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ISSUE 5

Casey Practice Digest

Substance Use Disorders in Families with Young Children

ISSUES AND OPPORTUNITIES



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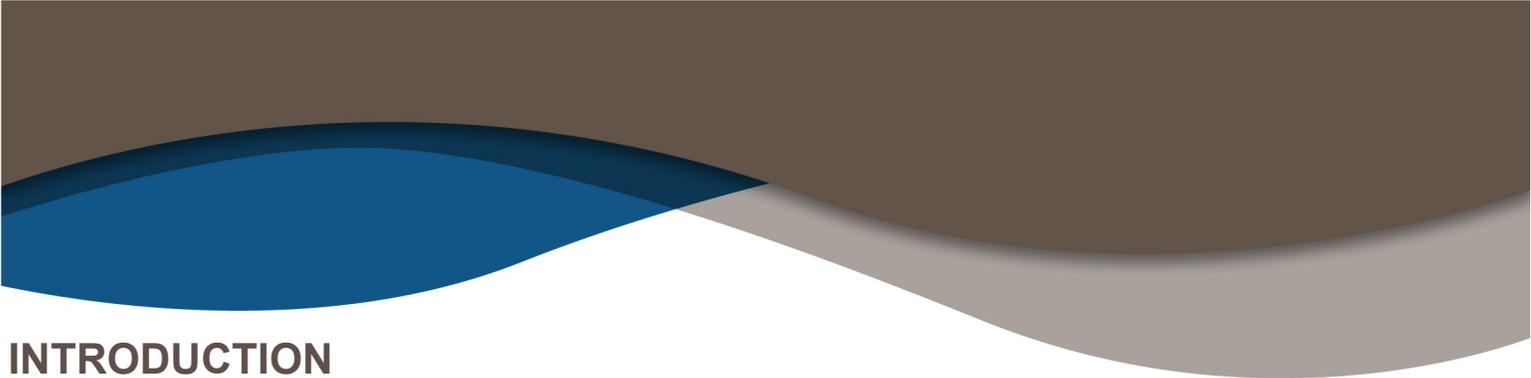
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The three main ideas covered in this digest that relate to **safe reduction**:



- Substance abuse treatment is an Essential Health Benefit, and the Mental Health Parity and Addiction Equity Act is extended, freeing up funding streams for system improvements and closing of service gaps.
- Substance abuse treatment and parenting education do not have to be provided in any particular order. High-quality parenting education may be a good way to engage parents, provided families are not overwhelmed with demands.
- Substance use disorders present life-long challenges. The work of a caseworker needs to be grounded in an understanding of the recovery and relapse process.



INTRODUCTION

By Dee Wilson, Editor

Parental substance abuse continues to be a major challenge for child welfare systems around the country as agencies attempt to safely reduce the number of children entering out-of-home care, increase reunifications, and reduce re-entries into care. Caregivers with substance use disorders often have co-occurring mental health conditions, domestic violence histories, and multiple other challenges to effective parenting. The extent, chronicity, and severity of risk and safety issues in families requires the best creative thinking and programming as child welfare agencies confront a wide range of policy and practice decisions.

This issue of the **Practice Digest** includes a joint interview with **Professor Richard Barth**, a child welfare scholar and Dean of the School of Social Work at the University of Maryland, and **Dr. Nancy Young**, Director of Children and Family Futures, on how to sequence services for caregivers with multiple issues, including substance use disorders, that impact their parenting. The guideline that substance abuse treatment should always precede other services was left behind years ago by experts on co-occurring disorders, but has not been replaced by a clear actionable rule. Professor Barth and Dr. Young offer their perspectives on this dilemma that occurs repeatedly in case planning and in court orders.

Child welfare agencies continue to search for, and sometimes experiment with, programs designed to protect the children of parents with substance use disorders without separating children from their parents. In-home programs implemented in the 1990s were widely viewed as ineffective; but an array of **innovative programs** has been developed in recent years, several of which are highlighted in this issue of the Digest.

Safety planning with parents who have chronically relapsing conditions requires an understanding of the recovery process, a subject discussed in depth in this issue. Finally, **policy and funding opportunities** made available through the Affordable Care Act are also explored.

There was a period 15-20 years ago when many child welfare practitioners and policymakers despaired of finding effective approaches to child protection for families with substance abuse histories. Since the mid-1990s however, an array of innovative programs including family treatment drug courts and parent mentoring programs, among others, has demonstrated that many substance abusing parents can be helped to engage in treatment programs and **safely retain or regain custody of their children**. Hopefully, this issue of the Digest will inspire continued efforts to develop better responses to what once seemed an intractable challenge.



Funding Substance Abuse Services: the Effect of the Affordable Care Act

By Steve Christian

The funding landscape for substance abuse treatment is undergoing radical change because of implementation of the Patient Protection and Affordable Care Act of 2010 (ACA).

This article examines how the ACA will affect access to substance abuse treatment for families and children. It also examines how the ACA may affect use of other existing funding

streams, primarily the Substance Abuse Prevention and Treatment Block Grant (SAPT).

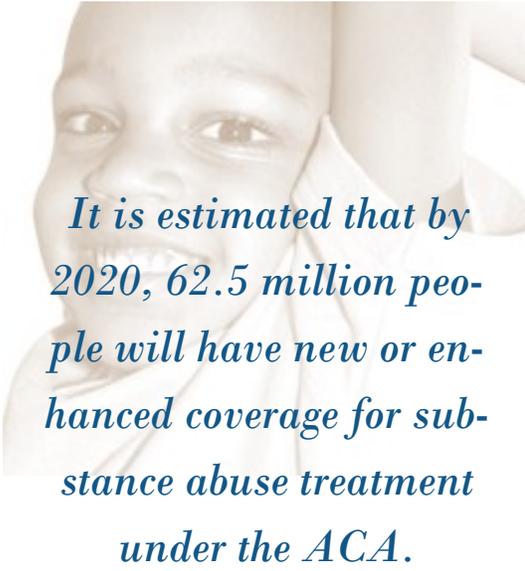
It is estimated that by 2020, 62.5 million people will have new or enhanced coverage for substance abuse treatment under the ACA. This number includes 32.1 million people who will have coverage for the first time, and an additional 30.4 million people whose existing coverage will be expanded. The ACA accomplishes this expansion through four components:

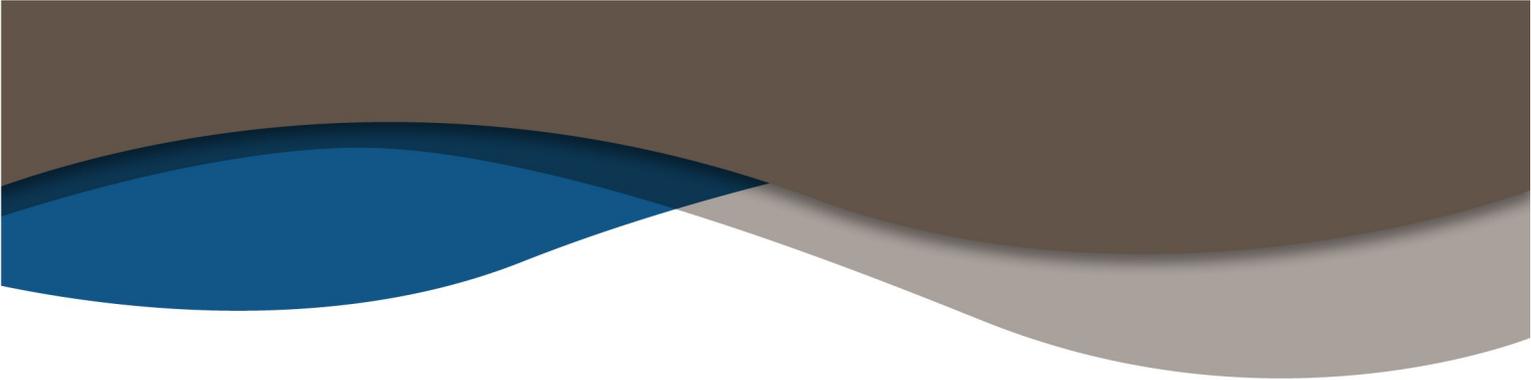
- **Health Insurance Marketplaces (HIMs, also known as exchanges):** These are organizations in every state that facilitate comparison-shopping and purchase of Qualified Health Plans offered by private insurers. Some HIMs are state operated, others have been established by the federal government. HIMs are intended to promote transparency and accountability, and to help educate and assist consumers in plan enrollment. Subsidies in the form of tax credits are

available for individuals and families based on income, up to 400 percent of the federal poverty level (FPL).

