FAMILY ENGAGEMENT AND COMMUNITY COLLABORATION IN SUBSTANCE ABUSE TREATMENT AND CHILD WELFARE

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Family Recovery Project Overview

- 5-year project funded by the US Administration for Children and Families/Children's Bureau
  - Regional Partnership Grant Program
- Technical Assistance provided by the National Center for Substance Abuse and Child Welfare (http://www.ncsacw.samhsa.gov)
- 53 grantees nationally

Family Recovery Project

- Overview
- Clinical approach
- Evaluation – early outcomes
- Systems collaboration
  - Family Recovery Council of Hampden County

A parent who is dependent on alcohol or other drugs cannot be an effective parent.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

Who We Serve

Families involved with the Department of Children and Families (DCF) who have lost custody of their children or are at imminent risk of losing custody:

- Children of clients
- Partners, other family members

Staffing

- Four Family Recovery Specialists (including bi-lingual) – provide *home-based* addiction and co-occurring disorders treatment
- Clinical Supervisor
- Project Coordinator
- Evaluation Team – Brandeis University
- "Core Team" – statewide and regional representatives from DCF, DPH/BSAS, IHR

Philosophy of Care

- Family focused
- Evidence-based
- Consumer-directed
- Trauma-informed
- Culturally relevant
- Strength-based

Home Visiting Model

Why in-home vs. community-based services?

- Target population: people who have not succeeded in community-based treatment
- Ambivalence
- Eliminates many barriers
  - Transportation
  - Child care
  - Stigma

The decision to reunify children with their parents should be based on the parents' abstinence from alcohol/other drugs.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

A person with a history of substance abuse needs to have at least 6 months of recovery to reunify with their children.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

Treatment and Other Services Provided

Integrated Treatment Model

- Substance use and co-occurring mental health disorders
- Intensive case management
- Individual, couples and family treatment
- Parenting
- Referral
- Liaison to DCF and other state agencies
- Children's services

Referral/Engagement

- Reluctant to meet with yet another provider
- Assessment – whole person, family-based, resiliency approach
- Children
  - Focusing on children's needs
- Balancing treatment and concrete needs

Early Recovery Treatment and Resource Coordination

Tools integrated from:

- MI, Stages of Change, CBT, Care Coordination, SUD psycho-education and treatment, Seeking Safety, & the Nurturing Program for Families in Substance Abuse Treatment and Recovery

Motivational Interviewing

- Provide evidence-based practices based on Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET)
- IHR focuses on strengths and competencies of each woman so she can become a leader in her own service plan and personal progress

Substance abuse providers should report relapses to child welfare workers.

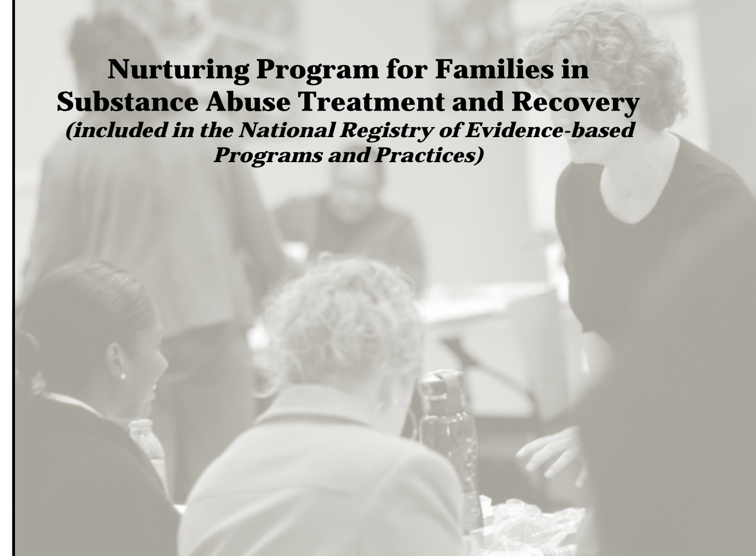
1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

Seeking Safety

- Cognitive-behavioral integrated trauma-substance use recovery group that provides women with specific strategies and tools to promote physical and emotional safety
- Provides specific tools to avoid/prevent relapse from substance use, mental health issues & trauma

It’s not only children who grow. Parents do too. As much as we watch to see what our children do with their lives, they are watching us to see what we do with ours. I can't tell my children to reach for the sun. All I can do is reach for it, myself.

