Family-Based Recovery:
A Home-based Treatment for Families Affected by Parental Substance Abuse

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The National Conference on Substance Abuse, Child Welfare and the Courts September 15, 2011

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Connecticut

- Population - 3,574,097
  - Approximately 817,015 under age 18
- No County Government (169 Town Governments)
- CT Department of Children and Families is a consolidated Children's Agency with mandates in:
  - Child Welfare
  - Children's Behavioral Health
  - Juvenile Justice
  - Prevention

U.S. Census Bureau 2010

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Connecticut Department of Children and Families

- DCF serves at any point in time 36,000 children and 16,000 families across mandates
- DCF with Department of Social Services (Medicaid) carved out Behavioral Health and manage the Connecticut Behavioral Health Partnership
- DCF Behavioral Health develops and implements policy, programs and services in the community
- DCF has developed a broad array of intensive in-home behavioral health services

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Drug Use in Connecticut

- In Connecticut during 2006-2007, 7.9% of men and women ages 12 and older reported using illicit drugs in the past month, compared to 8.1% overall in the U.S.
- In Connecticut in 2009, a study of women of childbearing age (18-44 years) revealed that:
  - 18.7% of women of reported smoking, compared to 19.6% of women overall in the U.S.
  - 19.7% of women reported binge drinking in the past month, compared to 15.7% overall in the U.S.

Source: PerisStats-March of Dimes

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FBR Model Overview

- In 2006, DCF invited two university programs to partner in this initiative:
  - Johns Hopkins University– contingency management substance abuse treatment (Reinforcement-Based Treatment; RBT)
  - Yale Child Study Center – attachment-based parent-child therapeutic approach (Coordinated Intervention for Women and Infants; CIWI)
- Family-Based Recovery (FBR) was designed as a home-based intervention, that merged these models of parenting support and substance abuse treatment

FBR Mission

The mission of FBR is

1) to ensure that children develop optimally in drug-free, safe and stable homes with their parent/s

2) to develop a replicable, evidence-based, in-home practice model

Family-Based Recovery

- DCF contracted with 6 providers
- Yale Child Study Center – provides QA
- DCF developed a MOA with the University CT Health Center for independent evaluation
  - Qualitative Analysis of FBR Implementation
  - Quantitative Analysis of maltreatment and placement outcomes (Matched Group Design)

FBR Clients

- A parent who is actively abusing substances and/or has a recent history of substance abuse (w/in 30 days)
- A child who is:
  - under the age of 36 months
  - resides with the index parent at the time of referral, or
  - in foster care with a plan for imminent reunification
  - at risk for removal from parental custody

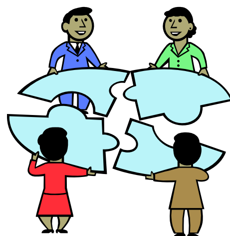
FBR Team

FBR Teams are composed of:
- 2 Full-Time Master's level clinicians
- 1 Full-Time Bachelor's level Family Support Specialist
- A Half-Time Supervisor
- A Part-Time Psychiatrist

FBR Team: Caseload Structure

- An FBR team's caseload is twelve families
- Each clinician provides:
  - Parent-child-related interventions to 6 families
  - Caregiver sobriety-related interventions to 6 families
- The Family Support Specialist works with all 12 families

FBR Key Constructs

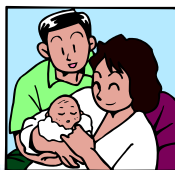


- Attachment critical for healthy development
- Substance abuse treatment works
- Risk management for stability and permanence

The FBR Way

FBR is more than a treatment for parents who are using substances: it is a way of engaging, treating and being with a client and his/her children. The FBR approach incorporates good clinical skills, motivational interviewing techniques with lessons learned about home-based work.

