

Helping Families With Co-Occurring Substance Use and Child Maltreatment: Strategies and Best Practices



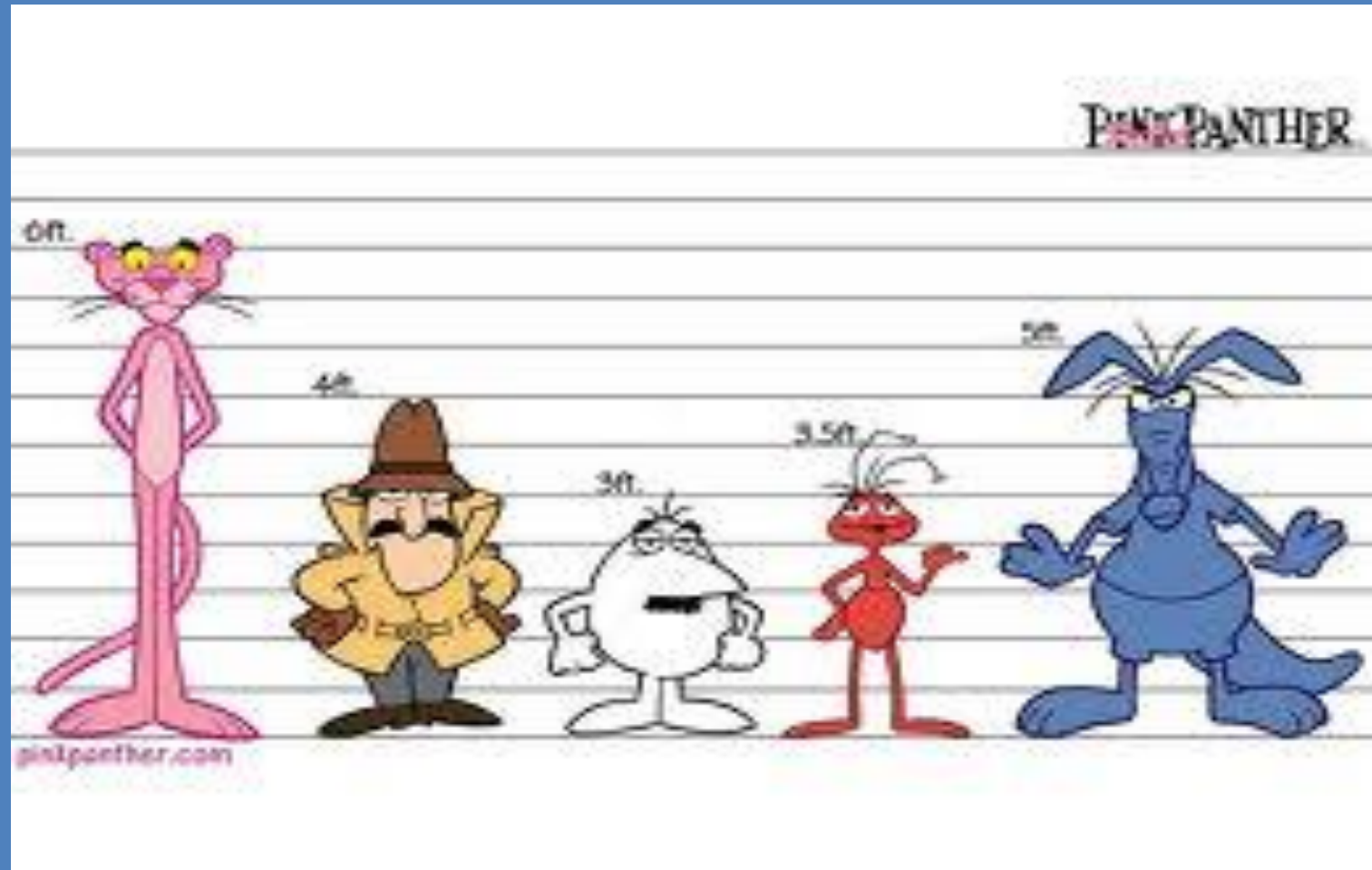
No One Left Behind: Building Supportive Communities and Families Affected by the Opioid Crisis

April 18, 2017
Tina Willauer

DISCLOSURE

- The speaker and members of the planning committee do not have a conflict of interest in this topic.
- There is no commercial support for this program.

Getting to Know You



What We Will Cover Today

- Collaborative strategies for working with families who have co-occurring substance use and child maltreatment
- Overview of the START model history, program elements and outcomes.
- START Implementation in Rural Appalachia: A Case Study



A scenic landscape featuring a dirt road on the left and a paved road on the right, both leading towards a bright horizon. The sky is filled with large, white, fluffy clouds, and the sun is shining brightly from the left, creating a lens flare effect. The overall atmosphere is bright and hopeful.

Understanding the Need: National and Statewide Data

Substance Use and Child Maltreatment

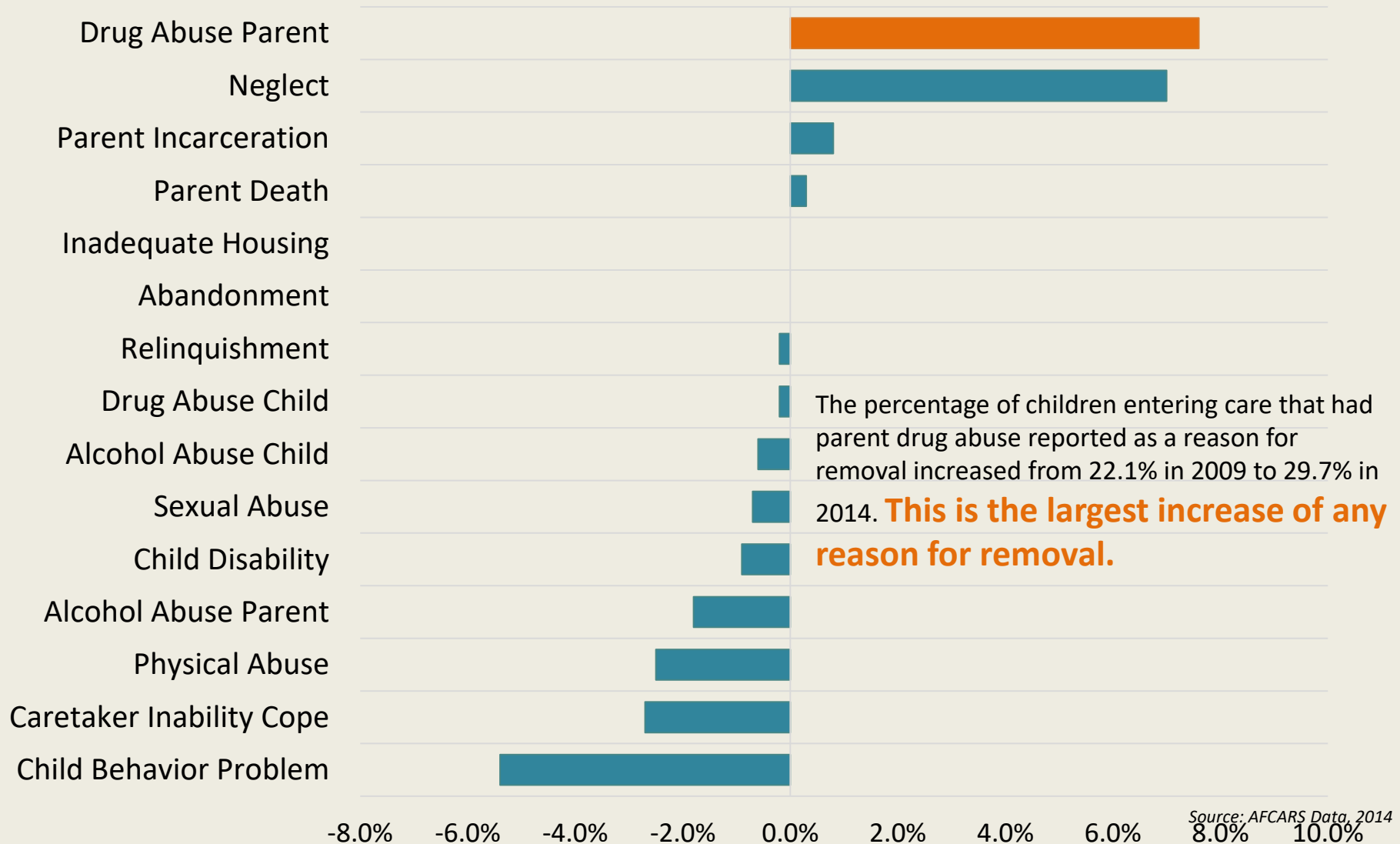
- An estimated 12 percent of children in this country live with a parent who is dependent on or abuses alcohol or other drugs (*SAMHSA, Office of Applied Studies, 2009*).
- Between 60–80% of substantiated child abuse and neglect cases involve substance use by a custodial parent or guardian (Young, et al, 2007)
- Maltreated children of substance abusing parents remain in the child welfare system longer and experience poorer outcomes (*GAO, 2003*).

Number of Children in Out-of-Home Care in the United States, 2010-2014

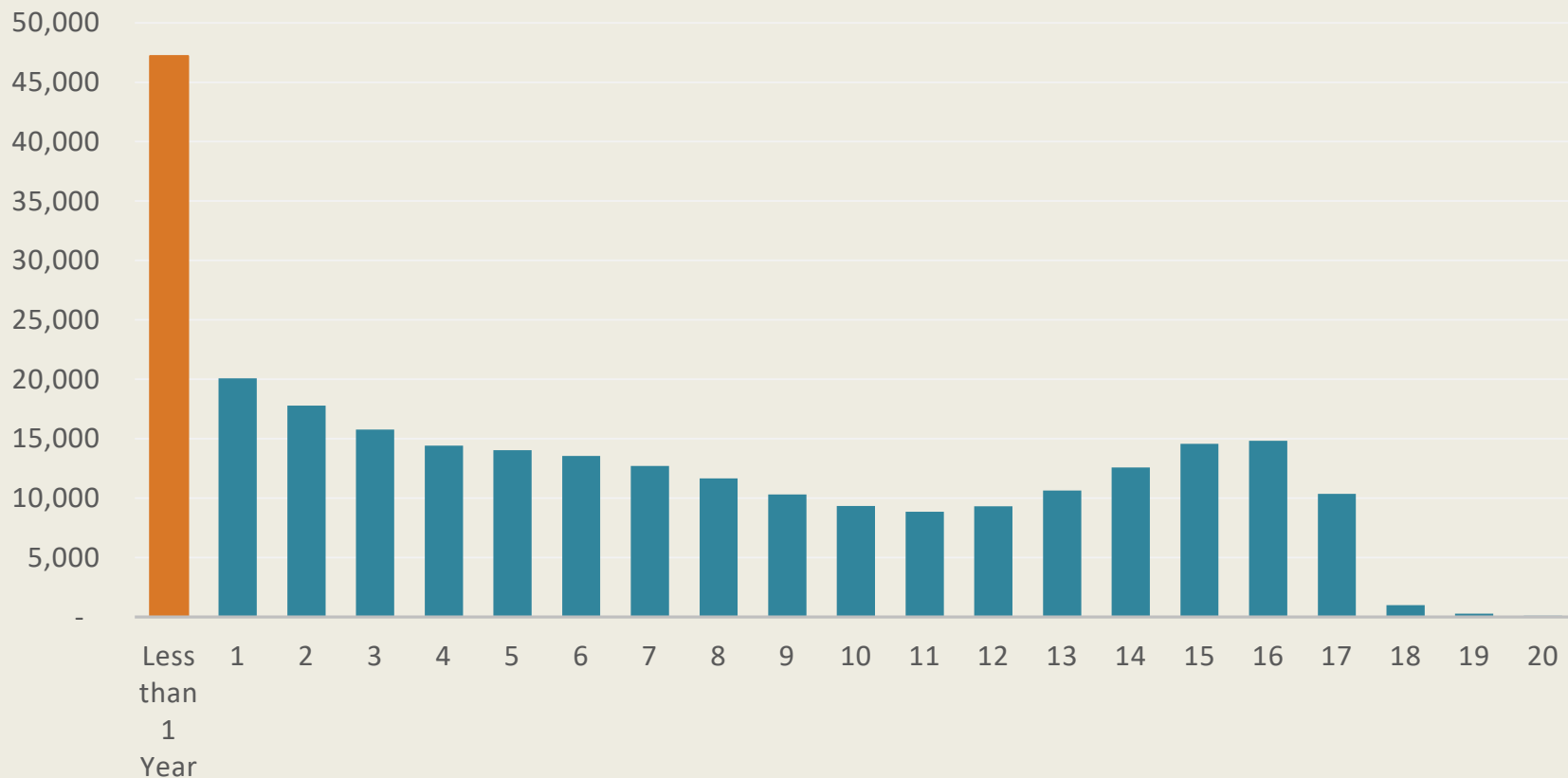


Source: AFCARS Reports, 2011-2014. Retrieved from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/afcars>