Joyce Maynard



Nurturing Program for Families in Substance Abuse Treatment and Recovery
(included in the National Registry of Evidence-based Programs and Practices)

Why the Nurturing Program?

- People parent based upon their own parenting experiences
- Parents cannot give what they don’t have
- Knowing how to nurture comes from being nurtured
- Internalizing nurturing experiences helps parents to recognize the emotional needs of their children

Nurturing Program, 3rd Edition
Additional Sessions on Being a Father

- Designed to enhance the *Nurturing Program for Families in Substance Abuse Treatment and Recovery*
- Developed as alternatives to three sessions (Families & Substance Abuse, Body Talk and Schedules & Routines)
- Additional activities added throughout curriculum
- Guide for Individual and Family Use almost complete

Treatment Plan

- Sharing, teaching and modeling life management skills
  - Better reactions, better results
  - Motivate to take action around job and/or education
- Relapse-responsive
- Treatment retention issues

Early Evaluation Outcomes

Characteristics of FRP Clients at Baseline Interview (N=67)

	N	%
Gender		
Female	60	89.5
Male	7	10.5
Age (Mean = 35.4; range 20-54)		
20-29	19	28.4
30-39	25	37.3
40-49	21	31.3
50-59	2	3.0

Characteristics of FRP Clients at Baseline Interview (N=67)

	N	%
Race		
White	43	64.2
Black	11	16.4
Multiracial	9	13.4
Unknown	4	6.0
Ethnicity		
Hispanic	10	14.9
Non-Hispanic	55	82.1
Unknown	2	3.0

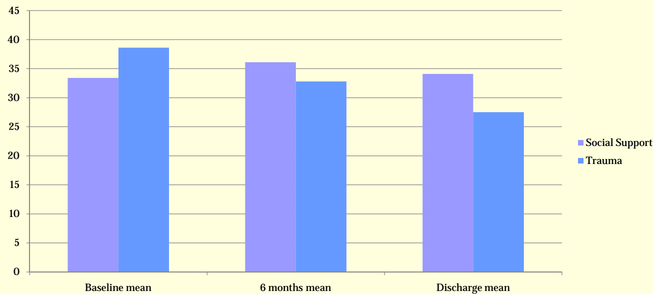
Characteristics of FRP Clients at Baseline, Follow-up, and Discharge

Characteristic	Baseline (N=67) (n)	%	6 Month (N=20) (n)	%	Discharge (N=15) (n)	%
Current Living Arrangements						
Independent Living	55	82.1	19	95.0	14	93.3
Dependent Living	3	4.5	-	-	1	6.7
Homeless	8	11.9	1	5.0	-	-
Unknown	1	1.5	-	-	-	-
Number of moves in past 12 months						
0	32	47.8	13	65.0	11	73.4
1	15	22.4	3	15.0	3	20.0
2	12	17.9	3	15.0	-	-
3-4	8	11.9	1	5.0	-	-
5 or more	-	-	-	-	-	-
Missing	-	-	-	-	1	6.7

Characteristics of FRP Clients at Baseline, Follow-up, and Discharge (Continued)

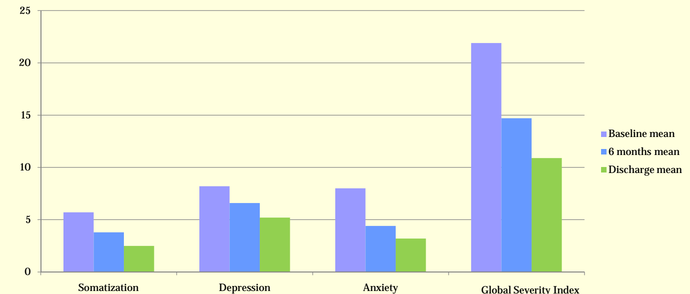
Characteristic	Baseline (N=67) (n)	%	6 Month (N=20) (n)	%	Discharge (N=15) (n)	%
Legal Issues Involvement						
Under Restraining Order/Protection	7	10.4	1	5.0	2	13.3
Arrest in Past 30 Days	1	1.5	0	0.0	0	0
Other Legal Involvement	21	31.4	5	25.0	2	13.3
No Legal Issues	38	56.7	14	70.0	11	73.4