- **Medicaid Expansion:** Beginning in 2014, states may expand their Medicaid programs to cover all adults earning up to 138 percent of the FPL, which can be increased at state option. To date, 22 states have opted to expand Medicaid,¹ four states are taking a “customized” approach to expansion,² five states are undecided³ and the remaining 20 states have opted not to expand their Medicaid program.⁴
- **Essential Health Benefits:** The ACA establishes 10 mandatory Essential Health Benefits (EHBs) for newly eligible Medicaid enrollees and most individual and small group health plans. Substance abuse treatment is one of the EHBs. States will have considerable flexibility in defining the EHBs in their Medicaid expansion plans, so that there will likely be variations among states in terms of covered services.
- **Mental Health Parity and Addiction Equity Act (MHPAEA):** This federal law requires many health plans that cover mental health or substance abuse disorders to provide comparable coverage for those services as they do for medical conditions. Prior to the ACA, MHPAEA only applied to plans funded by employers with more than 50 insured employees, enrollees in the federal health benefit plan, Medicaid managed care programs and the Children’s Health Insurance Program. Starting on January 1, 2014, with some exceptions, the reach of MHPAEA will be extended to plans funded by employers with 50 or fewer employees, plans purchased on the individual market (including plans purchased through HIMs), and enrollees in Medicaid expansion plans.

The ACA is likely to have a significant impact on funding streams that are currently used for substance abuse treatment





for low income clients. State and local funds, combined with the SAPT, now account for nearly one half of spending on treatment for this population. Under the ACA, many individuals who would have had to rely on these funding streams to obtain treatment will now be covered through private insurance or Medicaid, potentially freeing up both state and federal funds for system improvements and closing of service gaps.

- The Substance Abuse and Mental Health Services Administration (SAMSHA) recommends that, after implementation of the ACA, states direct their SAPT funds to four priority areas: 1) treatment for individuals without insurance or for whom coverage is terminated for short periods of time; 2) treatment and support not covered by Medicaid, Medicare, or private insurance for low income individuals 3) primary prevention for people not identified as needing treatment; and 4) collection of performance and outcome data to determine effectiveness of services.

- States must meet maintenance of effort requirements in order to receive SAPT funds; that is, states are required to maintain spending for authorized activities at a level that is not less than their average for the preceding two years. States may want to consider estimating the amount of such spending that will be offset by expanded coverage under the ACA and to plan for strategic investments to improve outcomes for certain target populations. One such population is families involved in child welfare, particularly those with children in foster care. State behavioral health agencies can collaborate with their child welfare counterparts, based on a review of data, to determine how best to reinvest freed up funds to improve services and supports for system-involved families.

¹ AZ, CA, CO, CT, DE, DC, HI, IL, KY, MD, MA, MN, NM, NV, NY, NJ, ND, OR, RI, VT, WA, WV

² AR, IA, MI, PA

³ IN, MT, OH, TN, NH

⁴ <http://www.commonwealthfund.org/Maps-and-Data/Medicaid-Expansion-Map.aspx>

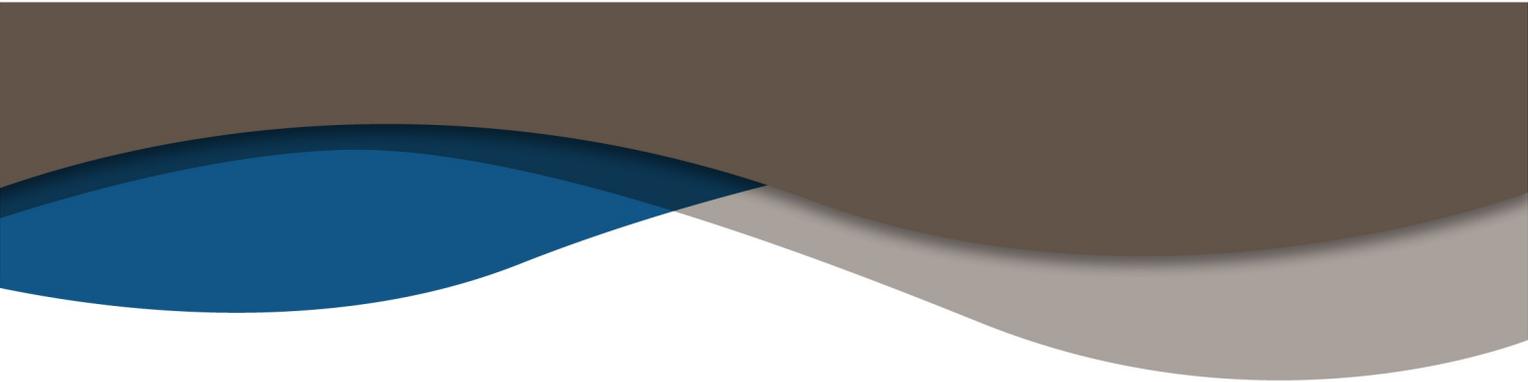
Program Highlight

The Parent Child Assistance Program (PCAP)

The Parent-Child Assistance Program (PCAP) serves high-risk mothers in Washington State who abuse alcohol and/or drugs during pregnancy. Primary goals of PCAP are (a) to assist mothers in obtaining treatment and staying in recovery; (b) to assure that the children are in safe, stable home environments and receiving appropriate health care; (c) to link mothers to community resources that will help them build and maintain healthy, independent family lives; and, (d) to prevent the future births of alcohol and drug-affected children.

Specially trained and closely supervised paraprofessional case managers each work with a caseload of 16 families beginning during pregnancy and for three years postpartum. Case managers provide regular home visitation and connect disengaged mothers to the comprehensive array of services that they need in order to achieve and maintain recovery (e.g., substance abuse treatment, housing, mental health services). PCAP serves approximately 735 families annually in nine counties in Washington and is replicated in other states.

PCAP costs approximately \$5,000 per mother per year for a three-year program in addition to the other services women access while in this program. A brief detailing the cost savings provided by this program can be found at <http://depts.washington.edu/pcapuw/publications>



Interview with Professor Rick Barth and Dr. Nancy Young: The Sequencing of Parenting Education and Substance Abuse Treatment

At Casey, we are frequently asked about the best way to sequence services for families with complex, multiple issues, such as substance abuse, mental health, poverty and family violence. What recommendations can you provide to caseworkers, especially to those working with families with young children?

Dr. Nancy Young (NY): In the world of substance abuse and mental health, we have tried to move beyond the idea that one service comes first, or that we can treat one without addressing the others. When an individual has co-occurring mental health and substance abuse issues, services for both need to be provided at the same time to avoid triggering the symptoms of the one that is not being addressed. The Co-occurring Matrix for Mental and Addictions Disorders,¹ a conceptual model, which categorizes the severity of mental health / substance abuse into four quadrants, has been very helpful for practitioners in terms of thinking about where individuals find themselves on the spectrum of substance abuse and mental health. Of course urgent safety issues for the child and parent, such as medical detox, need to be prioritized and attended to first.

Secondly, in order to engage parents in the change process, I am a proponent of starting with the clients' perception of their situation by asking *them* what they need to deal with first. They may not identify substance abuse or mental health as their most urgent need. It is not unusual for a parent to ask for support with e.g. dental health, and sometimes addressing those issues first can have a profound impact on their ability to engage in other services.

Professor Rick Barth (RB): Those are good observations, and from a science perspective, we don't have any particular strong research findings in this area. What we do know is that, while it may be best to have services running concurrently, obviously depending on the child's safety and the parent's individual circumstances, there is good evidence that they don't have to be, in order to be effective. Just like a housing-first program, for example, where we put families into stable housing before they are clean and sober, good parenting programs can help people be less depressed, which leads to

better outcomes on other issues. Also, an individual can, without being clean and sober, learn effective parenting (provided of course they are not a danger to someone else or themselves). So, if for some reason, programs cannot be ran concurrently, they can still be helpful. To be clear, this has not been tested expressly with a combination of substance abuse and parenting, but there is some evidence emerging from CDC that providing too many services concurrently gets in the way of improving parenting. The tension of trying to do too many things at once overwhelms families.