Percent Change from 2009 to 2014 in Drug Abuse as a Reason for Removal



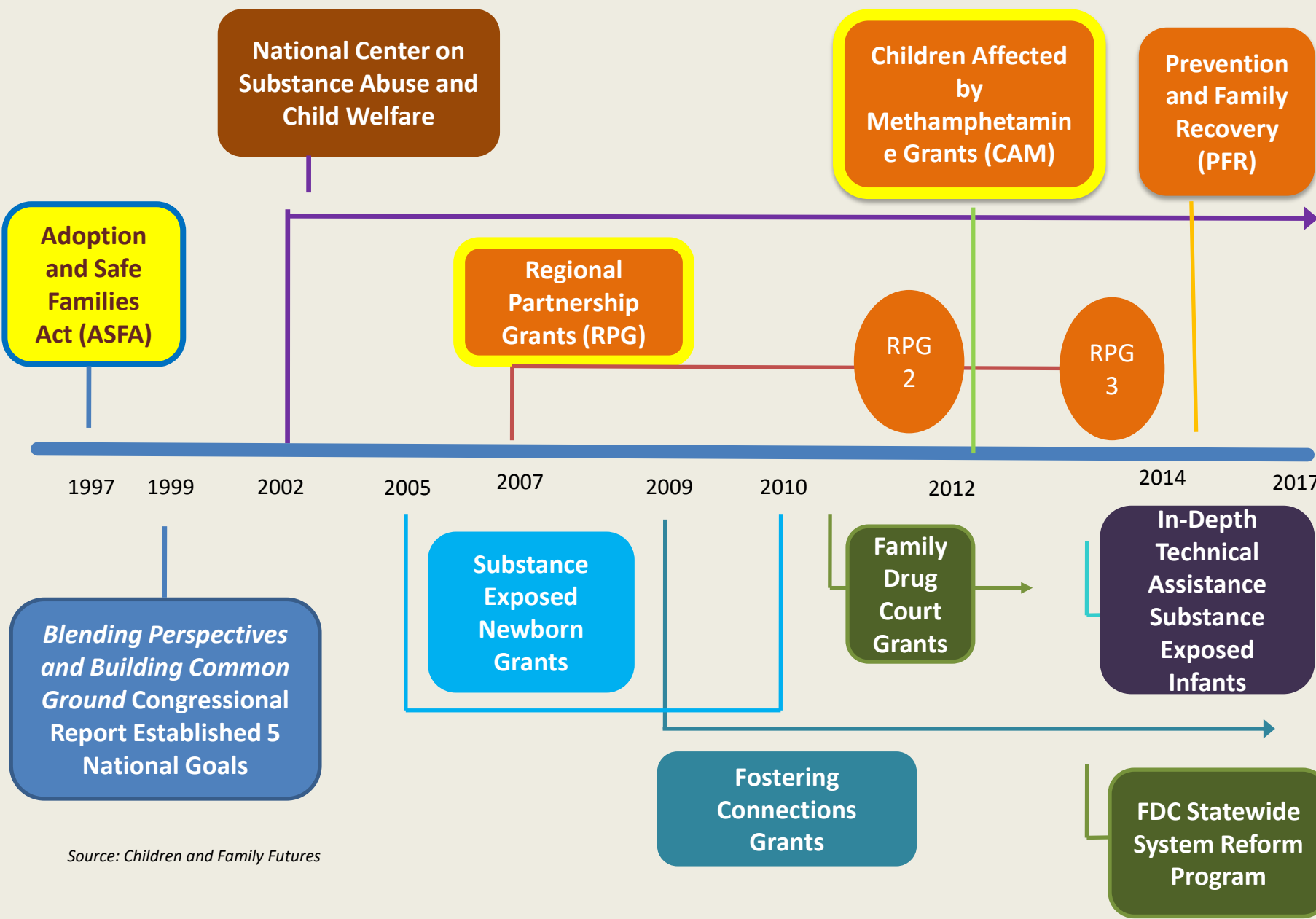
Age of Children who Entered Foster Care in the United States, 2015 (N=269,509)



Note: Estimates based on all children who entered foster care during Fiscal Year

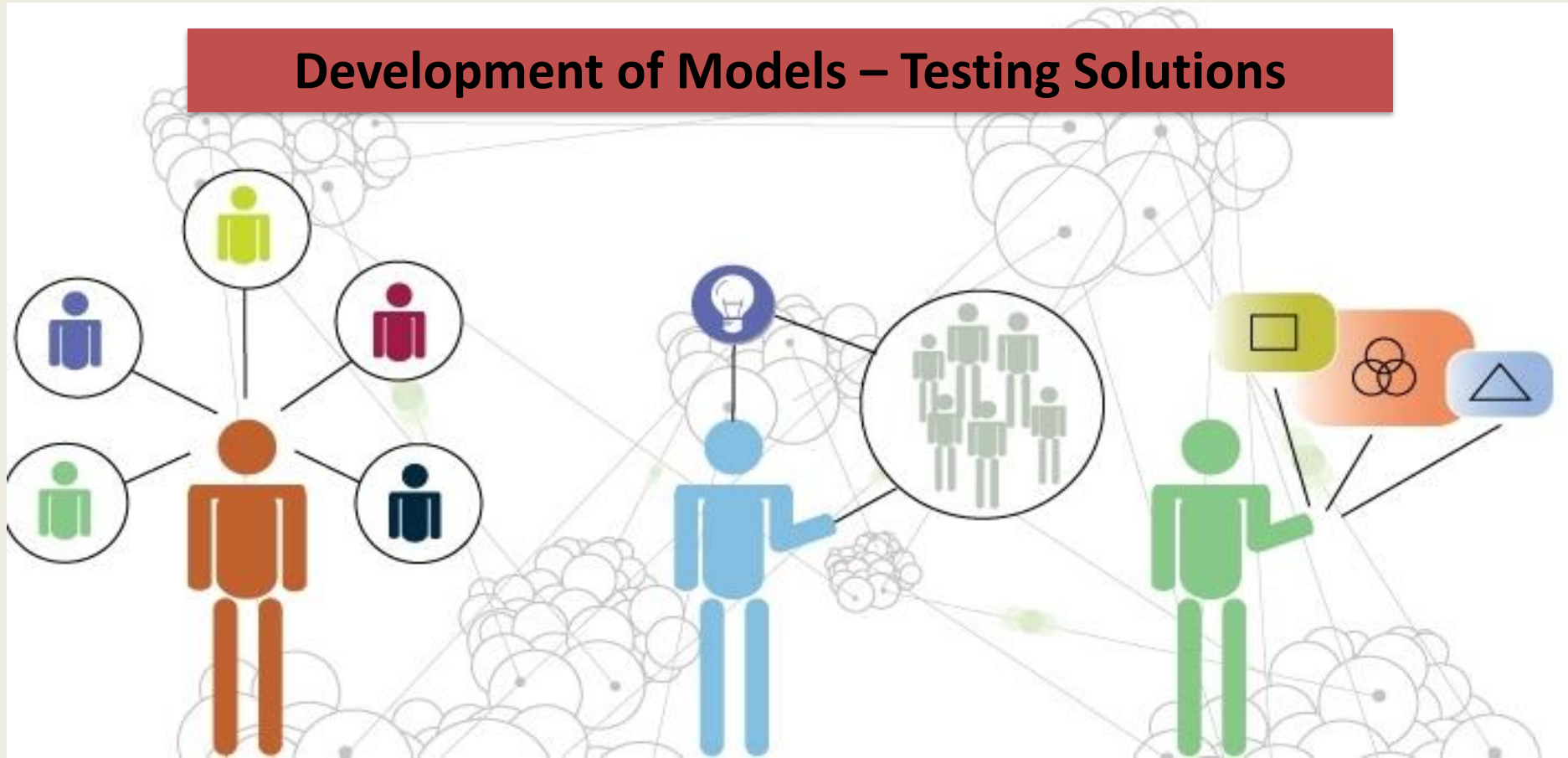
*Source: AFCARS Data,
2015*

Progress Since the Adoption and Safe Families Act (ASFA) 1997



Source: Children and Family Futures

Development of Models – Testing Solutions

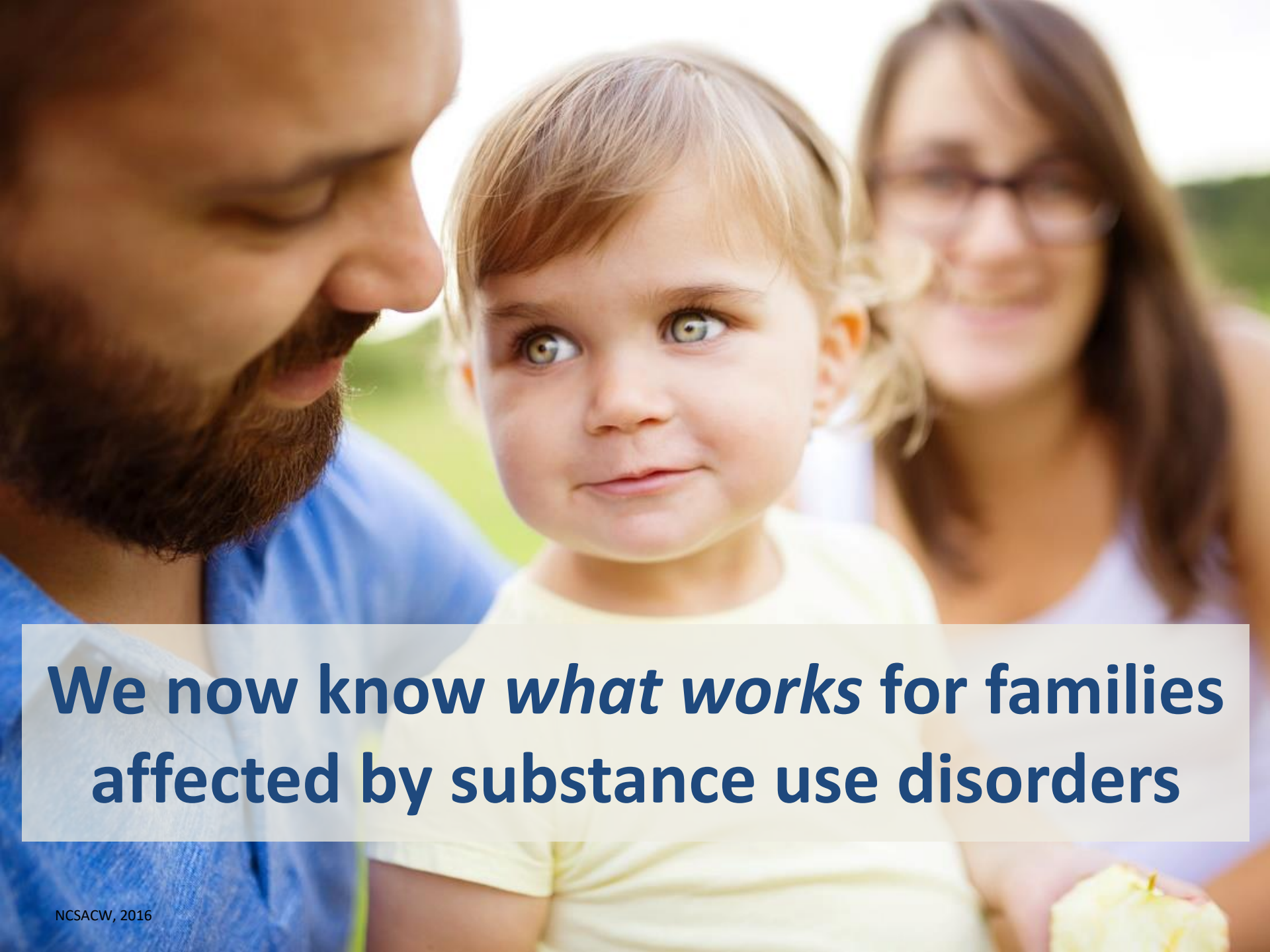


National Center on Substance
Abuse and Child Welfare

Regional Partnership Grants
2007-2012 - 53 Grantees
2012-2017 - 17 Grantees
2014-2019 - 4 Grantees

Children Affected by
Methamphetamine
12 Family Drug Courts

2002 — 2007 — 2010

A photograph of a family. In the foreground, a man with a beard is looking down at a young child. The child is looking directly at the camera. In the background, a woman with glasses is smiling. The image is used as a background for a text overlay.

**We now know *what works* for families
affected by substance use disorders**



Key Ingredients and Strategies

1. Identification
2. Timely Access
3. Recovery Support Services
4. Comprehensive Family Services
5. Increased Judicial Oversight
6. Cross-Systems Response
7. Collaborative Structures

How Collaborative Policy and Practice Improves

We know more....

Recovery

Remain at home

Reunification

Re-occurrence

Re-entry

5Rs

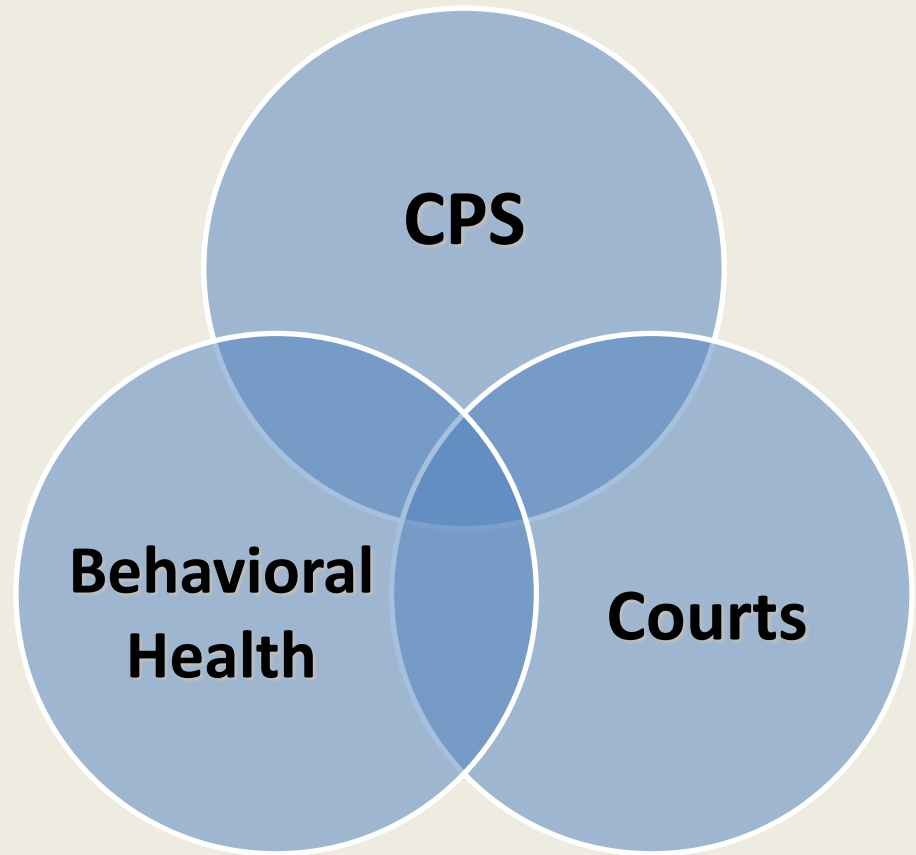


- **Parents/caregivers achieved timely access to substance abuse treatment, stayed in treatment (on average, more than 90 days), and reported reduced substance use**

- **The majority of children at risk of removal remained in their parent's custody**
- **Most children in out-of-home placement achieved timely reunifications with their parent(s)**
- **Less than 5% of children had a re-occurrence of substantiated maltreatment within six months after RPG Program Enrollment**
- **After returning home, very few children re-entered foster care**

Three Key Systems

- **No one system, agency or entity has the resources needed to effectively address this problem**
- **START is an integrated program that engages and partners with the behavioral health and court systems but is initiated and driven by CPS.**



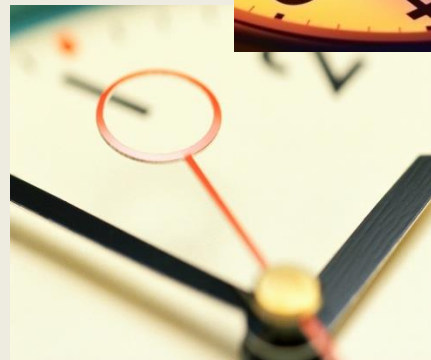


We know more....