Characteristics of FRP Clients at Baseline, Follow-up, and Discharge (Continued)



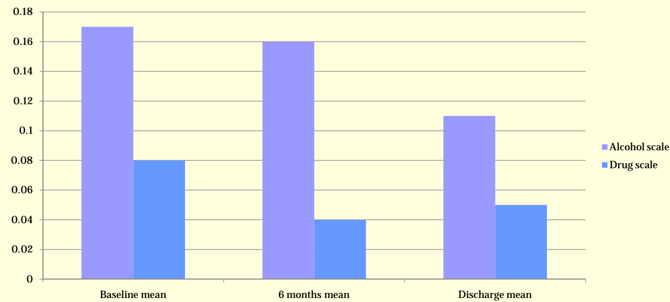
Social Support = higher number indicates more support. The highest possible score is 42.
Trauma = higher number indicates more trauma symptoms. The highest possible score is 68.

Characteristics of FRP Clients at Baseline, Follow-up, and Discharge (Continued)



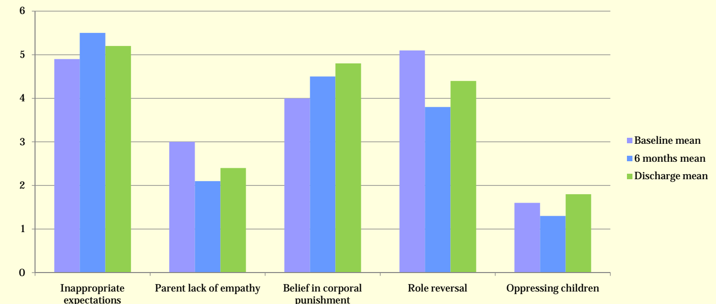
BSI = higher number indicates more negative symptoms. The highest possible GSI score is 72.

Characteristics of FRP Clients at Baseline, Follow-up, and Discharge (Continued)



ASI Lite = higher number indicates more severe problem. Composite scores range from 0 to 1.0.

Characteristics of FRP Clients at Baseline, Follow-up, and Discharge (Continued)



AAPI = higher number indicates lower risk. Scores are standardized with a norm of 5.5 and a range of 1 to 10.

Characteristics of Children of FRP Clients Living in the Household at Baseline Interview, at 6-Month Follow-up, and at Discharge

Characteristic	Baseline (n) %	6 Month (n) %	Discharge (n) %
# Children with a CBCL (ages >1.5 – 5 years)	19	6	4
Mean Score (Range)*	25.0 (6-72)	20.3 (3-44)	22.0 (4-33)
# Children with a CBCL (ages >1.5 – 5 years)	39	10	10
Mean Score (Range)	42.7 (4-113)	35 (6-96)	19.4 (1-63)

*Higher score = more severe behavioral problems.

Children's Indicators: FRP vs. Comparison Group[1]

Indicator	FRP	Comparison Group	Significance Testing
C1. 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 or caregiver through RPG case closure.[2]	87.5% (91/104)[3]	92.3% (288/312)	n.s.
C2. Occurrence of child maltreatment: Percentage of children who had an initial occurrence and/or recurrence of substantiated/indicated child maltreatment after enrolling in the RPG program:			
within 6 months	12.5% (13/104)	5.1% (16/312)	p<.05
within 12 months.	18.3% (19/104)	8.7% (27/312)	p<.05
within 18 months	19.2% (20/104)	9.9% (31/312)	p<.05
within 24 months	19.2% (20/104)	12.5% (39/312)	n.s.