NY: There is also emerging evidence from the twelve sites that were awarded SAMHSA contracts for enhancing children's services within Family Drug Court settings.² Those that did start with parenting were successful in getting parents engaged, because they focused on the most important need as identified by the parent, which was to reunite with their children. Also, due to funding and the historical origins of many of the programs, it is almost impossible to find a co-occurring mental health/substance abuse program that truly provides full services for both, rather than focusing on one issue with add-on services for the other.

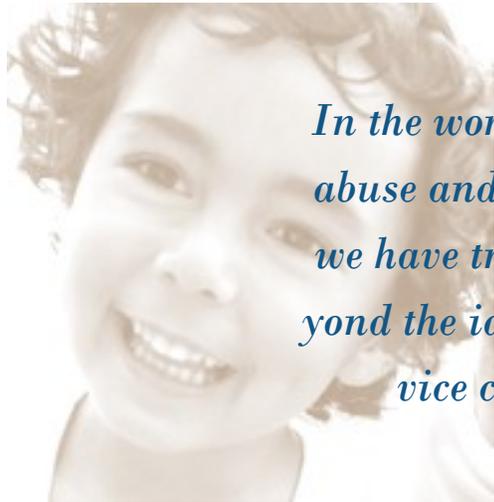
RB: If substance abuse services are folded in with other health services under the Affordable Care Act, and funding streams are better aligned, we may see more of this in this future.

Do you see differences between families that receive voluntary or court-ordered services?

RB: Family Drug Courts sort of blend the two. I don't think it makes much of a difference, because "requirements" don't really have much of an impact on families at that point. Many families have been court ordered multiple times, yet typically there is a very low completion rate.

NY: At the same time, emerging findings from drug court sites are showing that when we do have a family drug court that works with both populations, voluntary and court ordered, and employs outreach and engagement strategies, as well as supervision from recov-

ery mentors, case managers and social workers, there is more motivation and engagement needed for voluntary services. Families, whose children have been removed, have a sense of urgency caused by the desire to be reunited with their children. With in-home services it can be much more difficult to engage families in substance abuse services. For individuals whose brain chemistry has been interrupted due to substance abuse or mental health issues, it can be challenging to anticipate consequences and respond to situations that while possibly imminent, have not yet occurred.



In the world of substance abuse and mental health, we have tried to move beyond the idea that one service comes first.

What role does, or should, the completion of a parenting program play when considering reunification for families with substance abuse disorders?

RB: We generally do not have parent programs, where we assess parents' skills upon completion. Parent Child Interaction Therapy is the only such program, and a parent needs access to the child to complete it. If we have such programs in the future, then, yes, I believe assessment should be critical. In the instance of a physical abuse case, just incorporating two essential changes, such as replacing physical punishment with timeouts and balancing critical with positive statements in a healthy ratio, could make a significant difference for the child, even if the parent was not yet clean and sober. With child neglect or failure to supervise, these examples are obviously less likely to make a difference.

NY: From a perspective of being ready to parent within a reunification situation, completion of a course is not really relevant, but what does matter is the pattern of behavior. There is a big differ-

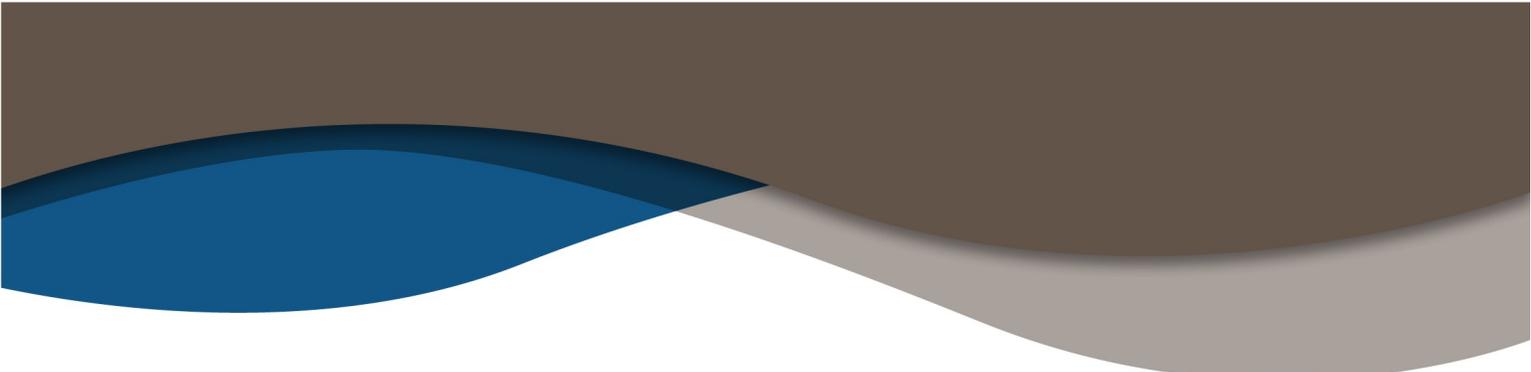
ence between a person who is using substances and neglecting their child vs. someone who is chemically dependent and neglecting a child. Substance use, abuse and dependence each present specific risks and dangers for the child and specific concerns for the child welfare worker. A parent who is using substances may drive with children in the car while under the influence or use during pregnancy. A parent who is dependent may engage in addiction-related behaviors, such as leaving children unattended while seeking drugs, despite a clear danger to children. Regular communication from treatment providers is essential: is the client showing up, are they communicating regularly, are they participating in parent groups and meeting the requirements for drug testing. That is how a parent can tell the court that they have established a positive pattern of behavior. Whether parents are fulfilling their responsibility over a period of time is much more meaningful than whether they have completed a program.

Would this be different if courts and caseworkers were better informed about the dynamic of recovery?

NY: I had the experience maybe a month ago of talking to senior leadership in a state about addiction and treatment. I started with the brain science of addiction and was surprised to notice that the majority of them had never heard this information. I think the courts and child welfare would benefit from knowing more about individuals with substance abuse issues, what happens in treatment and recovery, and what recovery looks like.

RB: I think they would benefit, but I don't find the framework of recovery precise enough to make case-level decisions. I am not optimistic that to have a better understanding of recovery, as we currently recognize and explain it, would be definitively helpful in individual case planning.

NY: I actually agree. There is a difference in how you approach the individual drug-seeking behavior. This type of information is not typically required to be taught in Social Work programs and is not well understood in science.



While I would argue that overall an understanding of addiction and recovery processes helps, in any one case decision for the majority of families with whom a case worker will come in contact, treatment and recovery or the science of addiction will not be the decisive factors. Often there are too many other issues occurring that play into that mix: such as domestic violence, housing, or a parent's support system.

The ongoing challenge is that child welfare workers misidentify substance use disorders in parents. In the NSCAW study, child welfare workers failed to identify a substance use problem in 61% of the caregivers who actually met DSM-IV criteria for alcohol or drug dependence.³ Understanding the dynamic of recovery would be helpful, but even better would be translating that understanding into improved practice, such as improved identification of substance use disorders, improved referral processes for substance abuse treatment and improved ability of caseworkers to engage and enhance the motivation of parents affected by substance use disorders.⁴

Due to the number of young children entering care, we have a particular focus on the 0-5 age group. In your opinion, do we as a society have now a better ability to protect children in their home than was true before? Are we, collectively, doing a better job at maintaining the safety of kids in the custody of parents who are abusing substances?

RB: That is a difficult question to answer. In the 1990's, we were removing a lot of children that did not need to be removed, where we could have worked more with relatives or kinship care. Considering those children, who are staying at home, are we doing better at protecting them? Looking at NSCAW data, which was collected in the late 1990's, the incidences of aversive parenting and dangerous parenting as reported by the parents themselves on the *Parent-Child Conflict Tactics Scale (CTS-PC)* are very high; similarly re-abuse rates over 18 months are very high. I hope we are doing better, but the base line data is pretty discouraging. When parents were using hard objects to hit children younger than 7, burning them, scalding them, when we see high rates of that kind of parenting, they were quite often continuing to use those methods after child welfare services. Maybe we are doing better, in this decade, but I don't think we are keeping cases open long enough and staffing them sufficiently to know for certain.