The Importance of Early Identification and Timely Referral to Services

The Five Clocks Facing Families, Providers and CPS

- Adoption and Safe Families Act (ASFA)
- Temporary Assistance to Needy Families (TANF)
- Child's developmental timetable
- Recovery process and substance use disorder treatment
- Time for staff to respond to the other four clocks



Time to Treatment Matters



**Child Welfare –
12-month
timetable for
reunification**

Conflicting Timetables

**Treatment and
recovery – ongoing
process that may
take longer**

Early engagement in treatment is crucial. Strategies to improve timely access include:

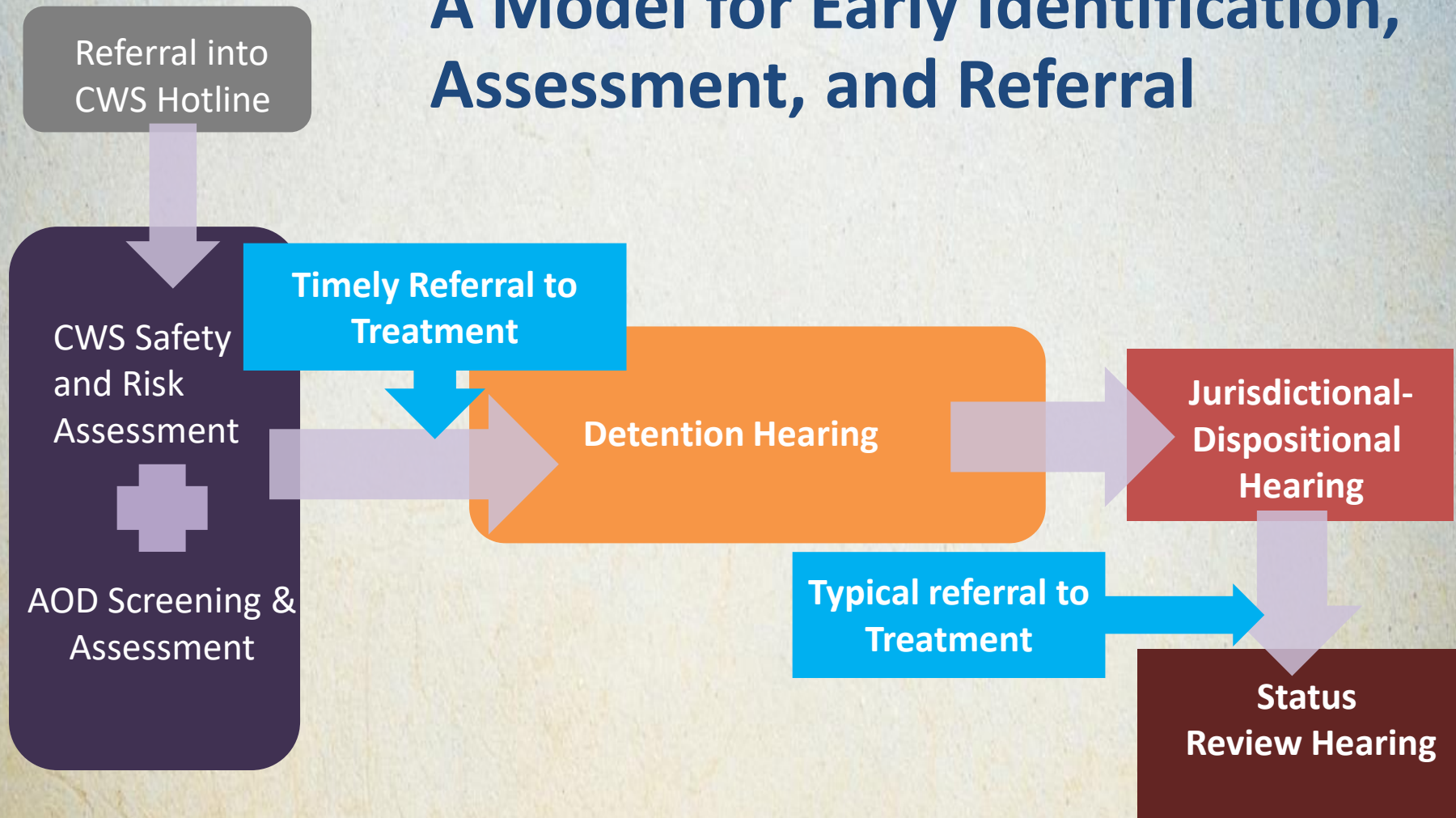
- **Screening and identification**
- **Service linkage and matching to parent need**
- **Warm hand-off to assessment**

A close-up, low-angle shot of an hourglass. The top bulb is filled with dark, fine-grained sand, while the bottom bulb is mostly empty, showing the clear glass. A small stream of sand is captured mid-fall, creating a series of overlapping, translucent, and slightly blurred shapes as it tapers towards the bottom. The lighting is dramatic, highlighting the textures of the sand and the smooth curves of the glass.

**Since timely
engagement and
access to
assessment and
treatment matters:**

**How can
identification and
screening be moved
up as early as
possible?**

A Model for Early Identification, Assessment, and Referral





Missed opportunities

*“Here’s a referral,
let me know when
you get into
treatment.”*

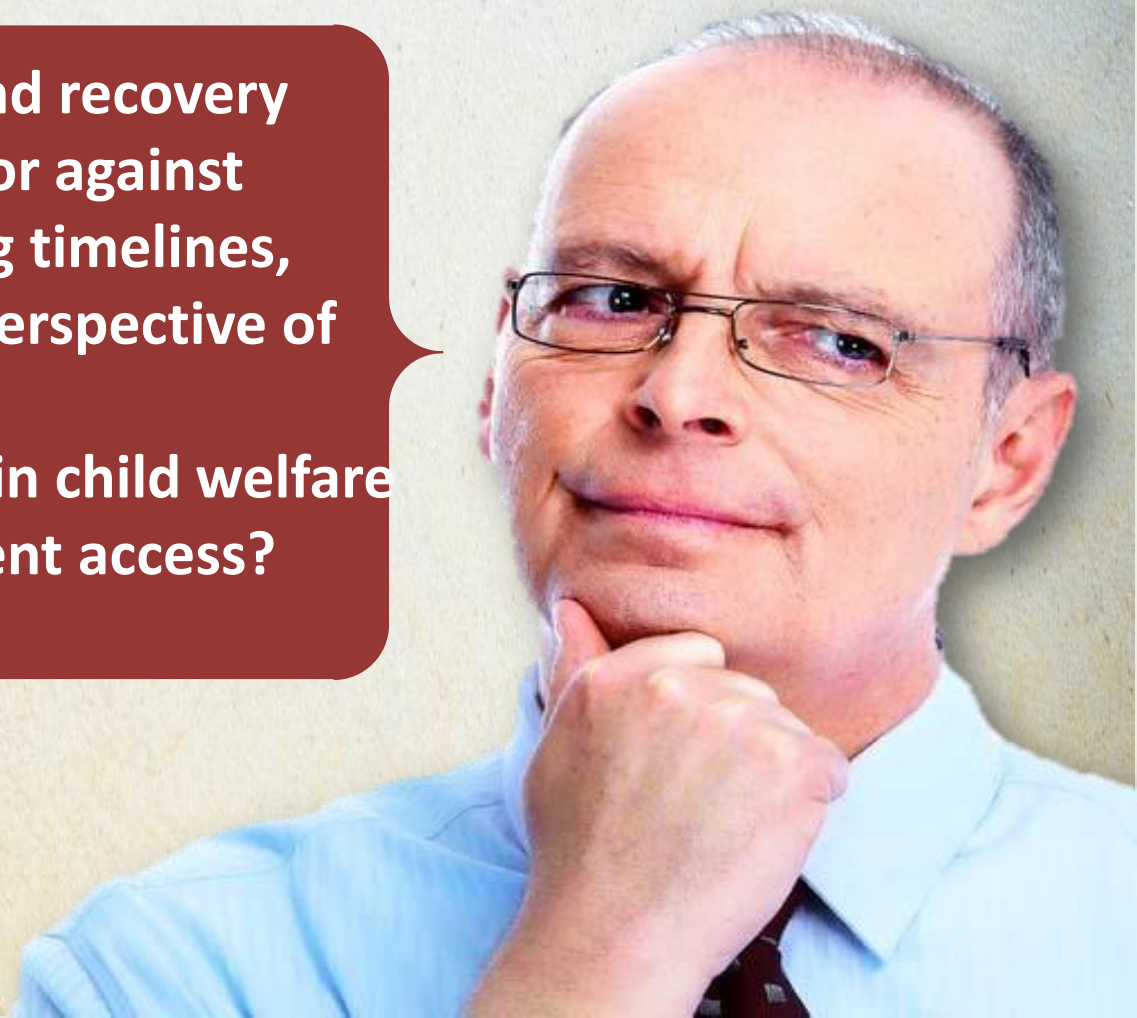
*“They’ll get into
treatment if they
really want it.”*

*“Don’t work harder
than the client.”*

“Call me Tuesday.”

Questions and Considerations...

- How do treatment and recovery timelines work with or against permanency planning timelines, especially from the perspective of the child?
- Do families involved in child welfare have priority treatment access?





We know more....

The Importance of Engagement, Evidence Based
Treatment and Recovery Support



Rethinking Treatment Readiness



Re-thinking “rock bottom”

Addiction as an elevator



“Raising the bottom”

Treatment and Recovery Support

- Treatment operates within an acute vs. chronic disease model. This focus is the most likely reason for lack of continuing care services, a staple of disease management for any other chronic illness.
- Like any other chronic illness that can be managed but not cured — substance use disorders require a period of continued monitoring and supports. Unfortunately, these post-treatment services are rarely available in adequate quantity or quality to forestall a relapse.
- Meyers, K, Cacciola, J, Ward, S, Kaynak, O, Woodworth, A. (2014) *Paving the Way to Change: Advancing quality interventions for adolescents who use, abuse or are dependent upon alcohol and other drugs*. Treatment Research Institute. Philadelphia, PA.

What is Recovery?

SAMHSA's Working Definition

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Recovery is not treatment!

Access to evidence-based substance use disorder treatment and recovery support services are important building blocks to recovery.

Recovery Oriented Systems of Care

A recovery-oriented systems approach supports person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustain health, wellness, and recovery from substance use disorders.

Recovery Support: Titles and Models

- Peer Mentor
 - Peer Specialist
 - Peer Providers
 - Parent Partner
- Recovery Support Specialist
 - Substance Abuse Specialist
 - Recovery Coach
 - Recovery Specialist
 - Parent Recovery Specialist

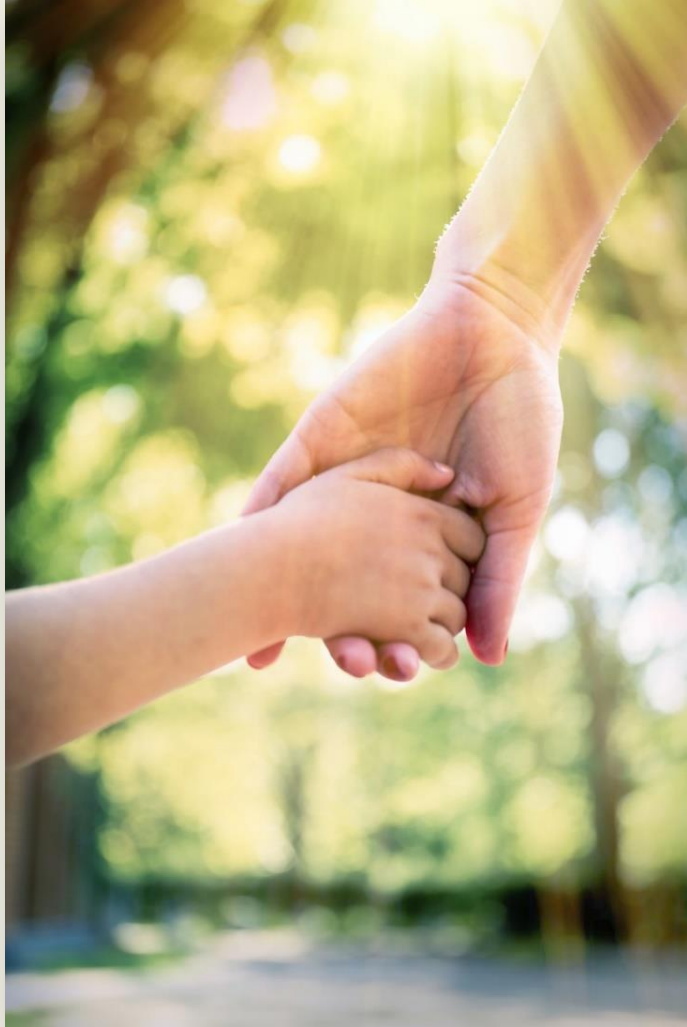
**Experiential Knowledge,
Expertise**

**Experiential Knowledge, Expertise +
Specialized Trainings**

YOU NEED TO ASK:

What does our program and community need?

Effective Substance Use Disorder Treatment



- Is readily available
- Attends to multiple needs of the individual (vs. just the drug abuse)
- Uses engagement strategies to keep clients in treatment
- Uses counseling, behavioral therapies (in combination with medications if necessary)
- Addresses co-occurring conditions
- Uses continuous monitoring

Treatment Should be Trauma Informed



EBPs for trauma survivors:

- Addiction and Trauma Recovery Integration Model (ATRIUM)
- Essence of Being Real
- Sanctuary Model
- Seeking Safety
- Trauma, Addictions, Mental Health, and Recovery (TAMAR) Model
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM and M-TREM)



Aftercare and Ongoing Support

Ensure aftercare and recovery success beyond treatment:

- Personal Recovery Plan – relapse prevention, relapse response**
- Peer-to-peer support – alumni groups, recovery groups**
- Other relationships – family, friends, caregivers, significant others**
- Community-based support and services – basic needs (childcare, housing, transportation), mental health, physical health and medical care, spiritual support**
- Self-sufficiency – employment, educational and training opportunities**

Questions and Considerations

- What strategies are used to engage and retain clients in treatment?
With clients who drop out or miss appointments?
- Does the program use peer mentors, recovery support specialists or recovery coaches to engage and retain clients?



