Substance Abuse and Mental Health Services Administration
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Grants to Expand Services to Children Affected by Methamphetamine in Families Participating in Family Treatment Drug Court

November 2014

Children Affected by Methamphetamine (CAM) Brief

ABOUT THE CAM BRIEF

Improving outcomes for families affected by parental substance use disorders and child welfare involvement starts with a cross-systems commitment and coordinated approach to address the multiple and complex needs of parents and children. Through collaborative efforts around the country, evidence is emerging of what families need to succeed in their efforts to reunify with their children and maintain their recovery. The brief summarizes the experiences, lessons learned, and outcomes of the collaborative efforts of the Children Affected by Methamphetamine (CAM) grant program (October 2010 – September 2014). The brief also provides an overview of the grant program, the grantees, and key implementation lessons learned and highlights the CAM program's interim safety, permanency, recovery, and well-being outcomes for the 1,850 families served during the first three years of the grant.

OVERVIEW, LESSONS LEARNED AND OPPORTUNITIES

CAM GRANTEES		
GRANTEE NAME	**CITY**	**STATE**
Butte County, California Behavioral Health, Adult Services, Treatment Courts	Chico	CA
Clark County Family Treatment Court	Vancouver	WA
Colorado Judicial Department, Denver Juvenile Probation	Denver	CO
County of Santa Cruz Family and Children's Services, Human Services Department	Santa Cruz	CA
Dunklin County, Missouri, 35th Judicial Circuit, Family Treatment Court	Kennett	MO
Nebraska Administrative Office of the Courts	Lincoln, Omaha and Papillion	NE
Oklahoma Department of Mental Health and Substance Abuse Services, Tulsa, OK	Tulsa	OK
Pima County Juvenile Court Center	Tucson	AZ
Sacramento County Department of Health and Human Services, Child Protective Services Division	Sacramento	CA
San Luis Obispo County Behavioral Health, Drug and Alcohol Services	San Luis Obispo	CA
Santa Barbara County Alcohol, Drug, and Mental Health Services	Santa Barbara	CA
Superior Court of California, Riverside County Collaborative Drug Court Division	Riverside	CA

OVERVIEW AND CONTEXT OF THE CAM INITIATIVE

In October 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) initiated the Grants to Expand Services to Children Affected by Methamphetamine in Families Participating in Family Treatment Drug Court (short title "*Children Affected by Methamphetamine (CAM) Grant Program*"). The purpose of the CAM grant program was to expand and/or enhance services to children (aged 0 to 17 years) and their families affected by parental methamphetamine and other substance use disorders and who are participating in a Family Treatment Drug Court (FTDC). The primary focus of the grant program was to provide direct services to children and supportive services to parents, caregivers, and families. Grant-funded services addressed multiple and complex issues, including child abuse and neglect, co-occurring mental health and substance use disorders, prenatal substance exposure, parent-child bonding and attachment issues, and multi-generational trauma.

All 12 CAM grantees were located west of the Mississippi River – with 6 grantees in California – reflecting the particular impact of methamphetamine use on Western and rural states. Grantees designed their respective CAM programs to address the unique community context of their FTDC. They were therefore diverse in their overall project design, target population, service implementation strategies, agency priorities, resources, scale and capacity, and intended outcomes.

Each grantee conducted their own local evaluation to capture their CAM project's performance in its unique community context. In addition, 11 of the grantees participated in a broader CAM performance monitoring effort that examined grantees' collective progress in improving the safety, permanency, recovery and well-being of children and families. Interim CAM performance indicator results are highlighted in Part 2 of this briefing series.

FAMILY TREATMENT DRUG COURT – OVERVIEW AND OPPORTUNITIES

The implementation of the Adoption and Safe Families Act (ASFA) in 1997 placed increased emphasis on achieving timely permanency for children in the child welfare system and stressed the importance of finding effective ways to address families' concurrent substance abuse and child maltreatment problems. *Blending Perspectives and Building Common Ground,* a 1999 congressional report mandated by ASFA, established the following five broad national goals to improve services to families affected by substance abuse and involved in the child welfare system: (1) building collaborative working relationships between child welfare, substance abuse treatment, and the courts; (2) assuring timely access to comprehensive substance abuse treatment services; (3) improving engagement and retention of parents in substance abuse treatment; (4) enhancing children's services; and (5) filling information gaps.

Over the past 15 years, considerable progress in meeting these goals has been made at the Federal, State, and local levels through various collaborative efforts. One successful collaborative model is the Family Treatment Drug Court (FTDC), which oversees child abuse and neglect cases that involve parental substance use disorders. Since the first FTDC opened in Reno, Nevada in 1995, the number of FTDCs has increased to over 300 jurisdictions[1] across the country. FTDCs bring together treatment and preventative services with case management in a cooperative, rehabilitative context, and coordinate these efforts with child protective services to address child safety, permanency, and well-being. Studies show that in comparison to traditional family reunification services, FTDCs have higher treatment completion rates, fewer days in out-of-home care, higher family reunification rates, fewer termination of parental rights, fewer re-entries into foster care, and cost savings for agencies.[2]

As an adaptation of the adult drug court model, most FTDCs have concentrated on meeting the treatment and recovery service needs of parents. Few FTDCs provide, either directly or through partnerships, services to meet the often complex needs of children and then integrate the needs of children and parents into a comprehensive, family-centered case plan. The CAM grant initiative sought to address this gap and meet the national goal of enhancing and expanding children's services.