NY: I don't have much to add to this, I agree. That's a hard question, and I don't know that any of us have an answer to that. With respect to parents affected by substance use disorders, we don't know how many of them need substance abuse treatment, how many of them are actually accessing services, and if the services they do receive match the severity of their disorder. I do want to point out that, according to the principles of effective drug treatment⁵, active engagement in services for less than 90 days shows outcomes equivalent to receiving no treatment. Far too often, lower dosage treatment is still the norm.

Can you speak to the development of Shared Family Care programs in which mother and child(ren) are placed together in a supportive family?

RB: I still am a big fan of shared family care, even though there is not enough rigorous evaluation yet to demonstrate that it is an evidence-based practice. In Shared Family Care, a mother of young children, sometimes with older siblings, is living in a household with a foster family, leading what we would consider a "standard" life style. That was actually a very good experience for many participating families, and parents learned a lot about daily, healthful structures. While foster families had to learn to step back, to do more mentoring and teaching, rather than taking over, I do think particularly for young children having that level of oversight was very good. The model could have been improved on, but the children were safe.

There is one place in Texas, which has converted a residential treatment facility into family cottages. The parents are the staff, and it is their responsibility to look after the children. Costs are comparable to standard residential treatment and considerably lower than a treatment foster care intervention.

In Philadelphia, a program called "New Life Better Life" attached a shared family living situation to a drug day treatment program. Families live in a conventional home and participate in positive family rituals and rhythms, while the mother attends drug treatment during the day.

The reason, in my opinion, that Shared Family Care has not taken off is that funding these types of interventions has been really difficult. They have mostly been funded through TANF and Family Preserva-

tion funds. There have been plenty of families willing to participate so that has not been the challenge. The difficulty is to fund these services under Title IV-E. Title IV-E funds do not allow for the provision of services where mother and child are not separated. No other country, as far as I know, funds their child welfare services like the US. Rather, they are all funded under community block grants. More flexible funding would allow Shared Family Care to become more of a presence in the child welfare continuum of care.

NY: While it is not exactly the same model, there is an interesting program in Jackson County, Oregon, called **OnTrack**, which was started by Dr. Rita Sullivan. The intervention originated from a housing model and provided emergency shelter for families. Now, it is a residential treatment facility

with apartments where the whole family can live together while going through the continuum of treatment and recovery services. Just last year the Oregon legislature passed a bill which has allowed the program to expand services to additional counties.

Assuming that children have been removed from the home, at what point in the recovery process is it safe to reunite children with parents in treatment programs? Are there reunification guidelines you would recommend for practitioners?

NY: This is one of the things where it is really difficult to suggest universal guidelines. Reunification guidelines do however need to speak to removing the imminent safety factors that resulted in the removal, while acknowledging that it is unrealistic to remove all of the potential risk factors. That's why again, regular communication from treatment providers and monitoring patterns of behavior in the parent are essential.

With the regional partnership grants, in some programs, time to reunification got really short. Families were able to reunify around the six- or seven-month mark. But what is important is that providing timely access to treatment and recovery coaching to this group

resulted in very low recidivism and return to care rates in comparison to statewide CFSR averages. So it can be done in a safe way. However, these are pockets of innovation – not system wide changes.

RB: It is very hard to generalize. In the Illinois study that Jeanne Marsh and others worked on, which also looked at pockets of innovation where they had substance abuse coaches in child welfare,

they did find that reunification was still pretty slow. Their sense was that even though people were functioning better, in terms of sobriety and employment, there is still a great reluctance on the part of judges to accept that people will relapse. If your theory says that relapses are often part of recovery, then we have to expect relapses. It

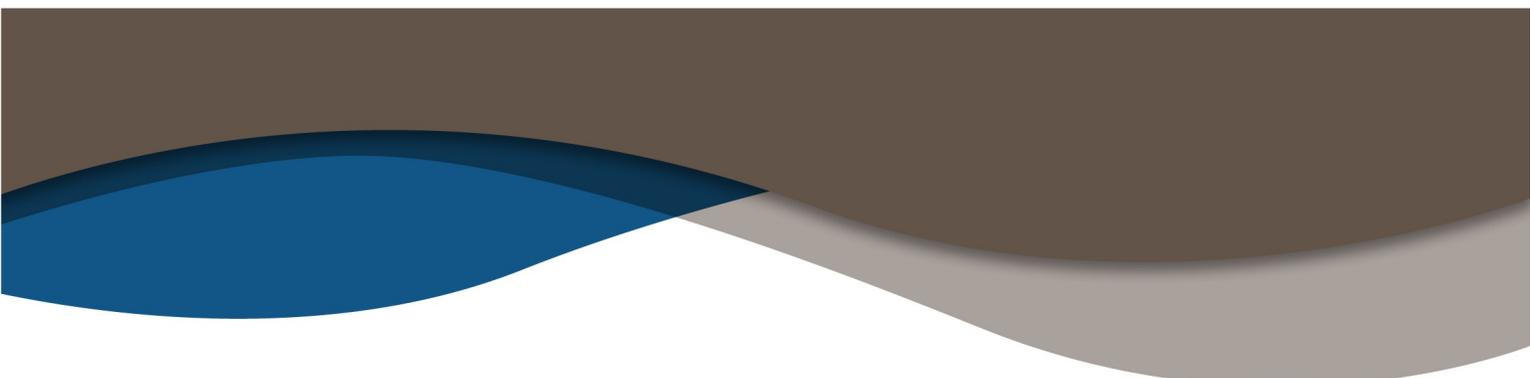
is interesting to see that Nancy has some data that suggests that the time to reunification doesn't need to be nearly as long as it was in Illinois. I would agree that the time frame depends on the integration that a family has with the child and the community. If the child is coming from kinship care, and there is some confidence that caretakers and family members will report problems early, the time frame can reasonably be shorter. Knowing whether the child will be in daycare and how much public exposure a child has are very important.

What kind of safety plan and what types of services would you recommend for such families post-reunification?

RB: The problem is that what I would recommend and what is generally fundable are pretty independent of each other. The approach of the Pathways Home Foster Care Reunification Intervention is one good example of the type of intervention that I would recommend: they emphasized real hands-on parenting experience after the children had gone home along with other kinds of care managements, which allowed the adults to move forward in life, and with their recovery.



The problem is that what I would recommend and what is generally fundable are pretty independent of each other.



NY: This question goes back to what I was mentioning earlier in terms of supporting a pattern of behavior. Often what is needed in terms of services is not what is available to families, such as after-care, supportive employment, housing, child care, and transportation. It is pretty difficult to say what would be universally needed. However, peer support and providing families with the types of services that assist in changing their networks, activities and patterns, and to ensure those types of support are available for a long enough period of time is important. In contrast, often what is funded in a system may not really be what is needed by the parent or the family. For example, changes that have happened in child welfare, such as implementing evidence-based therapeutic models, is highlighting the reality that these services may not fit with the population's needs, are more costly, and that often they are not funded at a level that serves the majority of families much less the whole system.

Child welfare workers must work with treatment professionals to ensure there is a safety plan for children of substance-abusing parents in the event of a parent's relapse. The plan could include people who will regularly check on the well-being of children, such as family members or neighbors; people or places, agreed upon ahead of time, where the child can stay if the parents abandon the children or are unable to provide a safe environment; monitoring of trigger behaviors that would bring safety plans into play; and identified safe havens where parents can send children if they feel they are going to start using substances or relapse into inappropriate behavior around their children. Relapse isn't always a part of the process, but it is a symptom of the disease. Coordinated safety plans can help parents prepare in the event of a lapse or relapse.

In relation to the above questions, can you speak to court-mandated actions and AFSA timelines?

RB: In regards to AFSA timelines, I think that the timelines probably shouldn't vary so much based on whether the parents are abusing substances or the reason for removal, but they should vary based on the ages of the children. Older children have a greater capacity to manage the intermittent progress and set-backs associated with their parent's substance abuse than younger ones. From that standpoint, when parents really become incapacitated by substance abuse, that is not something to which we want to expose children. AFSA timelines should be shortened for younger children and be

longer for older ones. The age of the child makes a big difference unless for other reasons, it is in not the best interest of the child. In my opinion, some jurisdictions move too fast and others too slow.