Medication Assisted Treatment: Strategies for Child Protective Services



MAT and CPS

- Roughly 2.4 million people met criteria for opioid use disorder in 2013, compared to 1.5 million people in 2003 (Jones, Campopiano, Baldwin, & McCance-Katz, 2015)
- CW-involved parents with opioid use disorders are an especially vulnerable population, characterized by housing instability, lack of social support, poverty, and educational deficits (Lundgren, Schilling, Fitzgerald, Davis, & Amodeo, 2003)
- Reunification rates are lower for parents with opioid problems than for parents with alcohol problems (Choi & Ryan, 2007; Grella, Needell, Shi, & Hser, 2009) and parents with cocaine problems (Choi & Ryan, 2007)

And Yet....

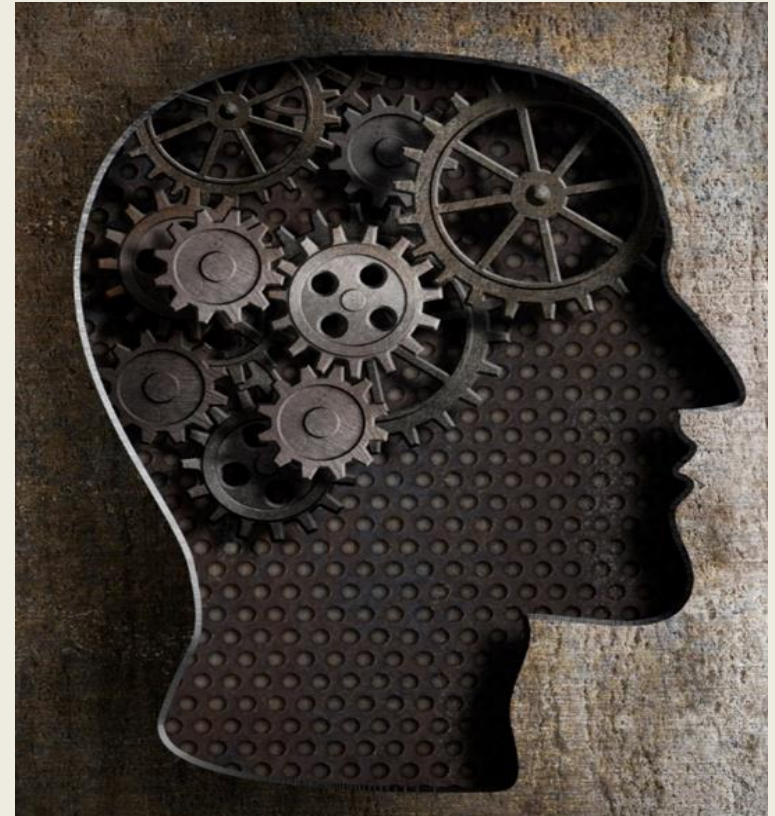
- Research and programming on opioid use and treatment for families in the CW system is especially lacking.
- MAT has been identified by the World Health Organization (2004) as the most effective treatment for opioid use.



Medication Assisted Treatment

As part of a comprehensive treatment program, MAT has been shown to:

- Increase retention in treatment
- Decrease illicit opiate use
- Decrease criminal activities, re-arrest and re-incarceration
- Decrease drug-related HIV risk behavior
- Decrease pregnancy related complications
- Reduce maternal craving and fetal exposure to illicit drugs



Fullerton, C.A., et al. November 18, 2013. Medication-Assisted Treatment with Methadone: Assessing the Evidence. *Psychiatric Services in Advance*; doi: 10.1176/appi.ps.201300235

The American College of Obstetricians and Gynecologists. (2012) Committee Opinion No. 524: Opioid Abuse, Dependence, and Addiction in Pregnancy. *Obstetrics & Gynecology*, 119(5), 1070-1076.

Dolan, K.A., Shearer, J., White, B., Zhou, J., Kaldor, J., & Wodak, A.D. (2005). Four-year follow-up of imprisoned male heroin users and methadone treatment: Mortality, reincarceration and hepatitis C infection. *Addiction*, 100(6), 820–828.

Gordon, M.S., Kinlock, T.W., Schwartz, R.P., & O'Grady, K.E. (2008). A randomized clinical trial of methadone maintenance for prisoners: Findings at 6 months post-release. *Addiction*, 103(8), 1333–1342.

Havnes, I., Bukten, A., Gossop, M., Waal, H., Stangeland, P., & Clausen, T. (2012). Reductions in convictions for violent crime during opioid maintenance treatment: A longitudinal national cohort study. *Drug and Alcohol Dependence*, 124(3), 307–310.

Kinlock, T.W., Gordon, M.S., Schwartz, R.P., & O'Grady, K.E. (2008). A study of methadone maintenance for male prisoners: Three-month post release outcomes. *Criminal Justice & Behavior*, 35(1), 1–15.

Barriers to using MAT

- Stigma, stigma, stigma
- Access and expense
- Bias toward abstinence-based approaches
 - CPS, BH, Courts
- Lack of communication between CPS and providers
- Diversion, irresponsible prescribing, lack of oversight



Child Welfare Considerations

- **Emphasize that MAT is a choice and is supported**
- **Cost can be a barrier to getting and staying on MAT**
- **Methadone and buprenorphine can be overly sedating.**
 - Plan for childcare after dosing until sedation resolved
 - Discuss with the prescriber
 - Note that co-sleeping is especially dangerous with sedating medications
- **Include on safety plans and case plans**

Child Welfare Considerations

- **Case can be closed while client is on MAT if stable**
 - Length of MAT determined by provider and patient
 - Unnecessary and unethical to require discontinuation or reduction. Can trigger a relapse.
 - Relapse risk is high when medication is stopped before clinically indicated.
 - Include MAT supports on aftercare plan at closure.

What does “success” look like on MAT?

- **Medication assisted recovery:**
 - Taking the medication as prescribed
 - Completely compliant with program requirements
 - Not using any illicit substances
 - Stability in work, family, community
 - No illegal behavior
 - Applying recovery principles to daily life



START and MAT

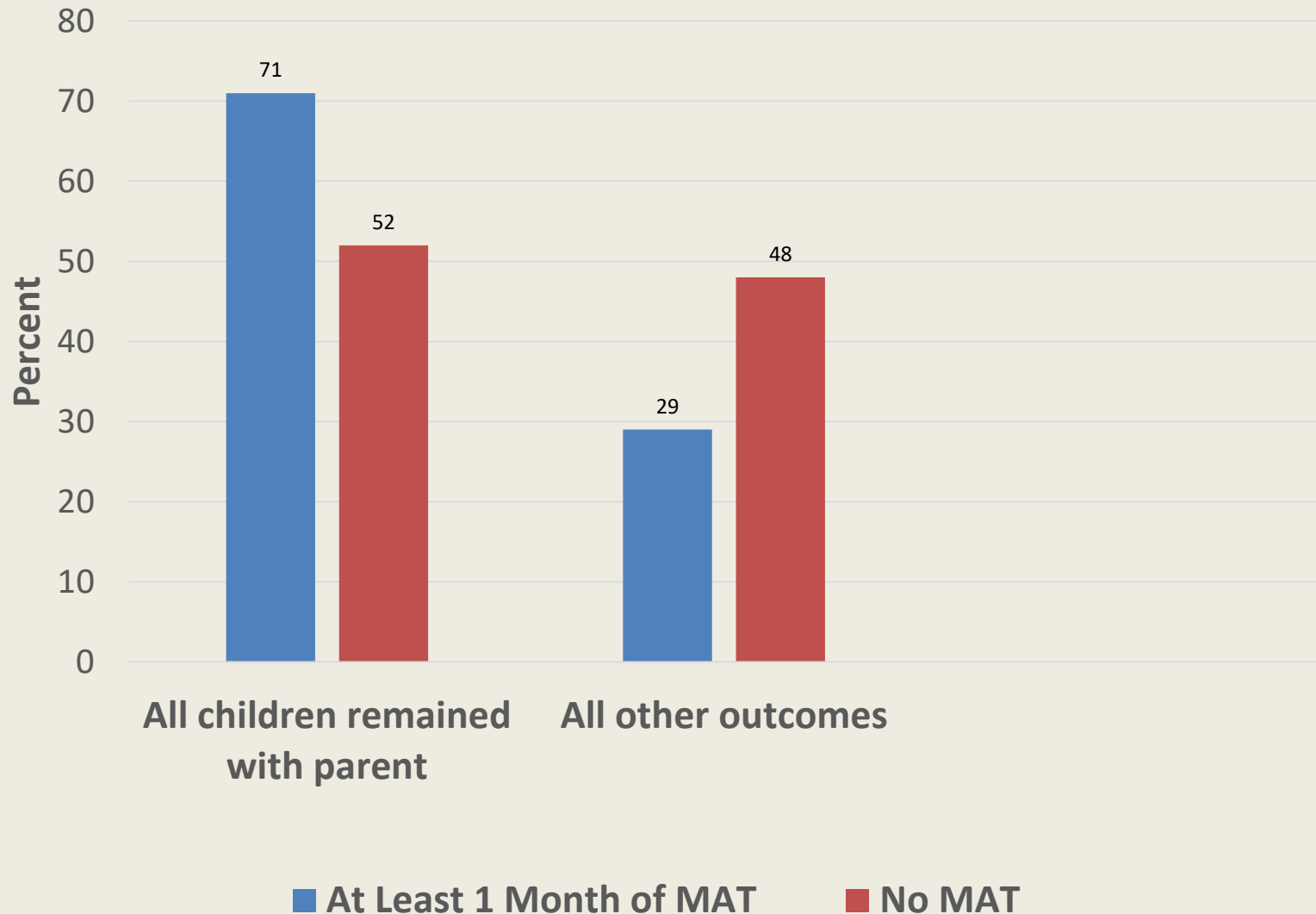
- We support the use of EBPs, including MAT
- Methadone, buprenorphine, naltrexone
 - ADJUNCT to treatment
 - Medication Assisted RECOVERY
- Why do we support MAT?
 - Child safety
 - Better family outcomes
 - Not our business how someone gets recovery



MAT Study:

- **Study Aims:**
 - Look at MAT use of START clients with opioid use history
 - Compare child outcomes for START clients who received MAT services with those who did not
- **Study Sample:**
 - Closed cases between 2007-2015
- **Measures:**
 - Demographics
 - Substance use at intake
 - Household opioid use (one adult vs. two or more adults)
 - Medication Assisted Treatment
 - Use of methadone, buprenorphine and naltrexone
 - Permanency (collapsed into 2 categories)
 - Remained at home with parent vs. all other outcomes

MAT and Child Permanency Outcomes



MAT Study Results:

- Compared to families who received no MAT:
 - 6 months of MAT: **60%** more likely to retain custody of children
 - 9 months of MAT: **90%** more likely to retain custody of children
 - 14 months* of MAT: **140%** more likely to retain custody of children
- Duration of MAT also positively associated with **reduced illicit opioid use** (Condelli & Duntelman, 1993), **other drug use and criminal activity** (Simpson & Sells, 1982), **and risk of viral infection and STDs** (Greenfield & Fountain, 2000)

*average length of START case

Making Improvements

- ❖ Education and training
- ❖ Collaborative meetings
- ❖ Case reviews that **ALWAYS** ask about MAT
- ❖ Financial support for MAT
- ❖ Research paper and presentations *
- ❖ Collaborative provider list *
- ❖ Practice guide *
- ❖ Legal brief



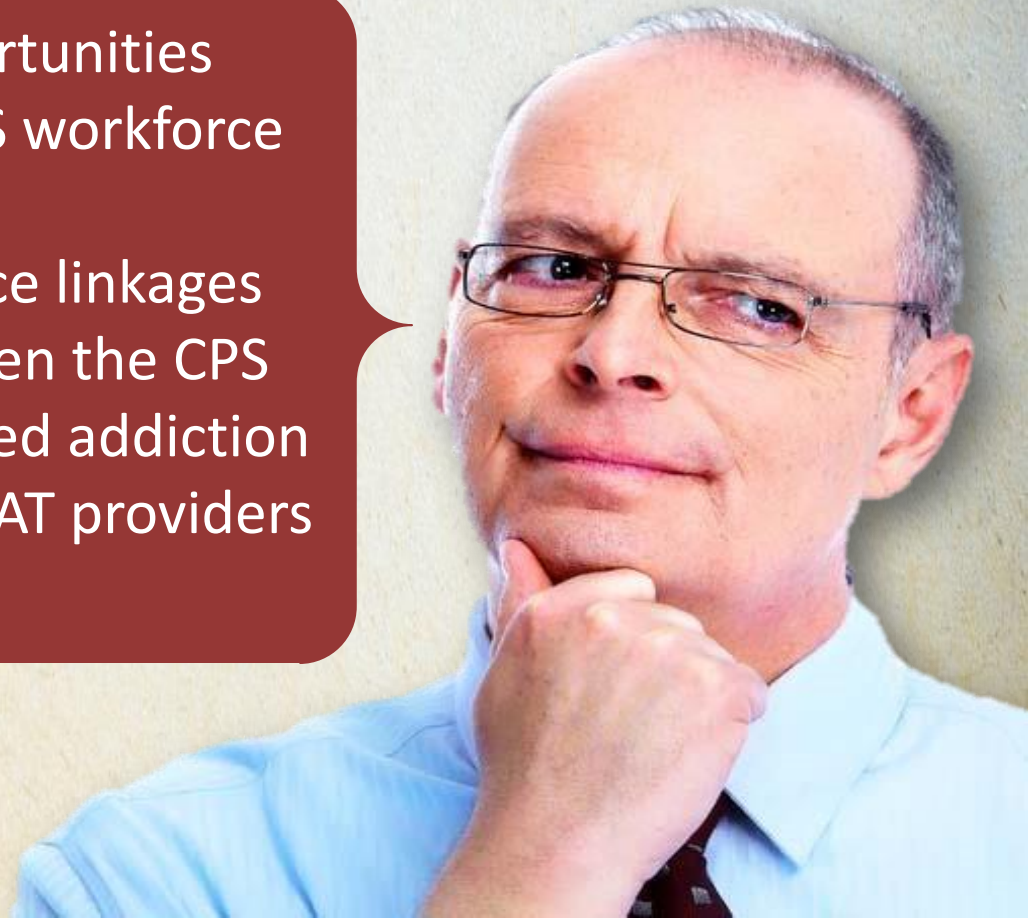
A Word About Naloxone

- Narcan (injection or nasal spray)
- Reverses overdose until get medical care
- Everyone at risk of OD should have a kit. Also family and friends.
- Consider whether your office should have a kit available.