[1] As of December 31, 2013, National Drug Court Resource Center

[2] Marlowe, D.B. & Carey, S.M. (May 2012). Research update on Family Drug Courts. NADCP Need to Know

IMPLEMENTATION LESSONS LEARNED

Over the four-year grant period (October 2010 – September 2014), several important implementation lessons emerged from reviews of grantee site visit reports, grantee bi-annual progress reports, NCSACW technical assistance reports, and the performance indicator data analyses.

1. *Expanded focus means forging new partnerships* – Increased emphasis on children brings new partners to the table. CAM provided an opportunity to mobilize and partner with agencies already serving children. These agencies include maternal and child health, early childhood development, play therapy, mental health, and youth services. The FTDCs demonstrated that no single agency or program can meet the needs of children alone and that broad-based partnerships are necessary to serve children effectively.
2. *An expanded focus requires continued interagency collaboration* – Building the capacity of FTDCs to provide children's services require a collaborative effort and mutual investment across CWS and treatment agencies and the courts. Grantees found they had to establish new or revise existing referral protocols, interagency communication approaches, data-sharing agreements, case management strategies, and other FTDC operations. These policy and practice improvements came only after grantees broke down barriers and openly discussed issues such as budgeting and financing, information sharing, or areas of territorial responsibility leading eventually to greater interagency buy-in and collaboration.
3. *Improved family functioning and relationships is a part of recovery* – Addressing the needs of children required grantees to recognize improved child and family functioning as core elements in parents' recovery. CAM grantees met the need to address child and family trauma, support quality visitation and the parent-child relationship through evidence-based parenting, attachment-based therapy, and other therapeutic interventions. The CAM performance data showed statistically significant improvements from intake to closure in all 10 domains of family functioning including living environment, parental capabilities, family interactions, family safety, child well-being, social/community life, self-sufficiency, family health, caregiver/child ambivalence and readiness for reunification.[3]
4. *Delivering evidence-based programming involved unanticipated resources* – Grantees indicated they did not anticipate some of the costs associated with implementing high quality, evidence-based services. For example, a parenting program that many grantees provided includes treatment groups for parents and children. Some families had to participate in multiple groups because of the differing age ranges of their children (the curriculum and treatment groups differ by age group) or because the parents needed to attend groups separately due to conflicts in their relationship. Each additional group was associated with unexpected incremental costs for more therapists, space and transportation.
5. *Providing recovery support is a key engagement and retention strategy* – Given the complex needs of participant families, grantees strengthened service referral and engagement efforts by employing specialized engagement or outreach positions, such as a Peer Mentors, Recovery Mentors, Recovery Resource Specialists, and Court-Appointed Special Advocates. These team members provided support and encouragement that often included logistical problem solving

[3] Assessed by the North Carolina Family Assessment Scale (NCFAS G+R)

around issues such as transportation to improve participation and retention in treatment. Participants viewed these staff members as allies who could appreciate the challenges of addressing recovery and parenting issues simultaneously.

6. *Matching service to need involves a thoughtful and coordinated process* – Grantees also recognized the importance of matching client needs to appropriate services. For most grantees, the delivery of CAM services expanded their FTDC's service array, resulting in a need for a more coordinated assessment, referral, and phased service delivery process. For instance, grantees found that families' participation in Celebrating Families was enhanced after first achieving a period of recovery or participating in parent-child therapy. Sites that offered intensive programming like Parent-Child Interaction Therapy (PCIT) ensured that their referral processes adequately assessed whether a family's identified needs required such a high-level, specialized intervention or could be met through an appropriate alternative service.
7. *Start planning for sustainability early* – The CAM initiative emphasized the need for early and ongoing sustainability planning. The unique local context of each CAM program –including agency priorities and partnerships, parallel reforms and opportunities, utilization of data and evaluation, fiscal constraints, and leadership – shaped the planning process. Grantees were encouraged to start negotiations with stakeholders early and often, knowing that gathering data, identifying potential funding streams, and fostering relationships and sharing outcomes takes time and patience. By the final year of the grant, grantees were actively engaged in sustainability discussions, including identification and/or engagement of stakeholders in discussions on sustainability, identification of the components to sustain, and dissemination plans for project outcomes. While grantees made substantial progress with many sustainability-planning tasks, completing a cost study and expanding the scale of their FTDC remained a challenge for most grantees.

IMPLICATIONS FOR THE FIELD

For all grantees, CAM represented a fundamental shift in focus from parent recovery to child and family well-being. Many grantees cited that delivering CAM services became "a new way of doing business" and they cannot imagine reverting to their practice and policies prior to CAM where there was little or no intentional focus on serving children. This new way of doing business is also now standard practice in a growing number of FTDCs and adult drug courts nationwide.