Parent-infant Intervention



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Complex Families

FBR families:

- Often come to parenting with legacy of childhood emotional neglect and abuse, loss, abandonment
- Problematic relationships in adulthood
- Emotion regulation more challenging with neglect/abuse hx, and for those modulating emotion with substance use

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Infant Mental Health Approach

FBR uses an Infant Mental Health approach:

- Encourages parent to identify and explore feelings re parenting
- Focuses on the infant's feelings: "speaking for the baby"
- Focuses parent on the needs of the child
- Links past with current caregiving experiences

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Emotion Regulation

- Parenting that requires emotion regulation can easily overwhelm/be a source of disconnection
- Goal: "Overriding" first response of anger or hopelessness, and reflecting on what is going on with this child at this moment
- FBR listens, observes, reflects with parents, contains the moment

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Infant Mental Health and Attachment

100

Infant Mental Health: the developing capacity of the very young child to experience, regulate and express emotion; form close, secure interpersonal relationships; explore and learn—all in the context of family, community and cultural expectations.

Attachment

100

- A young child's relationship with the primary caregiver is key to healthy development in socio-emotional, cognitive and health domains
- Parents' perceptions of being parented affect how they parent and how they see their child

Attachment-based Work

100

- Fosters change in maladaptive attachment relationships
- Targets Internal Working Model of the relationship for both parent and child

Competent Parents, Competent Babies

100

- We use the opportunity of a baby to help parents resolve issues with early caregivers ("Ghosts in the Nursery") that are interfering with the capacity to parent and establish secure attachments
- Our task: to help parents feel competent and be a "secure base" from which their children can explore the world; for babies to feel understood and safe in their parents' care

Reflective Functioning

- RF: seeing from the child's perspective, or being able to make sense of the child's behavior, emotion, feelings
- FBR uses natural parent-child interaction as opportunity for intervention: moment of anticipating/understanding a need; moment of shared delight or when parent can soothe child; staying present with child despite stress

Reflective Functioning

Techniques to enhance RF:

- Helping parent identify what emotions are baby's and what are parent's
- Helping parent see baby as separate being, developing with age-appropriate behaviors and needs
- Helping parent feel her/his unique importance to this child

Parent-Child Measures

- Measures that inform and guide the parent-child work are:
  - Parent Stress Inventory –Short Form
  - Edinburgh Postnatal Depression Scale
  - Postpartum Bonding Questionnaire
  - Genogram
  - Ages and Stages (ASQ and ASQ-Social Emotional) Questionnaires

Substance Abuse Treatment

Reinforcement-based Treatment

- Reinforcement-based Treatment (RBT) is an evidence-based behavioral approach to substance abuse treatment.
- RBT incorporates:
  - Community Reinforcement Approach (Budney & Higgins, 1998)
  - Motivational Interviewing (Miller & Rollnick, 1992)

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FBR: Basic Principles

Positive reinforcement is the most effective means of producing behavior change.

- The best way to eliminate an individual's drug use is to offer *competing reinforcers* that can take the place of drug use
- Competing reinforcers: People, Places and Things that can take the place of drug use
- FBR believes that the infant/child is the primary positive reinforcer

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FBR Tools for Treating Substance Abuse

- Functional Assessments
- Contracts
- Graphs
- Feedback Report
- Drug Testing/Vouchers

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Functional Assessment

The Functional Assessment (FA) is a clinical instrument that structures the gathering of information on a client's drug use at intake and after each relapse. Information is organized into categories:

- Internal and external triggers
- Behavior (route of use, amount)
- Short-term positive consequences
- Consequences

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Contracts

Contracts are used throughout treatment

- Early on in treatment as an agreement to "sample" abstinence
  - Sobriety Sampling Contract
- Whenever there is a need to emphasize a behavioral goal: "critical time points"
- Clients might "break the contract" and use, but hope contract will make the individual stop and ponder this choice

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Graphs

A clinical tool that:

- Makes abstinence and abstinence-related goals salient to the client
- Helps clients understand the ongoing relationship between substitution behaviors and abstinence
- Provides a concrete way for the clinician to reinforce (both socially and tangibly) progress towards goals
- Helps clinician predict relapses