Questions and Considerations

- What educational opportunities exist to educate the CPS workforce on benefits of MAT?
- How can practical service linkages be implemented between the CPS system, abstinence-based addiction treatment providers, MAT providers and the courts?





We know more....

The Importance of Family-Centered Approach



Child well-being occurs in the context of relationships

Adult recovery should have a parent-child component

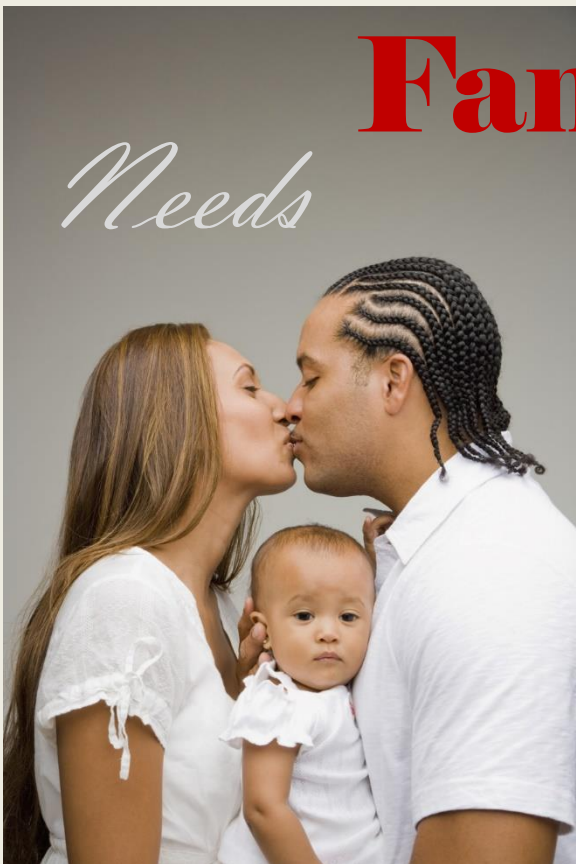
Relationships



- The parenting role of both women and men with substance use disorders is a complex matter that cannot be separated from their treatment
- Addressing the needs of both parents and children (individually and as a family unit) contributes to successful family outcomes
- Parents do better in treatment when their children remain with them
- Two-generation interventions for parents and children affected by substance use disorders also save money

Family Recovery

Needs



PARENTS

- Parenting skills and competencies
- Family connections and resources
- Parental mental health co-occurring
- Medication management
- Parental substance use
- Domestic violence

FAMILY

- Basic necessities
- Employment
- Housing
- Child care
- Transportation
- Family counseling

CHILD

- Well-being/behavior
- Developmental/health
- School readiness
- Trauma
- Mental health
- Adolescent substance use
- At-risk youth prevention



Parent-Child: Key Service Components

**Developmental &
Behavioral
Screenings and
Assessments**

**Parent-Child
Relationship Based
Interventions**

Trauma

**Quality and
frequent visitation
(Parenting Time)**

**Evidenced-Based
parenting**

**Community and
auxiliary support**

**Early and ongoing
peer recovery
support**

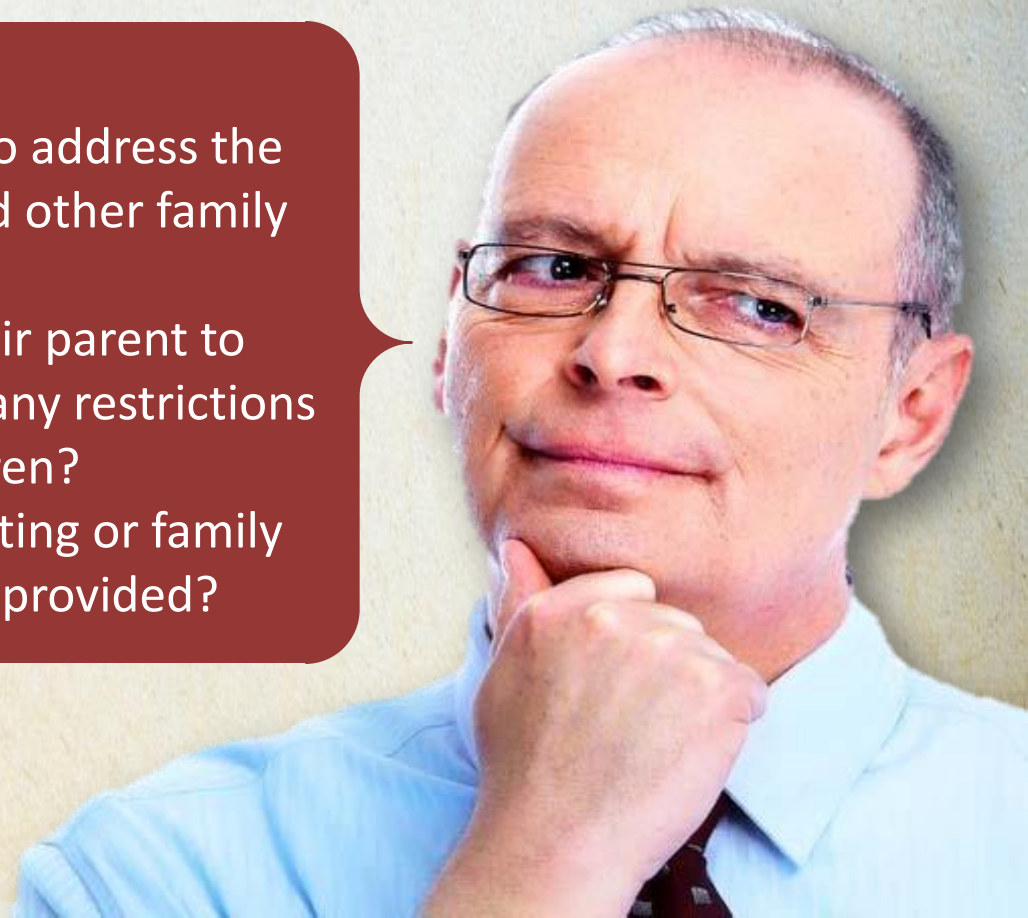
Children Need to Spend Time with Their Parents



- **Involve parents in the child's appointments with doctors and therapists**
- **Expect foster parents to participate in visits**
- **Help parents plan visits ahead of time**
- **Enlist natural community settings as visitation locations (e.g. family resource centers)**
- **Limit the child's exposure to adults with whom they have an uncomfortable relationship**

Questions and Considerations

- What services are provided to address the specific needs of children and other family members?
- Can children accompany their parent to treatment? If so, are there any restrictions on age and number of children?
- What evidence-based parenting or family strengthening programs are provided?



Collaborative Practice Implications

What system changes need to occur to support local, cross-system collaborative practices?

- Priority and timely access to effective treatment
- Address confidentiality
- Strengthen cross-system collaboration, communication, and training
- Enhanced understanding and acceptability of MAT
- Trauma training

Collaborative Practice Implications

What do child welfare staff need from substance abuse and mental health treatment practitioners to more effectively make decisions about the safety, permanence and well-being of children they are charged to protect?

What do substance abuse and mental health treatment practitioners need from child welfare staff to more effectively assess and treat parents and children?

*We can no
longer say
we don't
know what
to do.*



START

Sobriety Treatment and Recovery Teams



START History and Sites

- START adapted from model developed in Cleveland in 1990s with support from the Annie E. Casey Foundation
- KY began planning for K-START began in 2006 and has evolved the model to fit the needs of KY families.
- START has been implemented in six unique counties in KY: Kenton, Jefferson, Boyd, Martin, Daviess and Fayette
- IN START in Bloomington and Terre Haute.
- START has also been piloted in Bronx, NY and NW GA.



What is START?

- Child Protective Services (CPS) program for families with parental substance use disorder and child maltreatment.
- Integrative model that combines best practices among child welfare, family preservation and behavioral health
- Helps parents achieve recovery and keeps children in the home with their family when safe and possible.
- START is recognized on the California Evidence Based Clearinghouse for Child Welfare.



What is START?

- Serves CPS involved families with a substance exposed infant and/or young children 0-5.
- Partners with substance abuse and mental health treatment for services.
- Rapid timeline to engage families in services quickly and keep children out of foster care when safe and possible.
- Represents different approach to working with families involved with CPS due to parental substance use concerns.



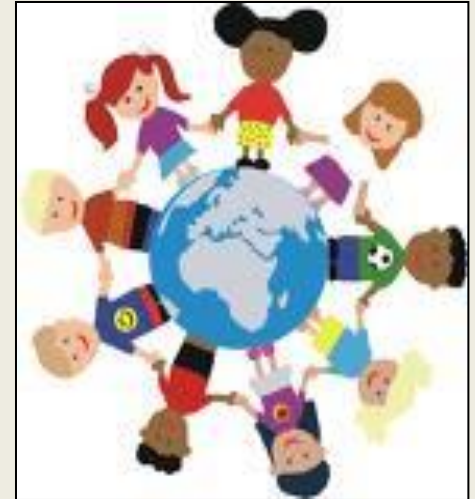
START: Essential Elements

- Early identification of families upon receipt of CPS referral.
- CPS Worker and Family Mentor paired co-located under a CPS START Supervisor.
- Capped caseload of 12-15 families for each CPS worker/family mentor dyad
- Weekly home visits
- Non-punitive approach
- Quick access to substance abuse assessment and treatment-within 48 hours



Overall Goals of START

- Preventing foster care entry
- Child Safety and Well Being
- Parental Sobriety and Recovery
- Permanency for children
- Family stability and self sufficiency
- Improved system capacity for addressing co-occurring addiction and child abuse.



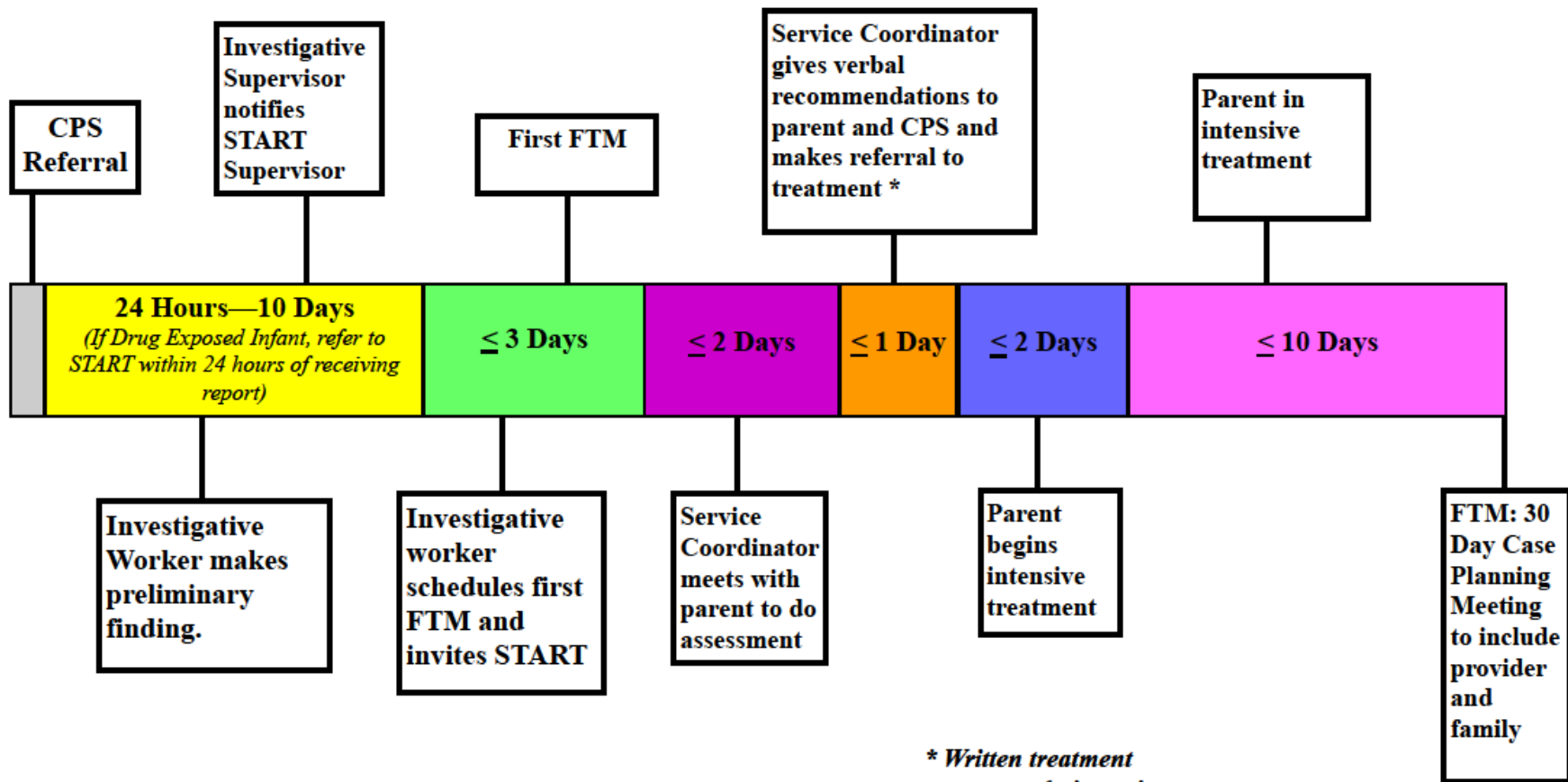
START Eligibility Criteria

- Family has a new CPS case opening for substantiated CA/N due to substance abuse
- Family cannot have a current open CPS case, but may have a history with the agency
- Family has at least one SEI or young child (target population is based on jurisdiction data).
- Family must attend initial FTM/Safety Meeting
- Funding eligibility requirements.