NY: The ASFA timelines should be the lever that spurs system-level collaboration. If there is only so much time a child can remain in out-of-home care before a petition for termination of parental rights is filed, and faster timelines for younger children, then it becomes all that much more urgent to ensure that parents get screened, assessed, referred, and engaged into treatment services as soon as possible. This is not something that child welfare can do alone and requires real partnerships with treatment agencies and the courts.

Should there be reunification incentives available to jurisdictions instead of adoption incentives?

NY: Absolutely.

RB: Actually, I think we should move away from both of those sets of incentives. As most likely there will be new funding available, I think the important aspect is to balance the incentives across all the programs across the service array. Trying to find more new incentives for reunification fails to address the importance of other case outcomes that might also be better if given more resources.

Thank you for your time.

Interview conducted by Dee Wilson and Katharina Zulliger

¹Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42.* DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005. <http://www.ncbi.nlm.nih.gov/books/NBK64184/figure/A74172/?report=objectonly>

²Information on the SAMHSA-funded Children Affected by Methamphetamine Family Drug Courts is available at: <http://ncsacw.samhsa.gov/technical/cam-default.aspx>.

³Gibbons, CB.; Barth, RP.; Martin, SL. *Substance abuse among caregivers of maltreated children.* University of North Carolina at Chapel Hill; 2005. Unpublished manuscript

⁴For a CFF presentation on outcomes and lessons learned, please refer to <http://www.cffutures.org/files/presentations/NADCP%20CAM%20Lessons%20Learned%20-%20Final.pdf>

⁵<http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment>



Dr. Young is the Director of Children and Family Futures, a California-based research and policy institute whose mission is to improve outcomes for children and families, particularly those affected by alcohol and other drugs. Dr. Young also serves as Director of the federally-funded National Center on Substance Abuse and Child Welfare, which is now in its twelfth year. Since 2010, she has served as the Director of the Office of Juvenile Justice and Delinquency Prevention’s technical assistance program

for Family Drug Courts, and the Administration on Children and Families’s technical assistance program for the Regional Partnership Grants Program for the past six years. Dr. Young is a graduate of Cal State Fullerton and received a Masters of Social Work degree and her Ph.D. from the USC School of Social Work. Her work and that of CFF has been recognized by the Outstanding Contractor of the Year award in 2006 from the Federal Administration on Children and Families and by a resolution issued in 2008 by the Orange County Board of Supervisors. She was also awarded the Directors’ Robert E. Anderson Service Award by the National Association of State Alcohol and Drug Abuse Directors. Se has been a foster parent and is an adoptive parent.

Richard P. Barth is Dean, School of Social Work, University of Maryland.

He has served as the Frank A. Daniels Distinguished Professor at the School of Social Work at the University of North Carolina at Chapel Hill (1998-2006). His AB, MSW, and PHD are from Brown University and UC Berkeley, respectively. He was the 1986 winner of the Frank Breul Prize for Excellence in Child Welfare Scholarship from the University of Chicago; a Fulbright Scholar in 1990 and 2006; the 1998 recipient of the Presidential Award for Excellence in Research from the National Association of Social Workers; the 2005 winner of the Flynn Prize for Research; and the 2007 winner of the Peter Forsythe Award for Child Welfare Leadership from the American Public Human Services Association. He has directed more than 40 studies and, most recently, served as Co-Principal Investigator of the National Survey of Child and Adolescent Well-Being, the first national study of child welfare services in the US. He has been a foster parent and is an adoptive parent. He remains an active researcher, currently involved with two federally funded projects.



The Regional Partnership Grant Program

Several of the programs highlighted in this issue of the digest, as well as the Oregon-based **OnTrack** program mentioned in the interview, are current or former Regional Partnership Grantees. Implemented in 2006 as part of the Promoting Safe and Stable Families program reauthorization, the grants are intended to fund innovative and collaborative approaches to addressing the underlying substance use disorders of caregivers with children in or at risk of out-of-home care. Administered by the Children’s Bureau, Administration for Children and Families, with support provided by SAMHSA and technical assistance made available through Children and Family Futures, the grant program has shown promising results. A cohort evaluation using data from the initial 53 five-year implementations funded in 2006, indicates the following outcomes:¹

- Regional partnership grantee **children** had significantly better outcomes in the following areas: removal from home, recurrence of child maltreatment, length of stay in foster care, timeliness of reunification and foster care-reentry.
- **Adults** served by grantees entered treatment faster, had longer stays in treatment, lower substance use and higher rate of employment.

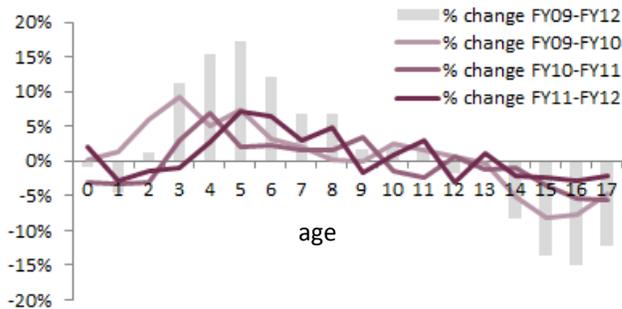
In 2012, twenty-five grants were awarded. For more information please refer to <http://www.ncsacw.samhsa.gov/>

¹ Boles, Sharon M., Young, Nancy K, Dennis, Kimberly, and DeCerchio, K. (2012) *The Regional Partnership Grant (RPG) Program: Enhancing Collaboration, Promising Results. Journal of Public Child Welfare, 6:4, 482-496*

Substance Abuse Data in Child Welfare

By Melissa Correia

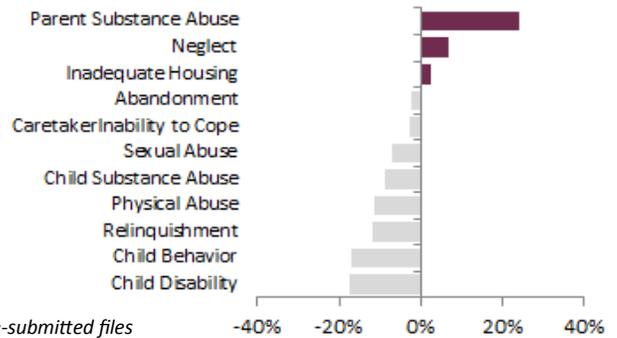
While entries have been stable, the entry of children ages 3 through 8 has increased noticeably.



Data source: Casey Family Programs, AFCARS state-submitted files

Children ages 5 and younger currently make up about 40% of the children in out-of-home care nationwide. The likelihood of removal from home is highest for infants, and while the overall number of entries into care has been relatively stable for the past few years, the number of children entering between the ages of 3 and 8 are increasing.

Between FY09 and FY12, parental substance abuse has increased as a removal reason for children entering.



Parental substance abuse is often reported as a removal reason in conjunction with neglect, which is the most common category of maltreatment for young children. Looking at available data from AFCARS, we find an increasing proportion of children entering care have parental substance abuse (a grouped category that includes both alcohol and drug use) identified as one of the reasons for removal.