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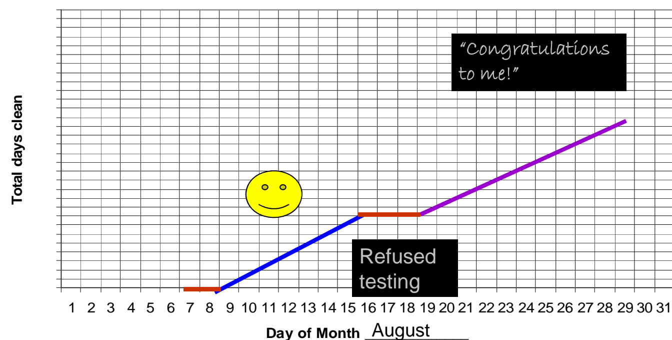
Days Clean Graph



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Feedback Report

Feedback is a technique that has been shown effective in getting clients to think about change. The Feedback Report:

- Pulls together the information the client has provided during the assessment phase
- Provides information tailored to the individual
- Provides SAMHSA data on client's drug(s) of choice
- Offers alternatives to drug use
- Organizes the arguments for change

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Social Club

A weekly group for clients and their children during which the clients:

- Receive peer and staff acknowledgement (reinforcement) and support for parenting and abstinence
- Practice interacting with other non-drug using parents in a non-drug environment
- Provide some continuity after graduation from FBR

Social Club

- Whatever the topic or activity, a goal of Social Club is for the conversation to ultimately link to issues of parenting and/or recovery
- It is the role of FBR staff to link the group topic/activity to parenting and/or substance use
- As the group process evolves and membership stabilizes this time will generally be client-led

Drug Testing

- The team conducts substance abuse screening (urine and/or breathalyzer) at each home visit
- An 8-panel urine dip stick yields results in 5 minutes
- Clients receive a $10 gift card for each clean screen during the first part of treatment
- Clients can earn up to **$720**

FBR Services

- FBR Services provides:
  - Core training to all new staff members
  - Weekly 1 hour consultation with each site
  - Weekly ½ hour consultation with each supervisor
  - Quarterly network meetings/trainings
  - Quarterly QA reports to sites and DCF
  - Annual credentialing reports

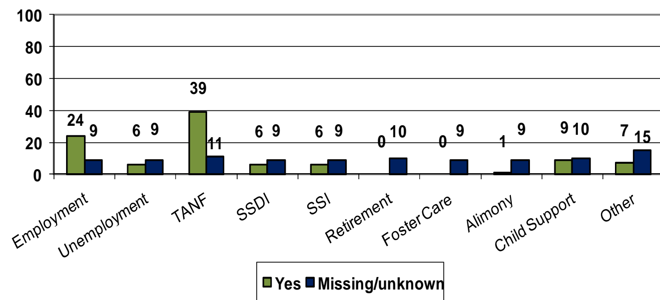
Quality Assurance Goals

- Ensure accurate and timely data collection
- Monitor caseloads
- Monitor adherence to clinical services inherent to FBR model (e.g., FBR Tools and Measures)
- Examine results of clinical measures and urine toxicology screens
- Summarize all of the above in quarterly reports for providers and DCF
  - One network (aggregated) report
  - Six site-specific reports on programmatic adherence and clinical outcomes

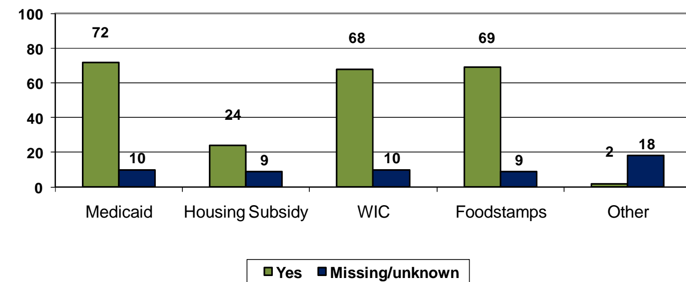
Case and Caregiver Characteristics

- Across all six regional providers to date, 389 cases served (830 clients); about 20-25 new intakes per quarter
- 84% of families served are headed by single mothers
- Average cash household income: $679/month
  - Non-cash: 72% Medicaid, 68% WIC, 68% food stamps
- Average maternal age: 27.1 years (s.d. = 5.7 years)
- Maternal Race/Ethnicity:
  - 51% Caucasian; 30% African-American; 15% Hispanic/Latina
- Marital Status: 74% Single, never married
- Educational Attainment: 70% HS diploma/GED or less

