites have reported working on ensuring that staff also have strategies in place to decompress and reduce burden.

Cultural, Historical and Gender Issues

- One site employed a gender-specific therapist for Seeking Safety groups.
Key Lessons Learned

- Use of peer mentors or recovery coaches is a very important part of being trauma-informed.
- All sites had a lack of (or strained) partnership with mental health – a key barrier to offering trauma-specific services.
- Sites demonstrated an understanding of what it means to be trauma-informed but expressed difficulty making concrete changes – the “how to”.
- Need for information sharing agreements came up in all sites.
- While most sites had staff attend a trauma training, they did not understand the need for multi-level training.
References and Resources


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From Systems Change to Practice Change

Laurie S. Markoff, Ph.D.
Director of Trauma Integration Services

www.healthrecovery.org
IHR’s Systems Change Process 2002-present

- Agency/Program completes Trauma-Integration self-assessment
- Chooses trauma champion: develops trauma integration team
- IHR provide on-site trauma training
- Trauma Integration Team develops implementation plan using IHR template
- Team can request additional training/TA
- May include training on trauma-specific interventions
- Program repeats assessment periodically
Resource Development

Developing Trauma Informed Organizations: A Tool Kit

- Trauma Integration Self-Assessment
- Staff Practice Survey
  - Administered Anonymously
  - Covers 6 domains of trauma-informed practice
- Trauma Informed Supervision Tools
  - Supervisor Self Check
  - Supervisee Learning Review
- Template for Developing A Trauma Integration Plan
Trauma Informed Organization

Trauma Informed Staff
Core Competencies for a Trauma-Informed Workforce

- Using an empowerment approach
- Building safe relationships
- Understanding and explaining current behavior as an attempt to cope with trauma and its impact
Trauma Informed Core Competencies

- Use an empowerment approach
  - Ask questions
  - Help identify choices and outcomes
  - Offer as much choice and control as possible
  - Avoid telling them what to do
  - Focus on strengths
  - Point out choices that lead toward goals
  - Be transparent-explain why you do what you do
  - Give information- knowledge is power
Trauma-informed Core competencies

- Build safe relationships
  - Use a collaborative approach
  - Ask questions - be curious and open minded
  - Do not make assumptions
  - Be non-judgmental
    - Avoid shaming
  - Be trustworthy
  - Check out and validate feelings
  - Use your own self-regulation
Trauma Informed Competencies

- Understanding/Explaining Behavior
  - Ask questions that help connect behavior to past adverse events
  - Understand/explain behavior as unsafe coping/attempting to survive
  - Recognize when someone is fight/flight/freeze and help focus on regulation so they can think
  - Teach/elicit self-regulation skills
  - Help identify triggers
Resources for Developing a Trauma Informed Workforce

- **Videos**
  - Trauma Informed Interactions with Clients currently available on website- www.healthrecovery.org
  - Trauma Informed Supervision will be available by October 1, 2015

- **Online Curricula**
  - Four one-hour modules on Trauma-Informed Treatment for SUDs will be available Fall 2015- funded by MA DPH/BSAS
Contact Information

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Q&A and Discussion
Improving Care of Substance Use, HIV, and/or HCV in Adolescents: Effective Approaches to Assessing, Treating, and Engaging Teens

Thursday, April 16, 2015
@ Mashantucket Pequot Museum and Research Center
Mashantucket, CT
Registration: $20 (Advance); $25 (At the Door)

For more information, please contact: Sara Becker at sara_becker@brown.edu
Or call (401) 863-6604
The New England Practice & Policy Webinar Series

**September 30, 2014**
Kick-Off Webinar

**December 9, 2014**
Screening and Assessment for Family Engagement and Retention

**March 26, 2015**
Conducting Trauma-Informed Systems Assessment

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NCSACW

Wrap-up, Resources and Tools
Guiding Principles

• Improving the outcomes of children and families affected by parental substance use demands urgent attention and the highest possible standards of practice from everyone working in systems charged with promoting child safety and family well-being.

• Since 85% of all children with substantiated abuse and neglect cases stay home or return home to their parents, child and family well-being requires services for both children and families.

• Success is possible and feasible. Staff in child welfare, substance abuse, and court systems have the desire and potential to change individual lives and create effective practices and responsible public policies.

• Family members are active partners and participants in addressing these urgent problems.
Guiding Principles

• The family is the focus of concern
• The team is the tool, and people, not tools, make decisions
• Problems don’t come in discrete packages; they are jumbled together
• Ongoing assessment is a shared responsibility
• Developing and sustaining effective collaborations is hard—but essential work
Essential Elements

• Shared mission and vision - agreement and understanding of target population and expected outcomes
• Clear and consistent referral process—preferably warm hand-off
• Coordinated case planning, information sharing,
• timely and ongoing communication and follow-up
• Understanding of and attention to competing “clocks”—timeframes –recognizing that time is of the essence!
Cross-System Collaboration

Includes collaborative practices and tools for linking substance abuse, child welfare, and family courts.

- Collaborative Practice Model
- Matrix of Progress
- Collaborative Values Inventory
- Collaborative Capacity Instrument

Please visit our resource page:
https://www.ncsacw.samhsa.gov/collaboration/default.aspx
Collaborative Practice

- SAFERR
- Cross-Systems Collaboration Primer
- Cross-Systems Data Primer

Please visit our resource page:
http://www.ncsacw.samhsa.gov/resources


3. Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Legal Professionals

Please visit: www.ncsacw.samhsa.gov

National Center on Substance Abuse and Child Welfare Online Tutorials
Resource: Substance Abuse Specialist in Child Welfare Agencies and Dependency Courts

6 State Case Studies

To download a copy, please visit:


To download a copy, please visit:
Resource: Screening and Assessment for Family Engagement, and Recovery (SAFERR)

To download a copy, please visit:
Just Released!

- Assists behavioral health professionals in understanding the impact and consequences for those who experience trauma
- Discusses patient assessment, treatment planning strategies that support recovery, and building a trauma-informed care workforce

To download a copy, visit: http://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf
Resources - Transition-Age Youth

National Collaborative on Workforce and Disability Policy Brief - http://www.ncwd-youth.info/policy-brief-02

SAMHSA TIPs: TIP 31 Screening and Assessing Adolescents for Substance Use Disorders and TIP 32 Treatment of Adolescents With Substance Use Disorders http://store.samhsa.gov/shin/content/SMA01-3596/SMA01-3596.pdf

New England Resources:

Rhode Island - Adolescent Health Care Transition Program - Office of Special Healthcare Needs at the Dept. of Health: http://www.health.ri.gov/programs/adolescenthealthcaretransition/

Massachusetts - Department of Mental Health Transition Age Youth (TAY) Initiative http://www.mass.gov/eohhs/gov/departments/dmh/transitional-age-youth-initiative.html

Connecticut - Dept. of Mental Health & Addictions Services - Young Adult Services Division http://www.ct.gov/dmhas/cwp/view.asp?q=334784


Maine - Maine Youth Transition Collaborative website - http://maine-ytc.org/