Data on Substance Use as a Risk Factor

There is no standardized data collection regarding substance abuse as a risk factor for families involved in the child welfare system. In some states, such as those that use Structured Decision Making, detailed risk assessments document details related to substance abuse, including the type(s) of substances, frequency, and history of use. However, these data are not collected nationwide or required in federal reporting. NCANDS reporting of maltreatment allegations uses broad categories of abuse and neglect, any of which could involve parental substance abuse. For children that do enter out-of-home care, AFCARS reports the removal reason(s). Parental drug and alcohol use are two of many options a child protective services worker may select. There is tremendous variation within and across jurisdictions with regard to this type of documentation. In some cases, the child welfare worker may only select “Neglect” as the removal reason, because that is the allegation that was substantiated, or resulted in the child entering care. This approach reflects a focus on the neglect-

ful behavior, rather than the use of alcohol or drugs. In a summary of this issue, Rick Barth reports:

“Substance abuse by a child’s parent or guardian is commonly considered to be responsible for a substantial proportion of child maltreatment reported to the child welfare services. Studies examining the prevalence of substance abuse among caregivers who have maltreated their children have found rates ranging from 19 percent to 79 percent or higher. One widely quoted estimate of the prevalence of substance abuse among care-givers involved in child welfare is 40 to 80 percent. An epidemiological study published in the American Journal of Public Health in 1994 found 40 percent of parents who had physically abused their child and 56 percent who had neglected their child met lifetime criteria for an alcohol or drug disorder. Substance abuse has its greatest impact on neglect. In the 1994 study noted above, respondents with a drug or

alcohol problem were 4.2 times as likely as those without such a problem to have neglected their children.¹

Substance misuse increases the risk for possible negative outcomes children. A recent article in the journal, *Social Work Research*, cites the following regarding substance use disorders and child welfare data:

“...on average, children of substance-abusing parents enter CWS at significantly younger ages than do other children, are victims of more severe maltreatment, come from families with greater numbers of presenting problems and are more likely to be rereported for maltreatment than are

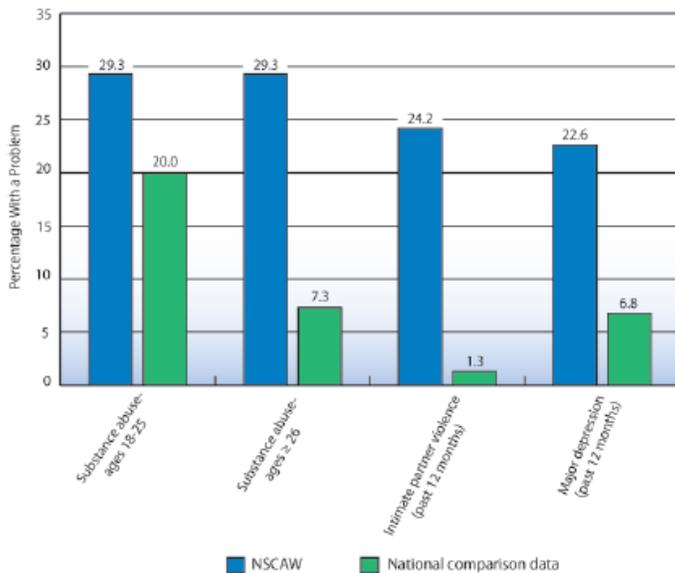
other CWS-involved children (Berger, Slack, Waldfogel, & Bruch, 2010). The former are also more likely to be placed in foster care and once there, to remain in care longer and experience greater numbers of placements (Barth et al., 2006).”²

¹Barth, Richard P. Preventing Child Abuse and Neglect with Parent Training: Evidence and Opportunities. In *Preventing Child Maltreatment* Volume 19 Number 2 Fall 2009

²Traube, Dorian E. The Missing Link to Child Safety, Permanency, and Well-Being: Addressing Substance Misuse in Child Welfare. In *Social Work Research* Volume 36 Number 2 June 2012

Services for In-home Caregivers

Need for Services Among NSCAW In-home Caregivers, Compared to Adults Nationally

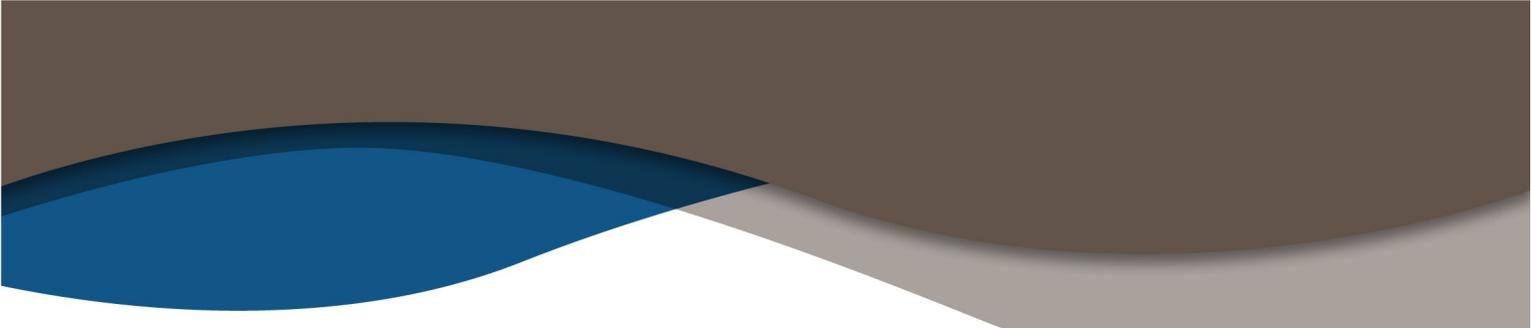


Compared to adults nationally, caregivers with child welfare involvement whose children remain at home after an investigation have much higher rates of substance abuse and may have a great need for services.

According to data provided in the *NSCAW Child Well-Being Spotlight: Caregivers of Children Who Remain In-home After a Maltreatment Investigation Need Services*, 86% of children who have been reported remain at home after the investigation. Even though those numbers tend to be lower for children whose parents suffer from substance use issues (see article above), there is a national trend toward providing whole family services with the goal of ensuring the child’s safety within the home or in shared housing while the parents’ substance use issues are being addressed.

The programs highlighted in this digest are strong examples of how such services can be provided to families with young children struggling with substance use disorders.

Wilson, E., Dolan, M., Smith, K., Casanueva, C., & Ringeisen, H. (2012). *NSCAW Child Well-Being Spotlight: Caregivers of Children Who Remain In-home After a Maltreatment Investigation Need Services*. OPRE Report #2012-48, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.



Caregivers with Substance Use Disorders: The Caseworker's Role in Supporting Recovery and Preventing Relapse

By Paul DiLorenzo

Walk into any 12-Step meeting and you will hear compelling stories of horror, cyclical depression, shameful events, long-term recovery and varying degrees of hope, enthusiasm and renewed spirituality. Each of these accounts could be from the same person because of the all-consuming nature of substance abuse and addiction.

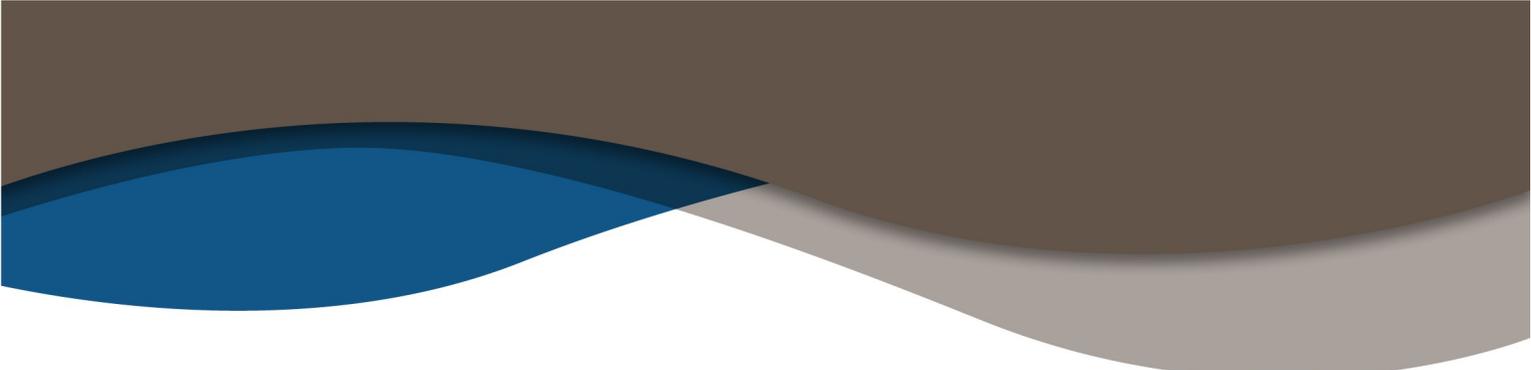
There are about 8.3 million children in the country who live with a parent who is alcoholic or needs treatment for illicit drug abuse.¹ Clearly not all of those children are involved in the child welfare system, but among families who are known to child welfare, the majority come from this group of families. Parental addictions can have a direct impact on the safety, stability and well-being of their children. The data regarding the intersection between substance abuse and child maltreatment is compelling (see digest data pages). Preparing child welfare staff, as well as that of other partners, to understand the nature of addictions, treatment, the potential of relapse and characteristics of recovery is critical in the support of families. If service professionals understand the brain science of addiction, the chronic nature of addictions, and that recovery is not a straight line, caseworkers can contribute to relapse prevention. As a practice issue, the case worker should know that relapse does not have to be characterized by the immediate or excessive use of a substance, but it can manifest in some other behavior that distinguishes an addiction as a disease of the brain with implications for the whole person. For the case worker, it is the behavior of the parent in the context of risks to the child(ren) that is paramount.