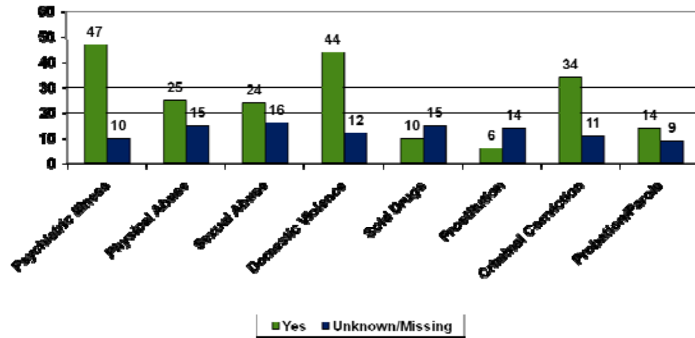
Sources of Cash Income



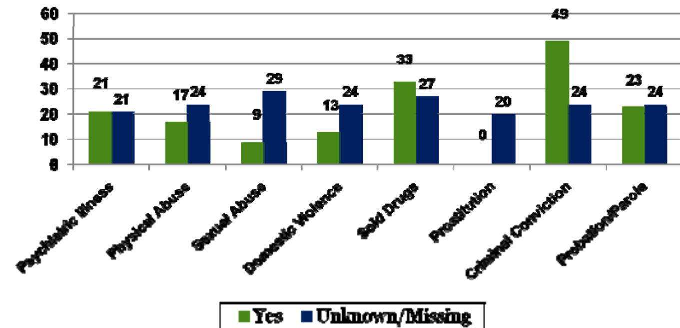
Sources of Non-Cash Income



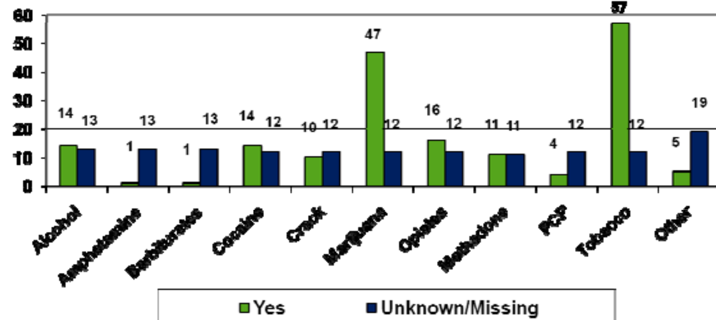
Maternal Risk Factors



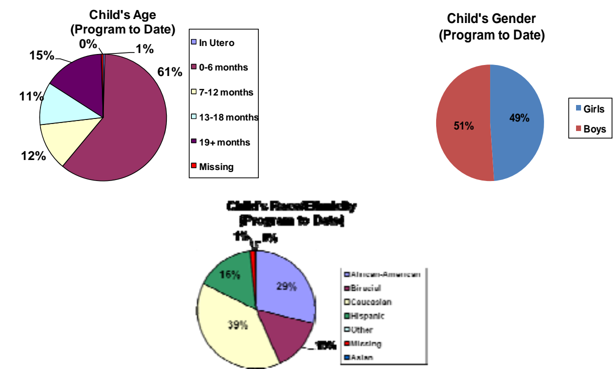
Paternal Risk Factors



Mother's Substance Use During Pregnancy



Child Characteristics

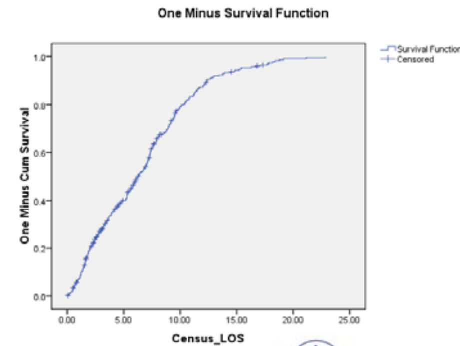


Child's Risk Factors

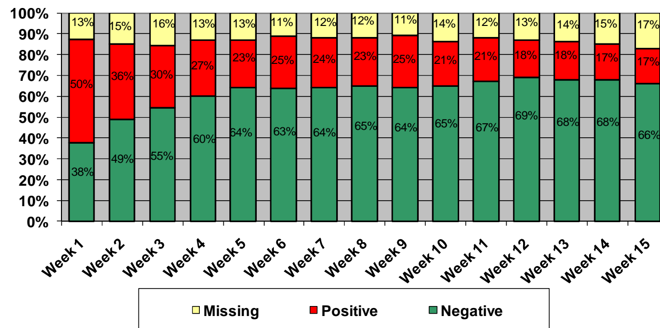
- Gestational Age: Mean of 37.8 weeks (s.d. = 2.9 wks)
  - Average gestation is 40 weeks
  - Births at less than 37 weeks are considered "preterm"
  - Nationally, about 12% of all births are preterm
- Birth weight: Mean of 6.4 pounds (s.d. = 1.3 lbs)
  - Babies weighing less than 5 lbs. 8 oz. at birth are considered "low birth weight"
  - National average birth weight is about 7 lbs. 8 oz.
  - About 8% of all births are considered low birth weight

Length of Stay

Median Length of Stay = 6.28 months



Urine Toxicology Screen Results



Urine Screen Results

- In Q3FY2011, there were 1,363 screens, 337 (25%) of which were positive for one or more substances.
- Among all 337 positive screens:
  - 64% were for marijuana
  - 15% prescription drugs
  - 10% PCP
  - 7% opiates
  - 7% cocaine

Clinical Measures

Measures	N	Pre-Test Score	Post-Test Score	T-Score and Significance
Edinburgh Depression Scale	189			
Total Score		6.98	4.81	5.37 **
Parenting Stress Index-Short Form	179			
Total Score		66.85	60.85	5.14 **
Parenting Distress		25.68	22.25	6.03 **