Some of the CAM grantees were able to clearly articulate the prospects for institutionalizing innovations and enrichments, while others were focused primarily within the projects and to a lesser extent towards integration and changing the larger systems. Future funding initiatives and technical assistance should guide FTDCs towards a greater awareness and identification of larger systems, its resources, and needs. For example, sustaining evidence-based parenting services and developmental and therapeutic services for children into the larger FTDC systems of care would involve leveraging existing resources and partnerships. System-change initiatives may also focus on infusing key ingredients of FTDCs into the larger child welfare, treatment, and dependency court systems.

The CAM grantees' experiences underscore the need for a greater awareness of the planning, implementation, and sustainability challenges inherent in a more comprehensive FTDC approach that effectively meets the specific needs of children and whole families. Further opportunities exist to expand these lessons and practice changes beyond single grant programs to impact more lives and change the futures of children and families affected by parental substance use.

SAFETY, PERMANENCY, WELL-BEING AND RECOVERY OUTCOMES

The purpose of the CAM program was to expand and/or enhance services to children (0-17 years) and families of those affected from methamphetamine and other substance use disorders and who are participating in a Family Treatment Drug Court (FTDC). In 2010, SAMHSA awarded four-year grants to 12 FTDCs to provide services to children, parents, and families to improve safety, permanency, recovery, and well-being outcomes.

HIGHLIGHTS

The CAM grantees' preliminary outcomes make clear that a comprehensive family-centered FTDC approach that addresses the specific needs of children and families, in addition to a parent's recovery, contributes to improved child, parent, and family well-being. Selected highlights are provided below, with more detailed results discussed later in the brief.

The majority of children at risk of removal remained in the custody of their parent(s) and did not experience maltreatment after entering the CAM program.

The majority of children in out-of-home placement achieved timely reunification with their parent(s). After returning home, very few children re-entered foster care.

Adults stayed in substance abuse treatment (on average, about 6 months) and nearly half successfully completed treatment.[4] The majority of adults also reduced their use of alcohol, marijuana and methamphetamine.

Families showed statistically significant improvements in their overall child well-being and family functioning, with the greatest gains made in family safety, readiness for reunification, and parental capabilities.

[4] Includes discharges for treatment completion (all parts of treatment plan or program were completed) and transfers to another facility when the individual was known to report and expected to continue further treatment. Federal treatment outcome monitoring also treats such transfers as successful discharges.

Grantee Program Designs

SAMHSA did not require grantees to implement specific evidence-based interventions for children and families. Rather, grantees designed their CAM programs to address the unique community context of their FTDC and major program goals. Grantees' program were therefore diverse in their overall design, target population, service implementation strategies, scale and capacity, and intended outcomes.

Still, grantees consistently implemented several program elements (see Table 1). All grantees included an evidence-based parenting program, such as *Celebrating Families!*, Nurturing Parenting, and SafeCare. In addition, grantees implemented developmental and behavioral assessments (e.g., the Ages and Stages Questionnaires or the Child Behavior Checklist) or interventions for children to address the effects of prenatal substance exposure or child maltreatment. For instance, some grantees partnered with developmental clinics for children's neuro-developmental and psycho-social assessments and treatment. Two-thirds of grantees also provided therapeutic strategies, such as evidence-based Parent-Child Interaction Therapy (PCIT) and Promoting First Relationships, to heal and strengthen the relationship between children and their parents.

As program implementation progressed, grantees identified a need to address children's and parents' trauma and several sites added or enhanced trauma services accordingly. During the grant period, grantees also recognized a need to strengthen service referral and engagement systems. Specialized client outreach and engagement strategies included the use of Peer Mentors, Recovery Mentors, Outreach Workers, Recovery Resource Specialists and Court-Appointed Special Advocates.

TABLE 1: CAM GRANTEE PROGRAM DESIGN COMPONENTS

Program Strategy	Number of Grantees
Parenting Education	12
Developmental and Behavioral Interventions	12
Engagement and Outreach	10
Therapeutic-Based Parent-Child Interventions	8
Trauma-Focused Children Interventions	5
Trauma-Focused Adult Interventions	4

Data Collection and Methods

Eleven of the 12 grantees submitted their cumulative case-level child and adult data to the CAM Data Collection and Reporting System twice per year.[5] The CAM Data System linked children and adults together as a family unit and tracked them over the course of the grant period. The interim outcomes presented here are based on 1,850 CAM participant families that entered the program from October 1, 2010 through September 30, 2013 (through the end of program year three; see Table 2).

TABLE 2: CAM PROGRAM SAMPLE SIZES (As of September 30, 2013)	
Children	3,592
Adults	2,445
Families	1,850

SAMHSA used multiple quantitative and qualitative data sources to provide a comprehensive descriptive and analytical picture of the 11 grantees' performance. The majority of the safety, permanency and recovery CAM performance measurement indicators align with existing standardized performance measures in federal child welfare and substance abuse treatment outcome reporting systems – e.g., Adoption and Foster Care Analysis and Report System (AFCARS), National Child Abuse and Neglect Data System (NCANDS), Treatment Episode Data System (TEDS), and National Outcomes Measurement System (NOMS).[6] To provide additional context for understanding CAM outcomes, comparison data are provided, where appropriate and available.[7]

Demographic Profile of Participants Receiving CAM Services

During the first three years, grantees served 1,850 families, including 3,592 children and 2,445 adults. Grantees served an average of 168 CAM families, with a range of 47 to 712 families. This broad range reflects the diversity of the 11 grantee program models, geographic regions served, and target populations. Nearly three-fourths (74.2%) of the families had been discharged from the CAM program by the end of year three. The remaining 25.8% were still active cases and receiving services. Among discharged families, the median duration of services was 126 days (4.1 months).