START Timeline

First 30 days of a START Case



Note: All days listed are work days.

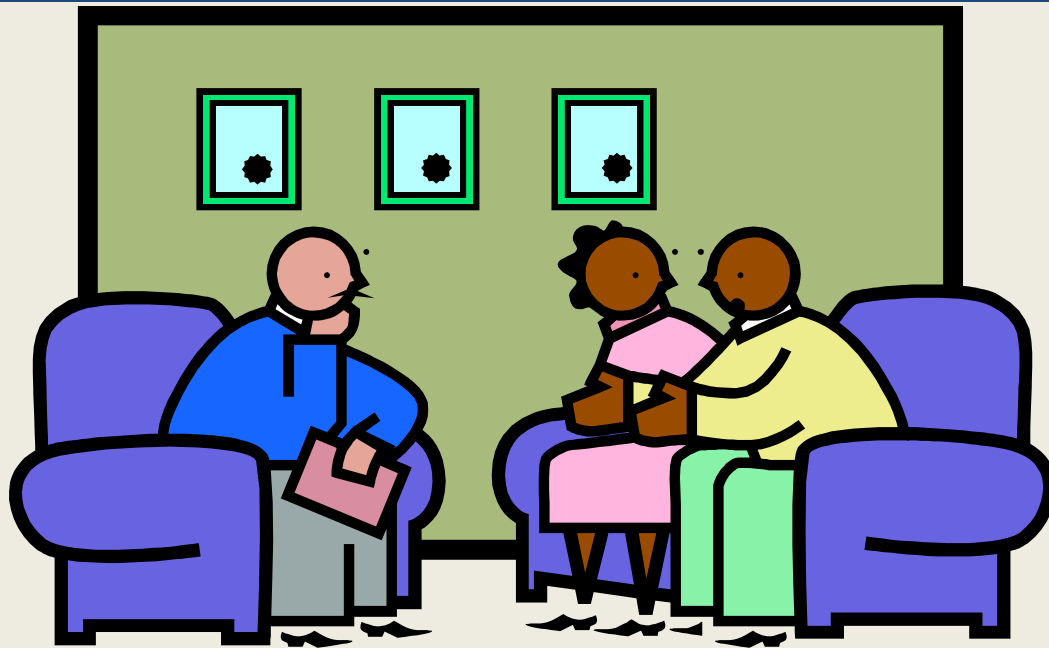
** Written treatment recommendations given to CPS within 5 days*

Funding START

- **Multiple funding streams cobbled together:**
 - Regional Partnership Grants
 - KY State General Funds
 - TANF
 - Medicaid
 - Casey Family Programs
 - Title IV-E Waiver
- **The Challenge: Bringing programs that work “to scale” and then sustaining them for children and families!**



START Strategies



Shared Decision Making

- Regular FTM's to plan and make team decisions
- Includes parents, CPS worker, community partners, family supports
- No secrets and no surprises
- Family-driven, strength-based approach
- Each system knows their “role” but contributes info
- Helps with family engagement and “buy in” with plan
- SUD Assessment begins at first FTM



Using START Strategies:

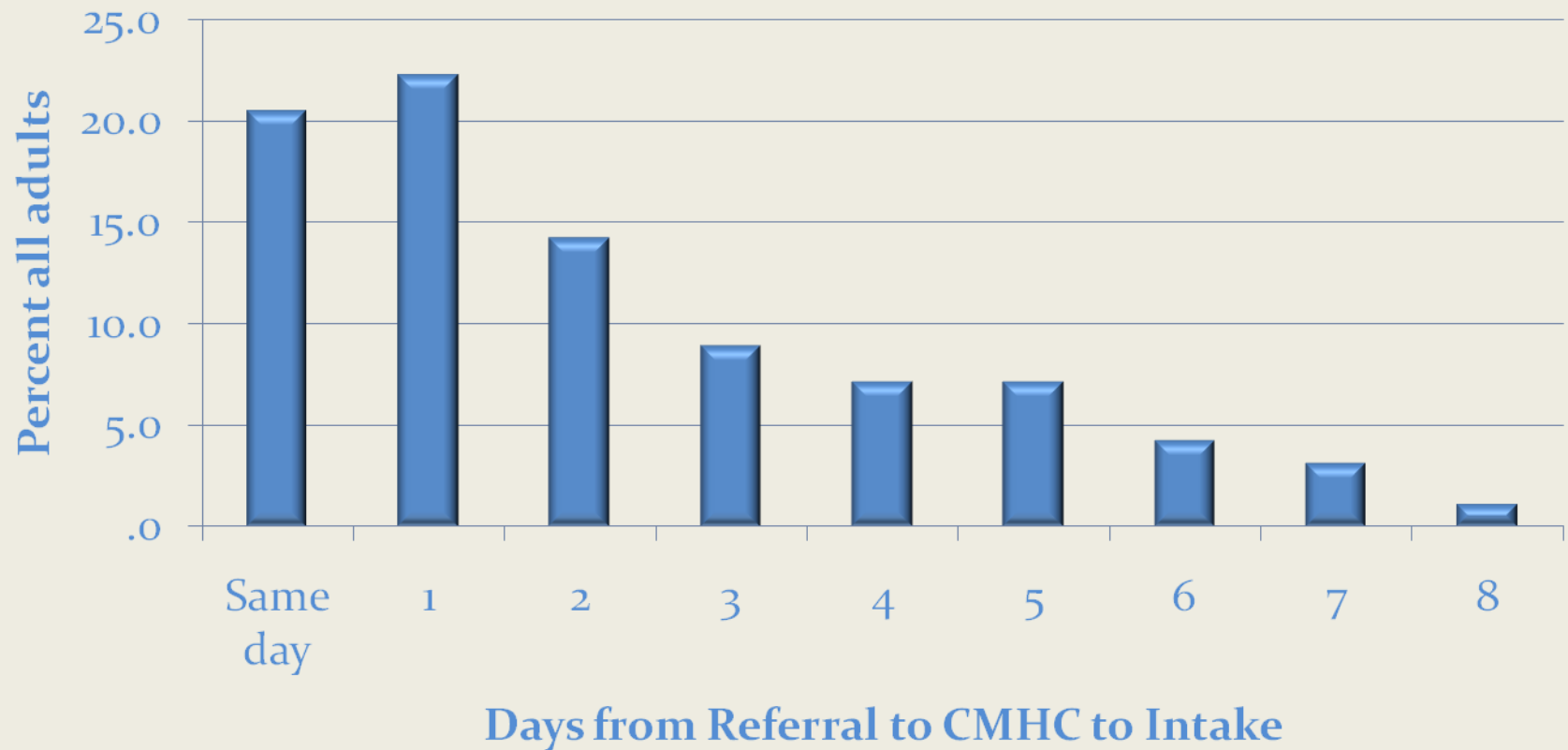
- **START attempts to maintain the children in the home whenever possible while working with the parents:**
 - Protective factors
 - Safety planning
 - Wraparound supports
 - Quick access to treatment
 - Sober caregiver/supervisor
 - Weekly visits; close monitoring



Child Placement Philosophy

- Placement is a shared decision that includes the family.
- Most children in START remain in home but, if an out of home care placement is needed, plan will aim to:
 - Keep child in the same county/community;
 - Place w/safe relatives or in a home setting;
 - Place children with siblings;
 - Set reunification as goal;
 - Ensure regular visits and contacts with parents; and
 - Train and support foster parents or relative caregivers.

Quick Access to SUD Treatment



90% go from Referral to Intake in 8 days

Family Mentors

- **A family mentor is a recovering individual who:**
 - Has maintained sobriety for at least 3 years; and
 - History with child protective services.
- The unique change agent within START is the teaming of a specially trained CPS worker with a family mentor.
- Family mentor engages family early and transports parent to first 4 treatment appointments.
- Provides accountability and recovery support to parents.
- Changes the office culture.



Behavioral Health Services

- Strong partnership between behavioral health service providers and CPS at state and local levels.
- Team works collaboratively to improve service delivery, overall practice and outcomes for families.
- Team and other community partners participate in ongoing joint and cross training.
- Use of evidence based practices.
- Weekly progress reports, close communication and crisis intervention in collaboration with START staff.
- Cross system data collection and sharing.

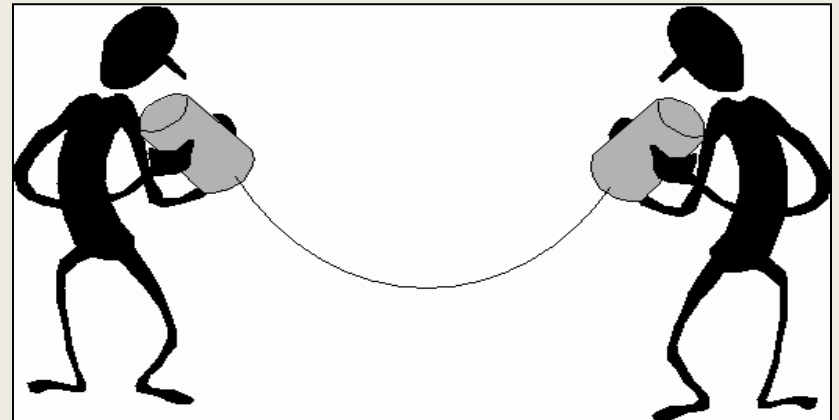
Using Evidence Based Practices

- Gender-specific groups
- Trauma-informed care
- Co-occurring Disorder Treatment
- Motivational Interviewing
- Cognitive Behavioral Therapy
- 12-step Facilitation Therapy
- Matrix Model
- Seeking Safety
- Relapse Prevention
- Living in Balance
- Helping Women/Men Recover
- Medication assisted treatment



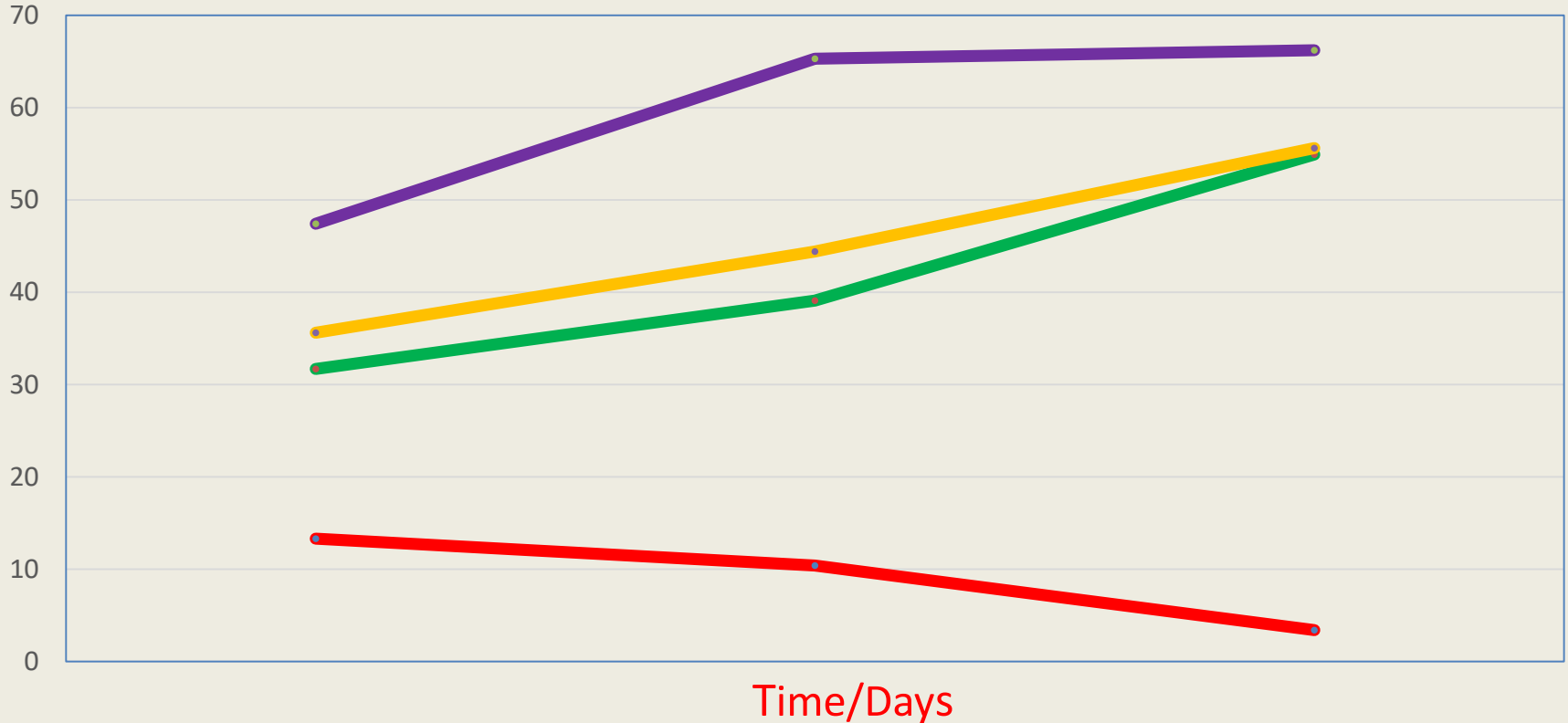
Communication is Key

- Weekly BH progress reports
- Phone/email if client no-shows or has a positive drug test or other child safety concern
- Family Team Meetings – being on same page in front of the client/family
- Cross Training
- Case consults
- Service Coordination
- Direct Line meetings
- Advisory and/or contract meetings
- Team building



Quick Access to SUDS Treatment and Parent and Child Outcomes

(n= 550 adults; 717 children -



—•— Days SUDS Referral to Intake —•— % Children Stay with Parent
—•— % Mother's Sobriety —•— % Father's Sobriety

• Huebner, R.A., Posze, L., Willauer, T.M., & Hall, M.T. (2015). Sobriety Treatment and Recovery Teams: Implementation fidelity and related outcomes. *Substance Use & Misuse*, 50(10), 1341-1350.

Main START Outcomes

- Women in START have higher rates of sobriety than their non-START child welfare-involved counterparts (66% vs. 36%)
- Children in START are 50% less likely to enter out-of-home placements than children from a matched comparison group
- At case closure, over 75% of children served by START remained with or were reunified with their parent(s)
- For every \$1 spent on START, \$2.52 is saved on out-of-home placement costs

Huebner, R.A., Willauer, T., and Posze, L. (2012). The impact of Sobriety Treatment and Recovery Teams (START) on family outcomes. *Families in Society*, 93(3), 196-203.