Parent-Child Dysfunctional Interaction		18.76	16.87	4.37 **
Difficult Child		22.17	21.43	1.49 NS
Parental Bonding Questionnaire	162			
Total Score		5.67	4.35	3.23 **
Impaired Bonding		3.33	2.64	2.68 **
Rejection-Anger		0.75	0.67	0.59 NS
Anxiety-Care		1.56	1.04	3.10 **
Risk of Abuse		0.06	0.01	1.42 NS

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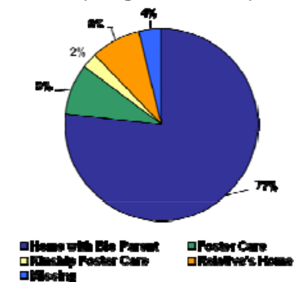
Placement of Index Child

Child Placement at Discharge
(Program to Date)



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Summary of QA Findings

Children remain in their homes:

– **FBR Result** : Among a high-risk sample of substance abusing parents, 84% of children remain in their homes at discharge

Parents reduce substance abusing behaviors:

– **FBR Result** : **50%** positive urine screens at Week 1; **17%** positive screens at Week 15

Parents address other clinical symptoms:

– **FBR Result** : Statistically significant, positive changes on measures of parenting stress, bonding to infant, and depression

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Acknowledgements

Yale University
Jean Adnopoz
Karen E. Hanson
Jeffrey J. Vanderploeg
Dale Saul
Jeanette Radawich
Amy Myers
Christian M. Connell

University of Connecticut
Jo Hawke
Karen Steinberg

Johns Hopkins/U. of Maryland
Michelle Tuten
Cindy Schaeffer
Jennifer Ertel

State of Connecticut
Dept. of Children & Families
Robert Plant
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