[5] One grantee was not required to upload performance indicator data because the relatively small grant award (compared to other grantees) was insufficient to support both program implementation and reporting on performance monitoring outcome measures.

[6] Performance measurement indicators were derived from the Regional Partnership Program (RPG) performance monitoring system.

[7] Contextual information is included for indicators where state or county-level measures are similar in definition and publicly available.

Children who received CAM services were predominately Hispanic (40.4%). Another 29.4% were White, 9.4% were Black, and 2.4% were American Indian/ Alaska Native. On average, children were 5.4 years old at CAM entry; however, 61.8% were aged 0 to 5 years. The greatest proportion of children were 1 to 3 years old (27.6%). School-aged children (6 years and older) comprised 38.2% of the CAM child population (see Table 3).

TABLE 3: SELECTED DEMOGRAPHICS OF CAM PARTICIPANT CHILDREN[8]		
DESCRIPTION	**NUMBER**	**PERCENT**
Total Children	**3,592**	**100%**
Gender	**3,562**	
Female	1,785	50.1%
Male	1,777	49.9%
Age	**3,556**	
Under 1 Year	662	18.6%
1-3 Years	982	27.6%
4-5 Years	553	15.6%
6-8 Years	579	16.3%
9-12 Years	483	13.6%
13 and Older	297	8.4%
Mean Age (years)	**5.4**	
Race/Ethnicity	**3,056**	
White Non-Hispanic	1,056	29.4%
Black Non-Hispanic	336	9.4%
American Indian/Alaska Native Non-Hispanic	86	2.4%
Asian/Native Hawaiian/Other Pacific Islander Non-Hispanic	16	0.4%
Hispanic (any race)	1,450	40.4%
Multi-Racial Non-Hispanic	112	3.1%
Unknown	536	14.9%

[8] Percentage calculations for child demographics exclude cases with missing information.

Table 4 shows most CAM participants were women (71.6%) who were the biological mother (65.8%) of the children receiving services. Nearly half (45.6%) of all adults were under the age of 30. Adults who received CAM services were predominately White (49.5%). Another 29.7% were Hispanic, 8.9% were Black, and 2.5% were American Indian/ Alaska Native. Methamphetamine was the primary substance at treatment admission for well over half (57.1%) of all CAM adults.

TABLE 4: SELECTED DEMOGRAPHICS OF CAM PARTICIPANT ADULTS[9]		
DESCRIPTION	**NUMBER**	**PERCENT**
Total Adults	**2,445**	**100%**
Gender	**2,434**	
Female	1,743	71.6%
Male	691	28.4%
Age	**2,407**	
Under 21 years	73	3.0%
21 to 24 years	374	15.5%
25 to 29 years	653	27.1%
30 to 34 years	624	25.9%
35 to 39 years	325	13.5%
40 to 44 years	184	7.6%
45 years and older	174	7.2%
Mean Age (years)	**31.6**	
Race/Ethnicity	**2,252**	
White Non-Hispanic	1,210	49.5%
Black Non-Hispanic	217	8.9%
American Indian/Alaska Native Non-Hispanic	62	2.5%
Asian/Native Hawaiian/Other Pacific Islander Non-Hispanic	17	0.7%
Hispanic (any race)	727	29.7%
Multi-Racial Non-Hispanic	19	0.8%
Relationship to Child	**2,300**	
Biological Mother	1,610	65.8%
Biological Father	561	22.9%

[9] Percentage calculations for adult demographics exclude cases with missing information.

TABLE 4: SELECTED DEMOGRAPHICS OF CAM PARTICIPANT ADULTS[9]		
DESCRIPTION	**NUMBER**	**PERCENT**
Other	129	5.3%
Primary Substance at Treatment Admission	**2,030**	
Methamphetamine	1,160	57.1%
Marijuana	326	16.1%
Alcohol	266	13.1%
Heroin/other opiates	167	8.2%
Cocaine	78	3.8%
Other	33	1.7%