START Video:

From Kentucky Educational Television (KET)

Filmed in Ashland, KY

October 2014



KET

START in Rural Appalachia

Implementation and Outcomes



Four Kentucky START Sites: 3 State, 1 Grant Funded

<i>Characteristics</i>	<i>Jefferson (Louisville)</i>	<i>Kenton (Covington)</i>	<i>Martin (Inez)</i>	<i>Boyd (Ashland)</i>
Selection Criteria: At least	Infant-drug exposed	Child < = 3 years	Child < = 3 years	Child < = 5 years
Child Population (2007 census est.)	170,787	40,409	2,885	10,259
Annual # child victims with substance abuse risks (SFY 2009)	1794	435	217	200
% children living in poverty	19.0%	14.9%	58.1%	24%

Background and Context

- **Rural KY Appalachian counties:**
 - **Poverty rates as high as twice the national average** (U.S. Census Bureau, 2014)
 - **An epidemic of nonmedical prescription drug use** (Hall, Leukefeld, & Havens, 2013; Leukefeld et al., 2005; Wunsch, Nuzzo, Behonick, Massello, & Walsh, 2013; Young, Havens, & Leukefeld, 2012)
 - **Annual rates of child abuse and neglect (CA/N) as high as 5.4 per 100 children** (Kentucky Department for Community Based Services, 2012)

Background and Context

- **Barriers to treatment:**
 - **Distance** (Cummings, Wen, Ko, & Druss, 2014; Fortney, Rost, Zhang, & Warren, 1999)
 - Cultural factors may also be influential
 - Rural Appalachian values of individualism and self-reliance may play a role in limiting substance users' identification of a need for professional treatment (Leukefeld et al., 2005)
 - Troubled history between Appalachians and absentee land-owning corporations (e.g., coal, timber) are thought to have fostered skepticism of outsiders (Keefe, 1988)
 - Recent study: *geographic discordance* — receiving treatment in a location that is both geographically and socio-culturally different — increased the odds of relapse and incarceration 12 months after treatment entry (Oser & Harp, 2014)

Method

- **2007:** Children's Bureau awarded a Regional Partnership Grant (RPG) to the Kentucky Department for Community Based Services (DCBS), the state's public child welfare system, to develop a START program in Martin County, Kentucky.
- **2008:** After 1 year of training and infrastructure building, the program began accepting families.
- **2 evaluation components:**
 1. Process evaluation
 2. Outcome evaluation

Process Evaluation and Fidelity Assessment

- Four key domains assessed:
 1. Community collaboration, measured by pre- and post-test Collaborative Capacity Instrument (CCI)
 2. Family participation in mental health services
 3. Type and duration of drug addiction treatment
 4. Amount of family mentor contacts
- Fidelity to quick-access service delivery standards
- Analysis of meeting and training notes

Outcome Evaluation

- Quasi-experimental design featuring families served by START in Martin County and a matched control group of families selected from two contiguous counties.
 - All three counties:
 1. Experienced high rates of substance use and CA/N
 2. Were served by the same family court judge and community mental health center

Outcome Evaluation

Four primary outcomes were assessed:

1. Children entering and exiting state custody.
 - Duration of the START program with follow-up to December 2012
2. Recurrence of child maltreatment.
 - Substantiation within six months of the first substantiation
3. Reentry into foster care.
 - Placed in foster care at any point during the evaluation period and then re-entered foster care up to 12 months later
4. Cost avoidance.

Result: Process Evaluation

- **Obstacles encountered:**

1. Limited infrastructure needed to establish fidelity to the START program model
 - Example:
 - No intensive outpatient addiction treatment, and only 1 recovery support group, when project was initiated
2. Negative attitudes about collaboration
 - Example:
 - Tension and mistrust between the local addiction treatment provider and CPS agencies
3. Early on, when 2 eligible cases were referred simultaneously, START workers selected the case with greatest need

Results: Process Evaluation

- 67 families served
 - 57 couples (85% of caregivers)
 - 66 biological mothers, 45 biological fathers
- Average adult age: 29.2 years
- Almost exclusively White (99.2%)
- Full or part-time employment at time of referral:
 - females (8.6%), males (42.4%)

Results: Process Evaluation

- Adults reported problematic use of 3.2 substances on average.
- Most commonly used substances were:
 - Opioids (76.6%)
 - Benzodiazepines (60.2%)
 - Barbiturates (38.3%)
 - Marijuana (38.35)

Results: Process Evaluation

- 153 children served (79 girls, 74 boys)
 - 30% under 1 month old at time of referral
- 80.2% received developmental services
- 66.7% received educational services (e.g., Head Start)
- 69.3% received mental health services
- 80.4% received medical services

Results: Type and Duration of Addiction Treatment Services for START adults

	<i>n</i> (%)	Average Number of Sessions	Average Months Duration
Detoxification	10.9%	N/A	N/A
Long-Term Residential	40.3%	51.0 ^a	1.8
Intensive Outpatient	66.4%	25.4 ^b	6.7
Outpatient Services	52.1%	24.5 ^c	10.0
Case Management	86.4%	29.7 ^d	7.9

Note. N/A = not applicable.

^a*Residential sessions included at least 6 hours of programming per day.*

^b*Intensive outpatient sessions included at least 2 hours of programming per day.*

^c*Outpatient sessions included 1–2 hours of programming.*

^d*Case management sessions were highly variable, ranging from 15 minutes to all day.*

Results: Recovery Mentor Contacts in Closed Martin Co. Cases ($N = 67$)

	Average (<i>M</i> , <i>SD</i>)	Minimum #	Maximum #
Months Served	18.5 (11.4)	1.4	49.4
Number of Mentor Contacts	74.4 (44.5)	15.0	189.0
Total Mentor Hours Spent with Family	70.2 (40.3)	14.7	167.7
Intensity: Average Number of Mentor Contacts with Family per Month Served	4.5 (1.9)	0.9	11.5

Results: Participation in Mental Health & Psychiatric Services

Nearly 85% of adults served by START-Martin County received mental health services;

Only 22.5% of adults in the matched control group received services ($\chi^2 (1) = 166.2, p < .001$).

Outcome Results for Children served by START-Martin County and Matched Control

	START-Martin (<i>n</i> = 153)	Matched Control (<i>n</i> = 345)	Results
Children entering state custody, <i>n</i> (%)	49 (32.0%)	93 (27.0%)	$\chi^2 (1) = 1.3, p = .25$
Children discharged from state custody by 12/2012, <i>n</i> (%)	29 (59.2%)	68 (73.1%)	$\chi^2 (1) = .04, p = .84$
Recurrence of CA/N within 6 months, <i>n</i> (%)	7 (4.6%)	35 (10.1%)	$\chi^2 (1) = 4.3, p < .05$
Reentered foster care within 12 months, <i>n</i> (%)	0 (0.0%)	9 (13.2%)	$\chi^2 (1) = 4.1, p < .05$
<i>Note: CA/N = child abuse/neglect.</i>			

Out of Home Care (OOHC) Cost Avoidance

- Of 153 children served by START, 49 (32%) were placed in OOHC
- Given an OOHC rate of 40%, typical in KY, 61 children served by START might be expected to have been placed in OOHC were it not for the program
- Assuming OOHC costs of \$30,000 per child, the difference of 12 children is a cost avoidance of \$366,000

Overcoming Barriers in Rural Appalachian (Martin) County

- “Pockets in Central Appalachia have 3x the national poverty rate, an epidemic of prescription drug abuse, the shortest life span in the nation”
(Diane Sawyer, 2009)
- Treatment providers struggle financially in rural areas due to sparse and isolated populations that are a barrier to economy of scale; there are fewer credentialed individuals

Overcoming Barriers to START Implementation in Rural Appalachian (Martin) County

- Building community readiness and supports for sober living
- Overcoming myths about addiction, child abuse, accountability and treatment
- Creating hope that treatment can work
- Family mentors were a catalyst for change through education and developing recovery support groups and town hall meetings
- Went from 1 fledging recovery support group to 12 weekly 12-step or other recovery support groups

Lessons Learned

- Assess leadership readiness
- Survey community resources and infrastructure
- Develop realistic timelines
 - Longer start-up periods may be required to accommodate infrastructure development and leadership readiness
- Build incrementally and collaboratively
 - Certain START practices, such as keeping children with their family during treatment, were contrary to the belief that removing children motivates parents that are addicted toward sobriety
- Provide consistent messaging to dispel myths and mistrust

Conclusions:

- In spite of significant challenges, the 6-month recurrence rate of CA/N among children served by START was half that of children in the matched control group
- Additionally, 0% of children served by START reentered OOHC, compared to 13% of children in the matched control group
- Under-resourced areas with substantial needs should not be abandoned – instead, such areas should be targeted – but with the understanding that additional time and support may be required to ensure success

Acknowledgements

- The START program and its evaluation were partially supported by the Children's Bureau (An Office of the Administration for Children & Families, U.S. Department of Health and Human Services) under Regional Partnership Grant CU90045.
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- Special thanks to all the DCBS and Behavioral Health agency leaders, addiction treatment providers, child welfare teams, technology and data managers, court personnel and many community partners who worked diligently to make the START program and evaluation possible.

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- Huebner, R.A., Willauer, T., and Posze, L. (2012). The impact of Sobriety Treatment and Recovery Teams (START) of family outcomes. *Families in Society*, 93(3), 196-203.
- Posze, L., Huebner, R.A., and Willauer, T. (2013). Rebuilding a family bond. *Addiction Professional*.
- Effective Collaborative Strategies for Families in the Child Welfare System., November 2016. National Center on Substance Abuse and Child Welfare.
- START is recognized on the California Evidence Based Clearinghouse for Child Welfare (CEBC):
 - <http://www.cebc4cw.org/program/sobriety-treatment-and-recovery-teams/detailed>

A scenic landscape featuring a two-lane asphalt road that curves gently to the right. The road is bordered by a gravel shoulder on the left and a concrete curb on the right. Beyond the road, there is a vast field of bright yellow flowers, likely rapeseed, stretching to the horizon. A small, leafy green bush stands near the road's edge. The sky is a vibrant blue, filled with large, fluffy white clouds. A bright sun is positioned on the far left, creating a strong lens flare that radiates across the scene.

Resources

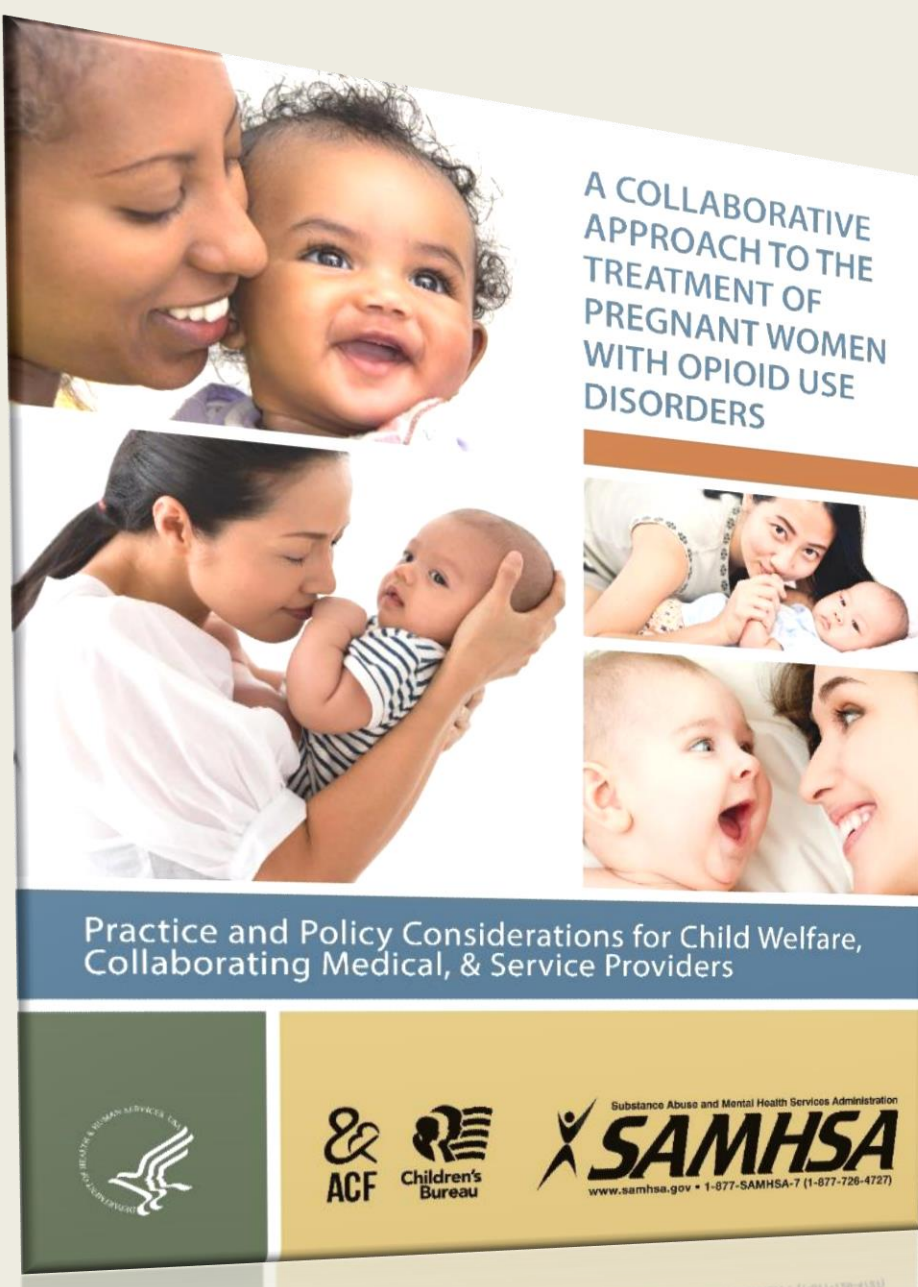
Purpose: Support the efforts of States, Tribes and local communities in addressing the needs of pregnant women with opioid use disorders and their infants and families

Audience

- Child Welfare
- Substance Use Treatment
- Medication Assisted Treatment Providers
- OB/GYN
- Pediatricians
- Neonatologists

National Workgroup

- 40 professionals across disciplines
- Provided promising and best practices; input; and feedback over 24 months.