[1]Data shown are for 104 FRP children and 312 comparison group children included in the 12/15/10 upload to RPG.
[2]In order to study an equivalent time period, the case closure date for comparison children is set at 24 months after their pseudo-enrollment date. Events taking place after this closure date are not included in this table.
[3]Numerator/denominator

Children's Indicators: FRP vs. Comparison Group

Indicator	FRP	Comparison Group	Significance Testing
C5. 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	38.6% (5 of 13 reunified within one year[6])	30.8% (8 of 26 reunified within one year)	n.s.
C6. Timeliness of permanency: Percentage of children placed in foster care who, in less than 24 months from the date of the most recent foster care placement, achieved: finalized adoption legal guardianship either	No data available	No data available	

[6]This measure is based on the 13 FRP children for whom a full year has ensued since their most recent entry into foster care. The status of children whose most recent stay in foster care has been less than 12 months can not yet be ascertained.

Children's Indicators: FRP vs. Comparison Group[4]

Indicator	FRP	Comparison Group	Significance Testing
C3. Average length of stay in foster care: For children removed to foster care after FRP enrollment, their average length of stay to-date (in days) from date of most recent entry into such care until date of discharge or end of report.	200.2 days (s.d. 169.1) – based on 13 removals after FRP enrollments	464.8 days (s.d. 289/.6) - based on 26 removals	p<.01
C4. Re-entries to foster care: Percentage of children returned home from foster care that re-entered foster care in: less than 6 months, less than 12 months less than 18 months less than 24 months	 2.5% (1/40)[5] 10.0% (4/40) 12.5% (5/40) 12.5% (5/40)	 5.6% (2/36) 19.4% (7/36) 19.4% (7/36) 19.4% (7/36)	 n.s. n.s. n.s. n.s.

[4]Data shown are for 104 FRP children and 312 comparison group children included in the 12/15/10 upload to RPG.
[5]Numerator / denominator

Family Recovery Project: Systems' Work with SUD Treatment Providers & DCF

Putting Collaboration Into Practice

Substance abuse treatment outcome measures should include indicators on safety, permanency and well being of the children of clients.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

Child Welfare Cases Associated with Substance Use and Abuse

- Parental substance accounts for 22% or 2,361 cases of child removal:
  - Alcohol Only: 521
  - (Non-specified) Drug Only: 1,639
  - Both Alcohol and (Non-specified) Drug: 201
- Parental recovery from substance abuse is a case plan goal in 32% or 7,945 of open Child Welfare cases
  - Excludes adoption cases, emergency services plans and CHINS cases

Massachusetts Department of Children Services

Children Associated with Parents in Treatment

- Approximately 47,000 adult enrollments (47% of total enrollments) into treatment involve a parent with at least one child*
  - 7,500 adult enrollments in Criminal Justice related treatment programs involve a parent with at least one child
  - Almost 14,500 of adults (14.3% of total enrollments) reported living with their child at the time of enrollment in treatment services*
- Over 3,300 adults (3.34%) reported receiving DCF Services

Massachusetts Department of Public Health
**May represent duplicate numbers based on enrollment data: One adult may have had multiple enrollments during the year. One adult may also have several children that were reported each time the adult enrolled into a treatment service.*

State Level Collaboration

- 1998 Strategic Plan – Addressing Substance Abuse in Child Welfare
- Governor's Interagency Substance Abuse Strategic Plan – 2005 & 2011
- Interagency Initiatives

Family Recovery Collaborative

The Family Recovery Collaborative (FRC) is the statewide group responsible for the coordination of statewide activities related to substance abuse, family systems and child welfare issues, co-facilitated by DPH/BSAS and DCF.

•NCSACW Technical Assistance 2005 & 2009
•Memorandum of Understanding
•Values and Principles

Shared Values Between Systems

Department of Children and Families (DCF) social workers and Substance Use Disorder (SUD) Treatment Program clinicians **share the goal of moving individuals and families towards health and recovery while ensuring child safety.**

Local Collaboration:
Family Recovery Council of Hampden County

Working together to support families in recovery from substance abuse and addiction.

Confidentiality of client records is a significant barrier to good cooperation among substance abuse treatment providers, children's services agencies and the courts.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

Family Recovery Council: Our Vision

Every family will have access to the services and supports needed to promote full recovery.