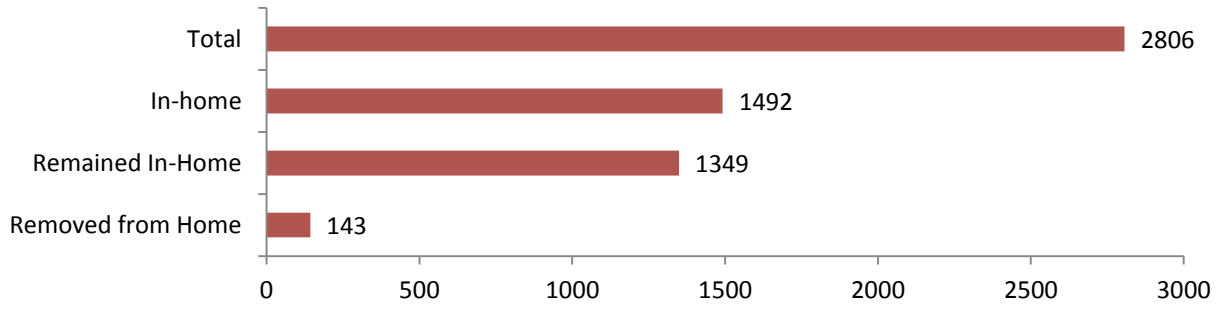
CHILD SAFETY – INDICATOR FINDINGS

Children Remain at Home

Percentage of children identified as at risk of removal from the home who are able to remain in the custody of a parent/caregiver through CAM case closure

- Over half (53.2%) of the children were in the custody of their parent/caregiver (i.e., in-home) at the time of CAM program enrollment (see Figure 1).

FIGURE 1: CHILDREN WHO REMAIN IN THE HOME THROUGH CAM CASE CLOSURE



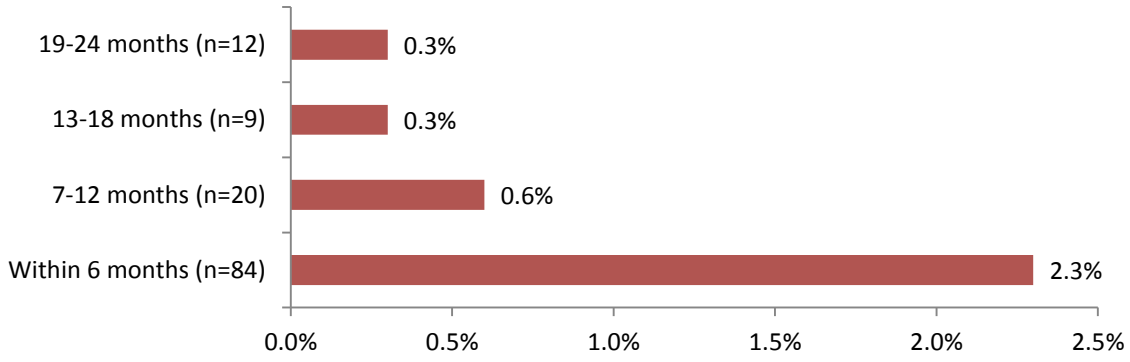
- Two grantees programmatic designs focused on providing services to children in the custody of their parent/caregiver comprising the majority of the children in-home at CAM program enrollment (47.1%).
- Nearly all (90.4%) of the children in-home at the time of CAM program enrollment remained in their parent's or caregiver's custody through CAM program case closure.

Occurrence of Child Maltreatment

Percentage of children who had an initial occurrence and/or recurrence of sustained/indicated child maltreatment within 6, 12, 18, and 24 months after enrolling in the CAM program

- A total of 2.3% of CAM children experienced child maltreatment within 6 months of program enrollment. This performance is substantially lower than the median rate of 7.3% for maltreatment recurrence within 6 months for the communities in which the grantees operate.
- The incremental proportions of children experiencing maltreatment at 12, 18, and 24 months was 0.6%, 0.3%, and 0.3%, respectively (see Figure 2). The cumulative percentage of children maltreated at any point within 24 months was 3.5%.

FIGURE 2: PERCENTAGE OF CHILDREN WHO HAD SUBSTANTIATED/INDICATED MALTREATMENT AFTER CAM PROGRAM ENROLLMENT



PERMANENCY – INDICATOR FINDINGS

Timeliness of Reunification

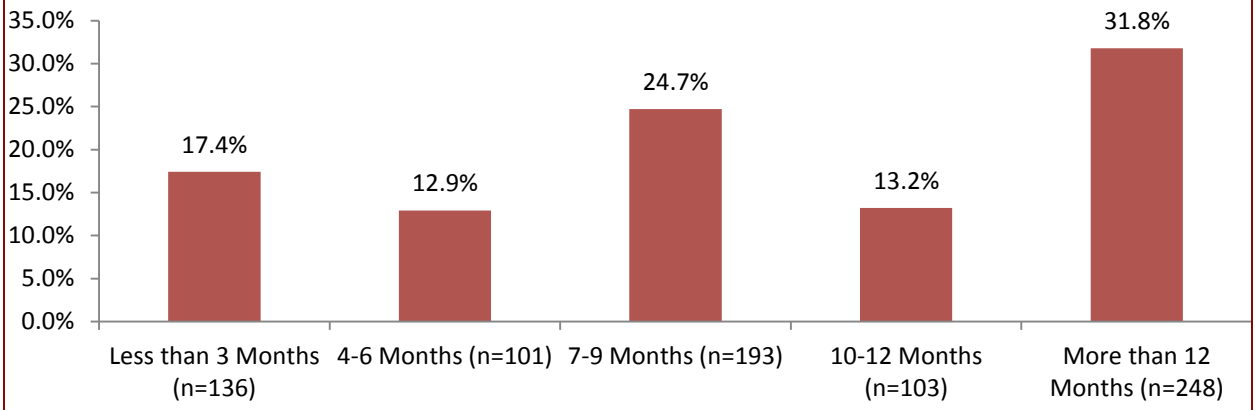
Percentage of children who were reunified in less than 12 months from the date of the most recent entry into foster care

- The majority (91.4%) of CAM children exiting out-of-home care were discharged to reunification.[10]
- Over two-thirds (68.2%) of CAM children were reunified in less than 12 months. The percentage of children achieving timely reunification is substantially better than the median of 56% for the communities in which the grantees operate.