Addictions to alcohol and drugs are chronic brain diseases resulting in physical, emotional, spiritual and social consequences. There is no cure for an addictive disease but there is effective disease management, recovery, and medications available for alcohol and opiate addictions. Long-term use of any substance leads to changes in the brain activity of the individual that requires an extended recovery period for the brain to heal.

Relapse among persons with a substance use disorder is common and can frequently occur in the early stages of recovery. Patterns of behaviors leading to relapse can actually happen long before a person resumes drinking or drug use and manifests in behavior similar to when the individual was in an active phase of their substance use. Dishonesty, irresponsibility, depression and anxiety, unreasonable resentments, isolation from others and sleeplessness are all harbingers of relapse and warning signs for caseworkers that intervention may be needed. And though the incidents can be a learning experience for a recovering parent, the slip backwards can also put their child(ren) at risk of harm or neglect. Once the parent does “pick up” again, it becomes far more difficult for the case worker or parent to predict their behavior.

Caseworkers in the child welfare systems are not addictions counselors and should be careful not to confuse their roles in relation to the parents. Nonetheless, there are several critical contributions that a caseworker can make towards relapse prevention and simultaneously to the safety and stability of a child.

- **Instilling hope and helping the parent make positive affirming connections.** Long-term sobriety depends on the parent’s ability to make formal and informal connections that will be in place after the child welfare system has closed its case with the family. Program approaches that encourage the use of recovering case aides and 12 –Step sponsors will provide parents with an empathetic circle of support. Concurrently, it will assure another set of eyes and ears that are tuned to the safety and well-being of the child(ren). Encouragement and facilitation of these connections by the case worker creates the immediate and long term support that all recovering persons need to reduce the likelihood of isolation and relapse.
- **Setting limits/achieving stability.** A primary component of the recovery process is taking responsibility for personal



behavior and consequences. For the child welfare professional, the immediate and ongoing concern is related to the safety, stability, and well-being of the child. Simultaneously, the first responsibility of a parent who finds their way into the child welfare system is to meet an acceptable level of competence in caring for their family. A case plan, developed in partnership with the client, can serve as a barometer for how well the parent is managing tasks and assuming responsibility for their life. If and when a case worker observes a pattern of non-compliance regardless of whether or not a parent is using substances, it might be a sign that a relapse has or is about to occur.

- **Looking forward.** Reclaiming personal responsibility in the recovery process allows a parent not only to rebuild relationships, but to rebuild self-esteem and hope. Personal responsibility allows people in recovery to “own” their mistakes as well as their successes. Parenting is not necessarily something that comes naturally for many adults who have experienced childhood trauma and adult onset addictive diseases. Case workers should use the opportunities to redirect the parent towards the possibility of reclaiming their role as the primary caregiver. In addition, connecting parents to other adults who have an extended degree of sobriety and can serve as mentors, provides a window into what possibilities lie beyond their current status in the child welfare system.

Program Highlight

Santa Clara Juvenile Dependency Wellness Court

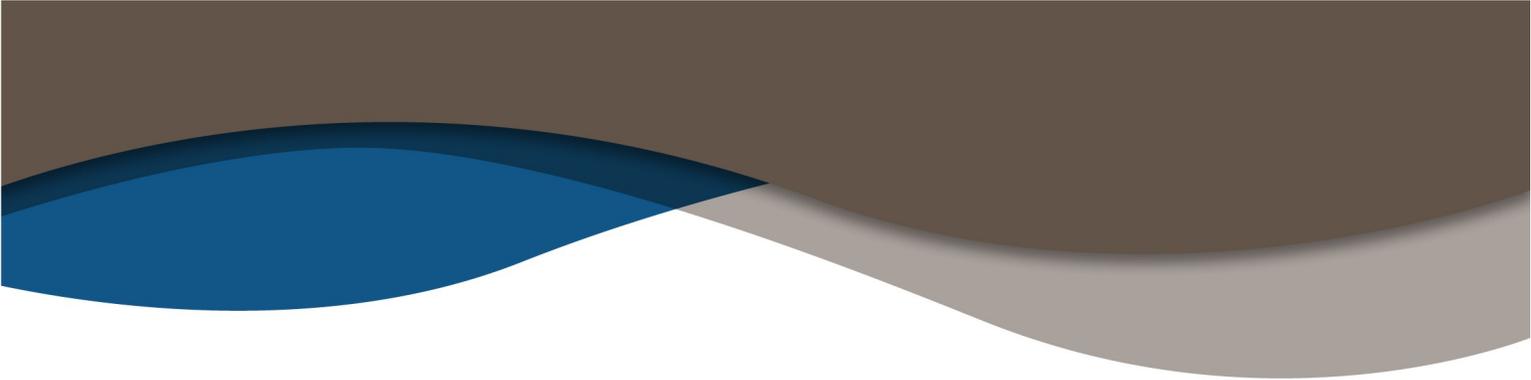
The Juvenile Dependency Wellness Court located in San Jose, is part of the Superior Court of California in the County of Santa Clara. Its current model of a dependency wellness court originated from a merger of the Dependency Drug Treatment Court (DDTC), established in 1998, and their Family Wellness Court (FWC), first created in 2008. The model now combines elements of both with a strong emphasis on services for substance abuse treatment and a focus on children’s well-being.

DWC runs parallel to the dependency legal proceedings. Visitation and reunification are not addressed in wellness court, and graduation from wellness court does not guarantee reunification. Instead, the court takes a therapeutic approach and focuses primarily on the recovery process of the parent. Participation by the parent is voluntary, and parent mentors, formally employed former graduates, play a crucial role in client engagement.

The model operates with a multi-disciplinary court-team, which includes representatives from the majority of the agencies that provide services to the client and family, including substance abuse, mental health and social services, child development, domestic violence, housing, and employment-related services.

Participation for the client is organized into five distinct phases that have to be completed in order. Presence at the court focuses primarily on progress and team feed-back in regards to the treatment plan, needs of the client, and next steps. Once engaged in the process, families are referred to a range of community-based support services, which include Celebrating Families!, screening and assessment services for children, and a range of health, substance abuse and mental health related services.

The Santa Clara Dependency Wellness Court is one of multiple Family Drug Treatment Courts and Infant / Toddler Courts that operate across the country.



Research has shown that connectedness to others is a deterrent for all kinds of negative behavior, including substance abuse.

- **Collaborating with others and intentional teaming.** In the same way that an addictive disease can consume all parts of a person's life, their recovery process must be built around a coordinated set of services and supports. Not surprisingly, child welfare case workers are critical partners in this team effort, especially when the youngsters are in substitute care. No other service delivery system that touches the parent, except for criminal justice, has the extensive power of judicial intervention. For parents anxious to be reunified with their children, the case worker can be the crucial conductor of the service array orchestra. Utilizing family team meeting models and engaging professionals from across the spectrum of support, as well as non-professional recovering peers, the case worker can enhance the network of helpers that are essential to relapse prevention, and simultaneously increase the level of safety for the youngsters.
- **Create opportunities for dialogue and complaints.** Things frequently do not go well for parents in early recovery, and there are multiple stress factors that can fuel their sense of frustration and lack of self-esteem. The essential messaging on personal responsibility can be difficult for these parents particularly in early recovery, and the adjustments that are needed in brain functioning and regaining their ability to make decisions for themselves and their children. A person in early recovery might rebel, resist, and ultimately relapse because the alternative behavior is so foreign and the brain reward system needs time to recover. Recovering parents whose children are part of the child welfare system face a similar experience navigating the mandatory demands of case plans and court orders. They may be struggling with executive functioning -- their ability to consider information and make decisions -- and feel powerless with the litany of directions and requirements re-enforces their already poor image of themselves as parents, their guilt, and their shame. The lack of choice, along with the need to please so many other people can create resentments that are actually rooted

in self-hatred and blame. Caseworkers do well to provide parents, especially those in early recovery, with an opportunity to do a reasonable amount of venting and complaining so that the resentment does not reach a climactic level. Empathetic listening and redirection into manageable tasks with measurable results will serve two purposes. First, it will provide the caseworker and the parent with some barometer of the client's level of frustration, anxiety, ability to make decisions and fragility. Second, it will provide the recovering parent a window into their new reality that life's situations and challenges do not change a great deal but the ability to cope can improve significantly.