Family Recovery Council: Our Mission

- **To remove barriers to treatment services** for families struggling with substance abuse and co-occurring mental health disorders
- **To improve communication and collaboration across systems**, in order to provide high-quality care and coordination of support for families in recovery

Family Recovery Council: Our Philosophy

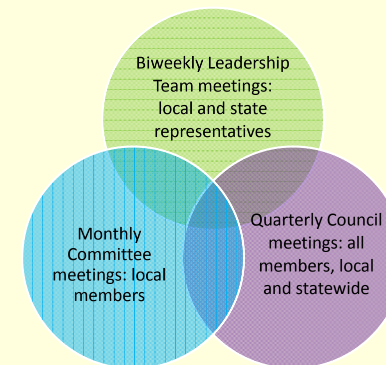
- When agencies work together, families are better able to access the services they need quickly and smoothly.
- Coordination of care will help engage and retain families in services, leading to better outcomes.

Family Recovery Council: Who We Are

Agencies and individuals committed to family recovery, including:

- Department of Children and Families (DCF)
- DPH: Bureau of Substance Abuse Services (BSAS)
- Substance Abuse Treatment Providers
- Early Intervention Providers
- Corrections System
- School Systems
- Legal System
- Community-Based Programs
- Mental Health Treatment Providers
- Faith-Based Programs
- Parents/Caregivers in Recovery

Family Recovery Council: Our Structure



Family Recovery Council: Core Leadership Team

- Team is comprised of:
  - State-level staff (from DCF and DPH/BSAS)
  - Local/regional staff (from DCF, DPH/BSAS, and the Family Recovery Project)
  - Executive Director, Institute for Health and Recovery
- Regular communication ensures smooth collaboration, planning, and oversight

It is commonly believed in my state that substance abuse providers should report relapses to child welfare workers.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

Clinical substance abuse treatment information should never be shared with child welfare, even with a signed release.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

Family Recovery Council: Communication Committee

- Goal: To establish best practices for smooth collaboration between the child welfare system, treatment providers, and other agencies.
- Best practice recommendations focus on:
  - Referral Process (including signed releases)
  - Substance Abuse Assessment
  - Communication around Ongoing Treatment
  - Collaborative Teamwork (e.g. Safety Planning, Case Conferences, clarifying expectations)

Communication Committee: Hot Topics

- Initial Parent Engagement: Consent Forms and Releases of Confidentiality
- Communication and impact on custody: building trust between systems
- Implementing change: time constraints in fee-based model, DCF Union concerns

Family Recovery Council: Cross-Training Committee

- Goal: To ensure that those who support family recovery better understand the issues involved, thereby improving their own practice and ability to work collaboratively.
- Cross-Training Activities focus on:
  - Training child welfare staff around substance abuse treatment;
  - Training substance abuse treatment providers around child welfare issues, parenting, and family recovery focus;
  - Training others in the "Collaborative Team" around family recovery issues (e.g. legal system, school system, corrections system, faith-based leaders, etc.)

Cross-Training Activities

- Local cross-systems conference
- Provider resource fairs at DCF offices
- Trainings on specific issues, such as:
  - Medication Assisted Treatment and Parenting
  - Substance-Exposed Newborns
  - Safety Planning
  - Balancing Addiction, Recovery, and Parenting

Family Recovery Council: Public Relations Committee

- Goal: To spread the word about family recovery and the work of the Council.
- Current projects include:
  - Developing brochures for parents (offering support and resources); in multiple languages
  - Developing an informative, engaging website
  - Promoting the importance of family recovery at conferences and other community events

Family Recovery Council: Quarterly Council Meetings

Goals:

•To share information and resources

•To build working relationships

•To establish best practices for collaboration

Family Recovery Council: Lessons Learned

- Listen to each other. Tolerating the discomfort of differing points of view builds trust and respect.
- Listen again. Then focus on problem solving.
- Be role models: cross-systems partners should plan, lead, and participate in meetings equally.
- Reinforce common goals and understanding: “Relapse is a **recovery** AND a **safety** issue.”
- Each family case provides an opportunity to move cross-systems collaboration forward.

Family Recovery Project

Questions, Comments, Thoughts, Ideas