[10] Federal government reporting counts discharges coded as "living with other relative" valid reunifications.

- Over one-sixth (17.4%) of CAM children were reunified in less than 3 months, 12.9% in 4 to 6 months, 24.7% in 7 to 9 months, and 13.2% in 10 to 12 months. Less than one-third (31.8%) were reunified in more than 12 months (see Figure 3).

FIGURE 3: PERCENTAGE OF CAM CHILDREN REUNIFIED

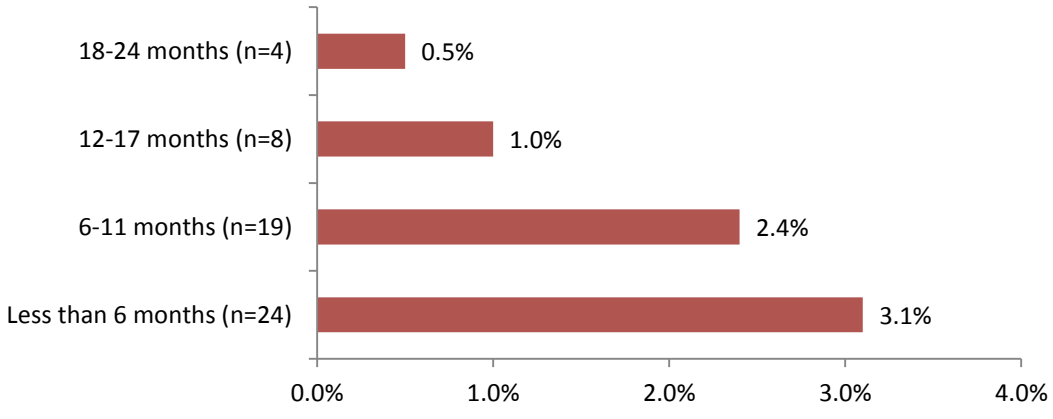


Re-entries to Foster Care

Percentage of children returned home from foster care that re-entered foster care in less than 6, 12, 18, and 24 months

- Grantees reported reunifying 783 children who were in out-of-home care.
- Among reunified children, only 55 children (7.0%) re-entered out-of-home care within 24 months after being returned home (see Figure 4).

FIGURE 4: PERCENTAGE OF CHILDREN RETURNED HOME THAT RE-ENTERED FOSTER CARE



- Most of those who re-entered foster care did so within 12 months of being reunified. Specifically, 3.1% re-entered out-of-home within six months, 2.4% in 7 to 12 months, 1.0% in 13 to 18 months, and 0.5% in 19 to 24 months.
- The percentage of CAM children who re-entered out-of-home care within 12 months (5.5%) was lower compared to the communities CAM grantees operated in where rates are estimated to be higher at 12.7%.

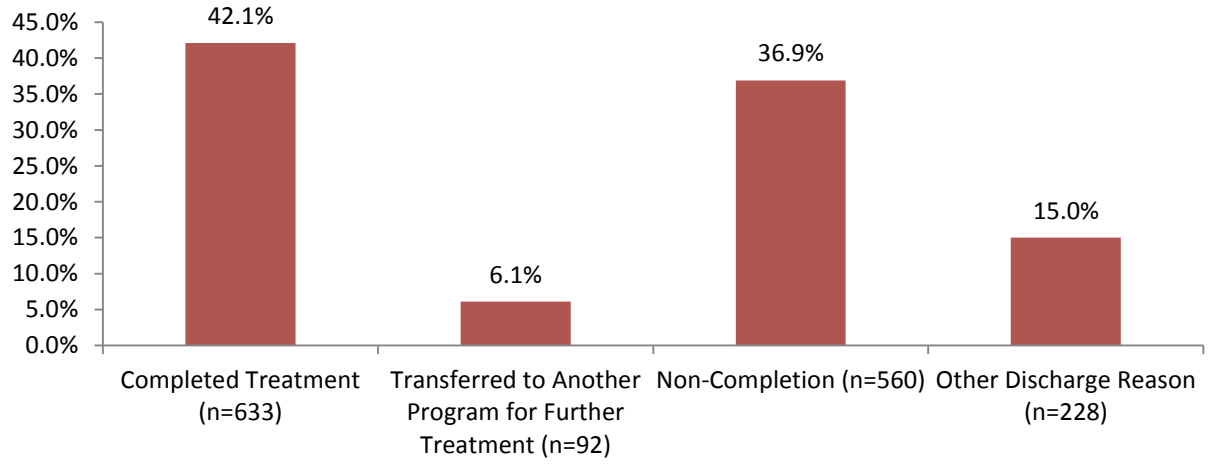
RECOVERY – INDICATOR FINDINGS

Retention in Substance Abuse Treatment

Percentage of substance abuse treatment episodes completed; average length of stay in substance abuse treatment episodes