- **Keeping the tasks manageable.** In early recovery, people in treatment are encouraged by treatment professionals and 12-Step sponsors to remain focused on not using substances, not making any major life decisions or not entering into any new situations that will produce unwarranted anxiety. A standard maxim in many recovery programs is, *No major decisions in the first year*. Ironically, child welfare caseworkers have a mandate to push parents to do just the opposite. They are counting on recovering parents to assume full responsibility as soon as possible. This is especially true when the youngsters are in care. Though it is crucial for the parent to take all of this guidance seriously, the pressure to attend to every bit of advice when they are still in such a fragile space can contribute to relapse. Caseworkers should help parents break down the tasks into a manageable, measurable plan. As the parent is able to accomplish these tasks, they gain a new or restored level of self-esteem. At the same time, the case worker is able to assess what level of stress the parent can handle in relation to the safety and well-being of the children. Keeping the restorative activities at a sensible pace demonstrates respect for the parent's physical, emotional and spiritual health.

¹<https://www.childwelfare.gov/pubs/usermanuals/substanceuse/chapterthree.cfm>

For more about the science of addiction, please refer to: American Society of Addiction Medicine <http://www.asam.org/for-the-public/definition-of-addiction> and <http://www.drugabuse.gov/publications/science-addiction>

Kentucky Sobriety Treatment and Recovery Teams

The Kentucky Sobriety Treatment and Recovery Teams (K-START) is a recovery coaching and collaboration model built on the nationally-recognized S.T.A.R.T program that began in Cleveland, OH. The goal of the program is to integrate best practices in substance abuse, behavioral health, and child welfare. The program serves parents with children birth to five years old with a substantiated incident of abuse and neglect with substance abuse as a primary risk factor. Parents need to be TANF-eligible.

The intervention pairs CPS social workers with a family mentor (peer support specialists in recovery) to share a caseload of families who are involved with child welfare for substance abuse reasons. The START team comprised of the CPS case worker and family mentor together serve a caseload of 12-15 families. Family mentors are people who have been in recovery for at least 3 years and have had prior involvement with child welfare. They meet frequently with the parents, about six times per month, on average, and coordinate closely with the CPS caseworker. They take parents to treatment providers, link them with other recovery supports, and provide coaching on recovery, relapse prevention, parenting, and daily living skills.

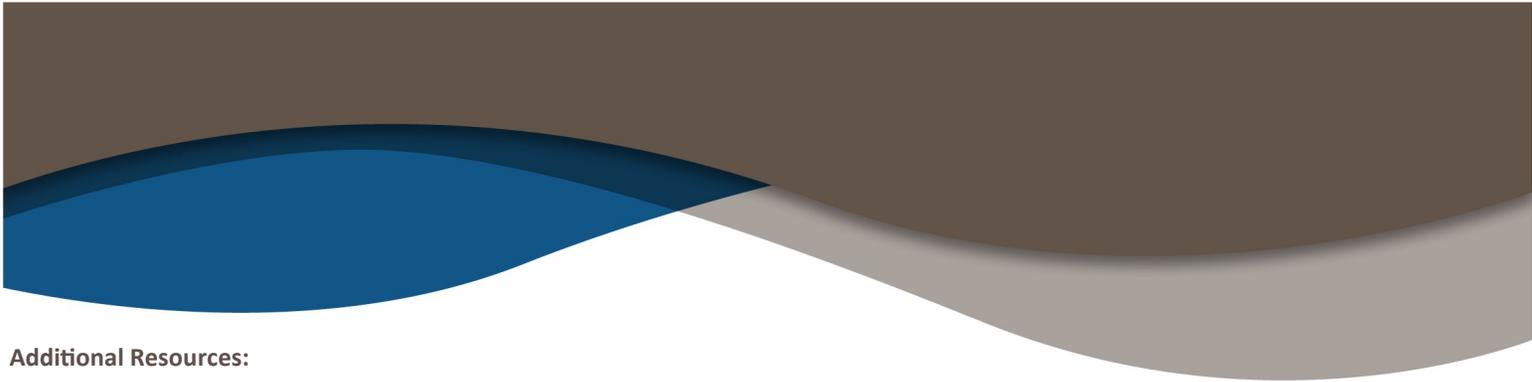
K-START currently operates at sites in four counties in KY, and is being implemented in Indiana. Average estimated program expenditures per child, including treatment services for parents, was approximately \$5,900 in 2010, though expenditures vary substantially by site (see resources in this digest for more information on how program cost was derived).

THE STRATEGIC PERSPECTIVE:

by Barry Salovitz, Senior Director

The effects of parental substance abuse on the safety, permanency, and well-being of children is the most common safety and risk factor in child welfare today. Ask any one of my colleagues, and they will say that we need programs that successfully engage caregivers with substance use disorders, programs that provide timely and effective treatment and programs that support the sobriety journey. In my work, in Indiana and Kentucky, I am witnessing the initial successes of the START model described in this issue of the digest (p. 17). The enthusiasm for this Model is real, pervasive, and uplifting. Finally, a model has combined many best practice strategies with system collaboration efforts that make sense and are making a real difference.





Additional Resources:

Parental Substance Use and the Child Welfare System <https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.cfm>

Young, Nancy K. , Boles, Sharon M., Otero, Cathleen Parental Substance Use Disorders and Child Maltreatment: Overlap, Gaps, and Opportunities in Child Maltreatment 2007; 12; 137 <http://cmx.sagepub.com/content/12/2/137.abstract>

National Drug Court Resource Center <http://www.ndcrc.org/>

Coverage and Service Design Opportunities for Individuals with Mental Health and Substance Use Disorders <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-12-03-12.pdf> December 3, 2012

Prevention and Early Identification of Mental Health and Substance Use Conditions <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf> March 27, 2013

Child Welfare Training Toolkit: Helping Child Welfare Workers Support Families with Substance Use, Mental, and Co-Occurring Disorders at www.ncsacw.samhsa.gov/training/toolkit

For more information on the Jackson County Collaboration and the **OnTrack** program mentioned in this issue, please refer to https://docs.google.com/file/d/0B7ZvqG_vQIVlamcycXZKdDZkMU0/edit?usp=drive_web&pli=1

Huebner, R. A., and Willauer, and Posze (2012). The impact of Sobriety Treatment and Recovery Teams (START) on family outcomes. *Families in Society: The Journal of Contemporary Social Services*, 93, 196 – 203.

Evidence-based and Promising Programs for families with young children and substance use issues are listed at this internal Casey link: <\\hqfile01\all casey\Early Childhood and Child Welfare>

About the Casey Practice Digest

The Digest provides Casey staff with access to the forefront of research, policy, and practice developments, bridging the gap between research and practice. Each issue is centered on a topical theme, and includes interviews with expert sources, maps and graphics displaying current trends at a high level, reviews of cutting-edge research with policy and practice applications, as well as resources for further exploration. The Practice Digest is produced by Knowledge Management and includes editors from Data Advocacy, Knowledge Management, Child and Family Services, and Public Policy Teams.

This issue includes contributions by Steve Christian, Policy; Melissa Correia, Data Advocacy; Paul DiLorenzo and Barry Salovitz, Strategic Consulting; Erin Maher, Research Services. Edited by Dee Wilson and Katharina Zulliger, Knowledge Management.

Program Highlights are descriptive and are intended to provide practice considerations for other jurisdictions. Programs were chosen based on available information and inclusion in the digest does not present an endorsement by Casey Family Programs of these programs over others. For a comprehensive program description, including financing and outcomes, please contact the local Strategic Consultant and request a site visit summary.

For questions or feed-back please contact kzulliger@casey.org or call (206) 352-4230.