Grantees reported data on 1,825 substance abuse treatment discharges by the end of year three. Figure 5 shows that 42.1% completed treatment and another 6.1% transferred to another program or facility for further treatment (considered a positive treatment outcome per federal treatment episode reporting). A total of 36.9% did not complete treatment and the remaining 15.0% of discharges were for other reasons.[11]

FIGURE 5: SUBSTANCE ABUSE TREATMENT DISCHARGES AMONG CAM ADULTS - PERCENTAGE BY DISCHARGE STATUS



[11] Excludes adults discharged from treatment, but whose discharge status is unknown. "Non-completion" includes clients who chose not to complete the treatment program or who transferred to another facility but did not report to the next program. "Other discharge reason" includes treatment terminated by the facility or because the client was incarcerated, left treatment for other specified reasons unrelated to treatment compliance, or died.

- Overall, the median length of stay in substance abuse treatment was 178 days (5.9 months).
- As expected, those who completed substance abuse treatment had the longest lengths of stay – 326 days (10.7 months). However, even those who did not complete treatment received treatment for 78 days (2.1 months).

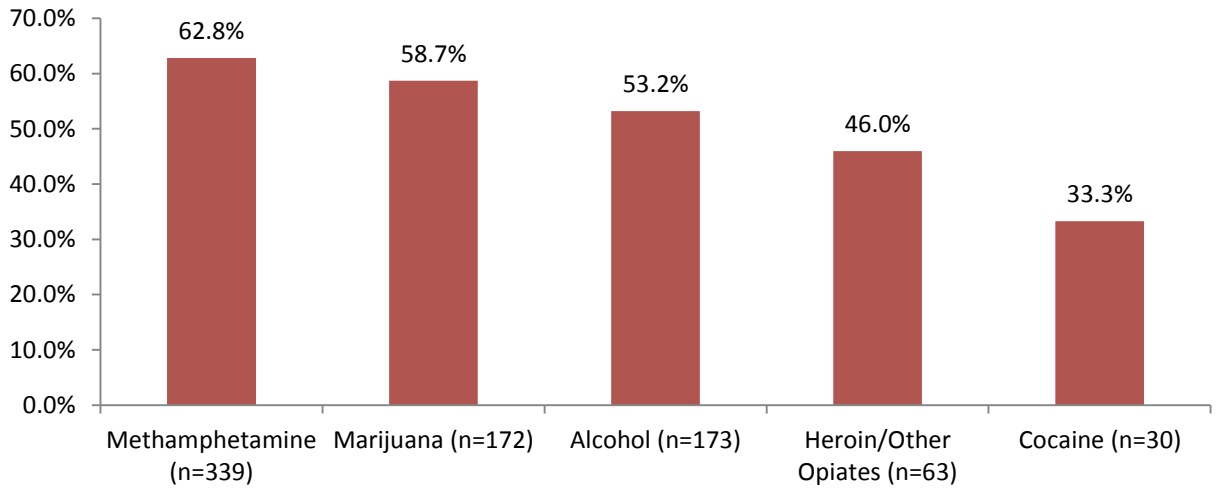
Reduced Substance Use

Percentage of parents or caregivers who report reduction in substance use, as measured by the number of days of use in the past 30 days at treatment intake and discharge

- The percentage of CAM adults with reductions in substance use ranged from 33.3% to 62.8% depending on the substance.
- Among CAM adults who reported any substance use in the past 30 days at treatment admission, the greatest reduction of use was report by those used methamphetamines (62.8%), followed by marijuana (58.7%), alcohol (53.2%), and heroin/other opiates (46.0%). One-third of the adults who used cocaine reported reductions in use (see Figure 6).

FIGURE 6: PERCENTAGE OF CAM ADULTS WITH REDUCTION IN SUBSTANCE USE FROM TREATMENT ADMISSION TO DISCHARGE

(Among Adults Who Reported Any Use in the Past 30 Days at Admission)

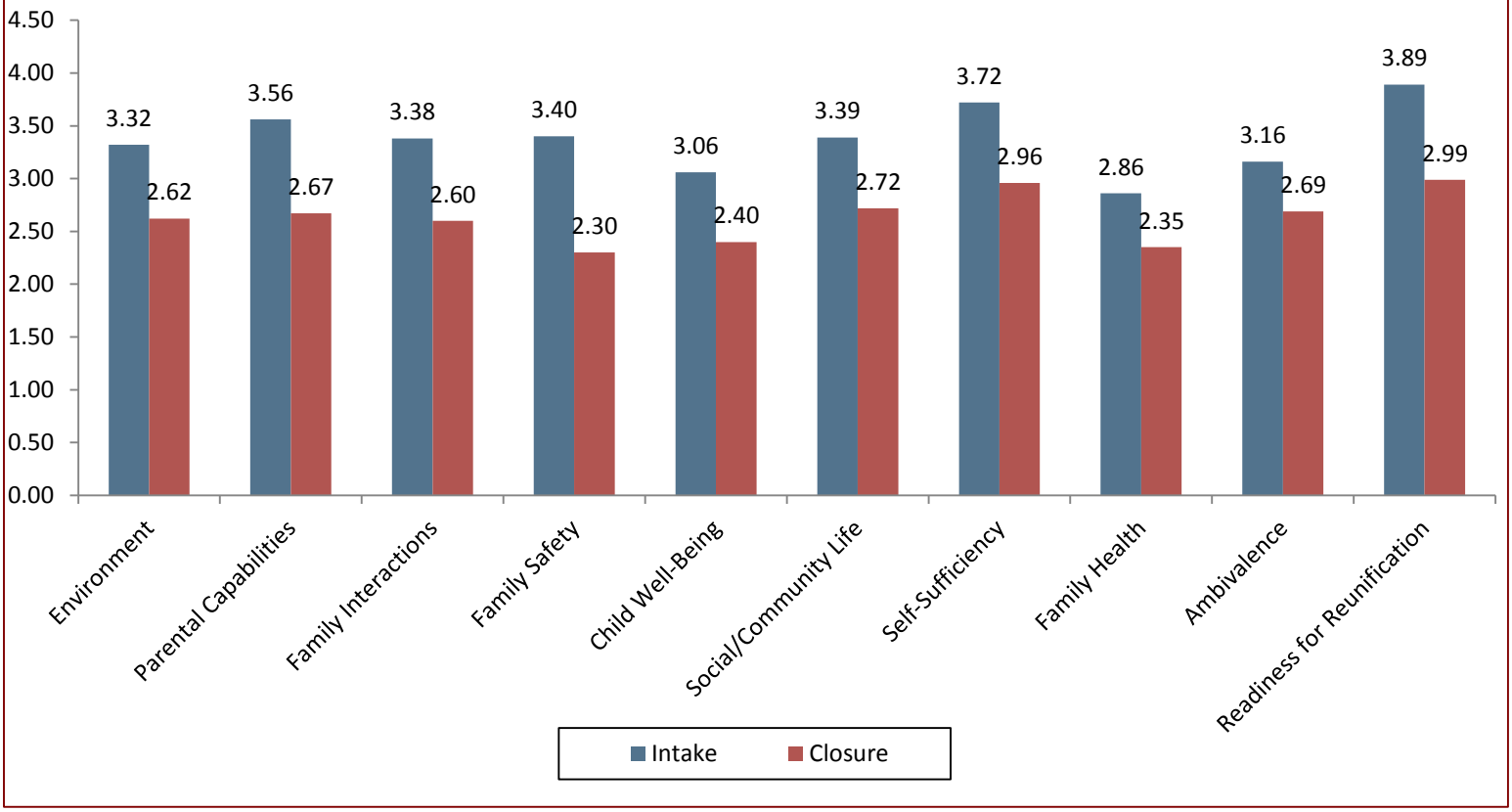


CHILD, ADULT, AND FAMILY WELL-BEING – INDICATOR FINDINGS

Grantees measured family and child well-being using the North Carolina Family Assessment Scale General + Reunification (NCFAS G+R). The NCFAS G+R is a family functioning assessment tool used to inform case management and family treatment options across 10 domains of family functioning. Grantees administered the tool at program intake and closure.

- Families showed statistically significant improvement from intake to closure in all 10 domains of family functioning including the environment,[12] parental capabilities, family interactions, family safety, child well-being, social/community life, self-sufficiency, family health, caregiver/child ambivalence and readiness for reunification (see Figure 7).[13]
- The largest mean differences were for the domains of family safety followed by readiness for reunification and parental capabilities.

FIGURE 7: OVERALL MEAN NCFAS SCORES FOR EACH DOMAIN AT INTAKE AND CLOSURE*



*p < .05 for all domains. Lower scores indicate improvement.

[12] Includes the areas of housing stability, safety in the community, environmental risks, housing habitability, personal hygiene, and learning environment.

[13] Scores range from 1 to 6 with 1 signifying a clear strength, 3 signifying baseline/adequate and 6 signifying a serious problem.

SUMMARY

Overall, performance monitoring suggests positive outcomes among CAM participants. Children enrolled in the CAM program services were kept safe with lower rates of repeat maltreatment than in the general child welfare population. More than 90% of children remained in their home with their parent/caregiver throughout program participation and the majority of children exiting out-of-home care were discharged to reunification. Less than 6% of reunified children re-entered foster care within 12 months after being returned home. Positive outcomes in the domain of recovery included decreases in parental substance use and nearly half of the adults discharged from substance abuse treatment (whose discharge status was known) had positive treatment outcomes. Additionally, significant improvement in family well-being from intake to closure was seen across 10 domains of family functioning. These preliminary results for families at the intersection of child welfare, the courts and substance abuse suggest the promise of targeted child services for improving outcomes for children and their parents.