Available for download here:

https://www.ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf

Understanding Treatment of Opioid Use Disorders in Pregnancy

III) Treatment of Opioid Use Disorders in Pregnancy

These resources offer guidelines for the use of MAT to treatment opioid use disorders in pregnancy and the post-partum period. Included is information on dosing during pregnancy, breastfeeding while using MAT and the use of buprenorphine with pregnant women. Also included are resources on the treatment of other substance use disorders in pregnancy.

- *American Congress of Obstetricians and Gynecologists (ACOG), Committee on Health Care for Underserved Women and the American Society of Addiction Medicine (ASAM): Committee Opinion, Opioid Abuse, Dependence and Addiction in Pregnancy* www.acog.org
- *Studies on the use of methadone and buprenorphine for the treatment of opioid use disorders during pregnancy:*
 - *Maternal Opioid Treatment: Human Experimental Research (MOTHER) – approach, issues and lessons learned.* Jones, et al, 2010. A National Institute on Drug Abuse (NIDA)-supported clinical trial that examined the use of methadone and buprenorphine maintenance therapy during pregnancy. No significant difference was found with respect to any serious maternal or neonatal adverse events. <http://www.ncbi.nlm.nih.gov/pubmed/23106924>
 - *A Cohort Comparison of Buprenorphine versus Methadone Treatment for Neonatal Abstinence Syndrome.* Hall, et al, 2016. [http://www.jpeds.com/article/S0022-3476\(15\)01451-1/abstract](http://www.jpeds.com/article/S0022-3476(15)01451-1/abstract)
- *Medication Assisted Treatment During Pregnancy, Postnatal and Beyond:* Discusses the needs of pregnant women seeking medication assisted treatment. Karol Kaltenbach, PhD presents findings from the Maternal Opioid Treatment: Human Experimental Research (MOTHER) project. Facilitated as part of a webinar series – see the textbox, *National Center on Substance Abuse and Child Welfare:*

National Center on Substance Abuse and Child Welfare
Webinar Series
The following are selected webinars from the series. Contact NCSACW for additional information.

- 1) Medication Assisted Treatment for Families Affected by Substance Abuse Disorders
<http://www.cffutures.org/presentations/webinars/medication-assisted-treatment-families-affected-substance-abuse-disorders>
- 2) Medication Assisted Treatment During Pregnancy, Postnatal and Beyond
<http://www.cffutures.org/presentations/webinars/medication-assisted-treatment-during-pregnancy-postnatal-and-beyond>
- 3) Opioid Use in Pregnancy: A Community's Approach, The Children and Recovery Mothers (CHARM) Collaborative
<http://www.cffutures.org/presentations/webinars/opioid-use-pregnancy-communitys-approach-children-and-recovering-mothers-charm>
- 4) The Use of Medication-assisted Treatment during Pregnancy: Clinical Research Update
<https://cff-ncsacw.adobeconnect.com/p5okpdez3l/>
- 5) Substance Use in Pregnancy, The OB/GYN Perspective
<http://www.cffutures.org/presentations/webinars/substance-use-pregnancy-obgyn-perspective>
- 6) Treatment of Opioid Use Disorders in Pregnancy and Infants Affected by Neonatal Abstinence Syndrome
<http://www.cffutures.org/presentations/webinars/opioid-use-disorders-and-treatment-pregnancy-webinar>
- 7) In-Depth Technical Assistance for Substance Exposed Infants (SEI) Conversations Across Six SEI-IDTA Sites

Medication Assisted Treatment During Pregnancy, Postnatal and Beyond

<http://www.cffutures.com/presentations/webinars/medication-assisted-treatment-during-pregnancy-postnatal-and-beyond>

The Use of Medication-assisted Treatment during Pregnancy: Clinical Research Update

<https://cff-ncsacw.adobeconnect.com/p5okpdez3l/>

Treatment of Opioid Use Disorders in Pregnancy and Infants Affected by Neonatal Abstinence Syndrome

<http://www.cffutures.org/presentations/webinars/opioid-use-disorders-and-treatment-pregnancy-webinar>

NCSACW Online Resources

Please visit:

<https://ncsacw.samhsa.gov>

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Home » Training » Tutorials » Tutorial 2: Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals

OVERVIEW **MODULES** ASSESSMENT RESOURCES CERTIFICATE

Module 1: Primer on Substance Use Disorders for Child Welfare Professionals

Objectives

- Alcohol and Other Drugs
- Pathways from Use to Addiction
- Diagnosis
- Adverse Effects
- Trauma and Substance Use Disorders
- Recovery

Module One: Primer on Substance Use Disorders for Child Welfare Professionals

Participant Objectives of Module One

After reviewing this module, child welfare professionals will:

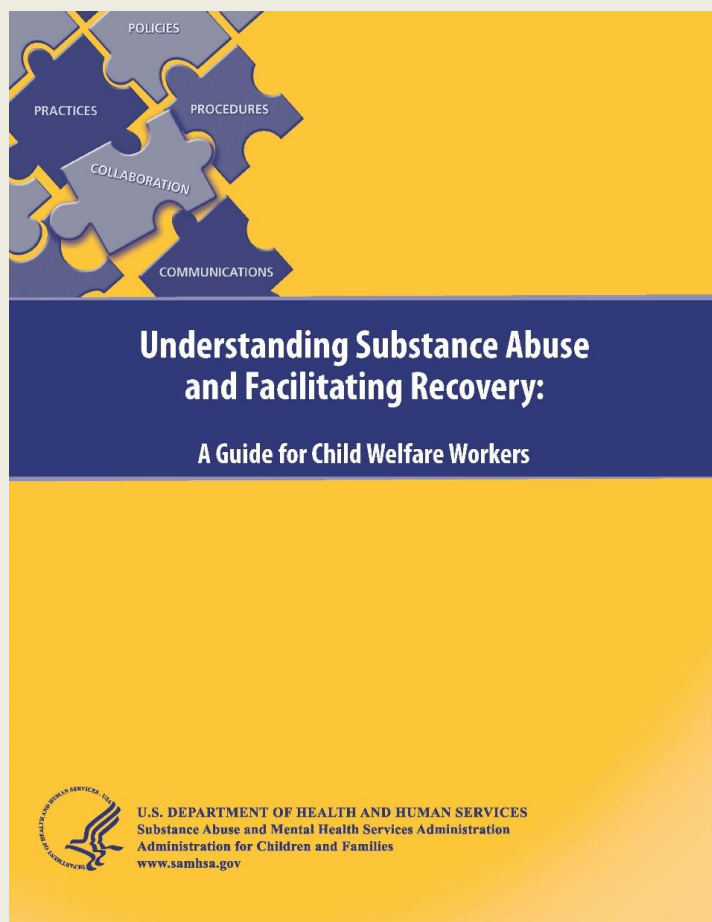
- Understand substance use disorders as a disease that impacts the brain.
- Understand the impact of substance use disorders on family relationships.
- Understand how substance use disorders are diagnosed.
- Gain the critical context needed to understand parents with substance use disorders, and to effectively manage the challenges faced by the parents and their children.

Module 2: Engaging Families in Substance Abuse Treatment

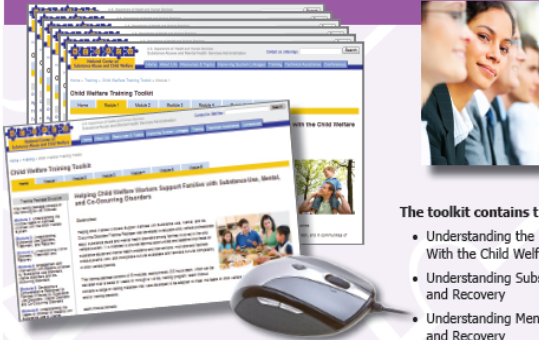
Module 3: Substance Use

Page 1 of 2

Understanding Substance Use and Facilitating Recovery: A Guide for Child Welfare Works



What You Need To Know About Substance Abuse and Mental Health Disorders To Help Families in Child Welfare.



Helping Child Welfare Professionals Support Families With Substance Use, Mental, and Co-Occurring Disorders Training Toolkit

This toolkit is designed to help educate pre-service or in-service child welfare professionals about substance abuse and mental health disorders that exist among families in the child welfare system. It is intended to provide learning opportunities and baseline knowledge on substance abuse and mental health problems and interventions, motivate and facilitate cross-systems work, and incorporate cultural awareness and facilitate cultural competency in child welfare practice.

The toolkit contains the following six modules:

- Understanding the Multiple Needs of Families Involved With the Child Welfare System
- Understanding Substance Use Disorders, Treatment, and Recovery
- Understanding Mental Disorders, Treatment, and Recovery
- Engagement and Intervention With Parents Affected by Substance Use Disorders, Mental Disorders, and Co-Occurring Disorders
- Developing a Comprehensive Response for Families Affected by Substance Use Disorders, Mental Disorders, and Co-Occurring Disorders
- Understanding the Needs of Children of Parents With Substance Use or Mental Disorders

Each module is approximately 2–3 hours and can be delivered over a series of weeks or through a 1–2 day training program. The modules each contain an agenda, training plan, training script, PowerPoint presentation, case vignettes, handouts, and reading materials. References include a trainer glossary, training guide, and a bibliography.

Don't miss out on this valuable product!
Get your FREE toolkit today!

Modules can be downloaded individually or as a package at <http://www.ncsacw.samhsa.gov/training/toolkit/>.

PUBLICATIONS ON IMPROVING COLLABORATION (CONTINUED)

Introduction to Cross-System Data Sources in Child Welfare, Alcohol and Other Drug Services, and Courts



An overview of the primary data reporting systems across the three agencies. It can be used to help identify the prevalence of substance abuse and child welfare issues and measure outcomes for families receiving substance abuse treatment and child welfare services.

Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services With Child Welfare (TAP 27)

An overview of the challenges and opportunities that various State and county-level jurisdictions experienced while building collaboration across the child welfare, substance abuse, and dependency court systems.

TRAINING AND STAFF DEVELOPMENT RESOURCES

Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers



An indispensable tool for anyone new to the child welfare system. It explains how to recognize substance abuse, motivate families to seek treatment, and facilitate cross-system collaboration.

Child Welfare Training Toolkit: Helping Child Welfare Workers Support Families with Substance Use, Mental, and Co-Occurring Disorders



A trainer's guide to educate child welfare professionals about substance use and mental health disorders. The kit contains six modules, each with a training plan, trainer scripts with PowerPoint slides, handouts, case vignettes, and training guidelines to facilitate discussions.

To download these publications, go to <http://www.ncsacw.samhsa.gov> and <http://www.childwelfare.gov/index.cfm>. Some publications are available in hard copy and can be ordered at <http://store.samhsa.gov/home> or by calling 1-877-726-4727.

ONLINE TRAINING COURSES

All online courses are free and intended for anyone working with families involved with the child welfare, substance abuse, and court systems. The trainings take about 4 hours to complete and can be stopped and started as needed. A certificate is awarded upon completion, and FREE continuing education unit (CEU) or continuing legal education (CLE) can be credited for each course.

Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals

An online course that provides information to treatment professionals so that they better understand how child welfare and family dependency court requirements affect parents in treatment. It offers strategies for effectively collaborating with child welfare agencies. This course is approved by the National Association of Addiction Professionals to provide four CEUs.

Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals

OTHER RESOURCES

Substance-Exposed Infants: State Responses to the Problem



An overview of selected State policies and practices to address the needs of infants exposed to substances prenatally. A 5-point intervention framework is provided, which serves as a model for others and explains how to evaluate existing programs and identify gaps in services.

Drug Testing in Child Welfare: Practice and Policy Considerations



An excellent reference to help policymakers and program managers incorporate drug testing policies and procedures into their agency's comprehensive family and child welfare assessment protocol. This publication includes an overview of drug testing methods and an appendix with a sample drug testing policy form.

OTHER RESOURCES (CONTINUED)

Funding Comprehensive Services for Families With Substance Use Disorders in Child Welfare and Dependency Courts

A look at existing resources for providing comprehensive services to families with substance use disorders.

Family-Centered Treatment for Women With Substance Use Disorders—History, Key Elements, and Challenges

An introduction to the concept of family-centered treatment for women and their families, including application of various treatment modalities and strategies to overcome commonly encountered barriers.

Funding Family-Centered Treatment for Women With Substance Use Disorders

A resource paper that helps treatment providers and State substance abuse agencies identify and access potential sources of funding for comprehensive family-centered treatment. It is a companion to *Family-Centered for Women With Substance Use Disorders—History, Key Elements, and Challenges*.

A Review of Alcohol and Drug Issues in the States' Child and Family Service Reviews (CFSRs) and Program Improvement Plans (PIPs)

A summary and analysis of substance abuse issues from CFSRs and PIPs in all 50 States, the District of Columbia, and Puerto Rico.

Annotated Bibliography on Cross-System Issues

A bibliography including major literature and research papers on cross-system issues involving child welfare, substance use disorders, and dependency courts.

Methamphetamine Addiction, Treatment, and Outcomes: Implications for Child Welfare Workers

The latest, up-to-date research on parental use of methamphetamine and its effects on children and families.

Methamphetamine Resource List

A comprehensive list of all the methamphetamine resources available through the various agencies and associated organizations.

Get a **FREE** copy of these tools and protocols today!

To download these publications, go to <http://www.ncsacw.samhsa.gov> and <http://www.childwelfare.gov/index.cfm>.

Some publications are available in hard copy and can be ordered at <http://store.samhsa.gov/home> or by calling 1-877-726-4727.



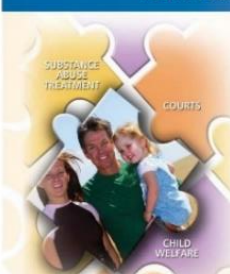
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Visit our Web site at
<http://www.ncsacw.samhsa.gov>
For assistance, call 866-493-2758.



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Substance Abuse and Mental Health Services Administration
Administration for Children and Families

Additional Resources

National Center on Substance Abuse and Child Welfare Technical Assistance Products



PUBLICATIONS ON IMPROVING COLLABORATION

Screening and Assessment for Family Engagement, Retention and Recovery (SAFER)



This step-by-step guide provides a framework to strengthen screening and assessment practices while building a collaborative team among the child welfare, substance abuse, and dependency court systems. Appendices include examples of screening and assessment tools, factsheets, and information about confidentiality.

Facilitating Cross-System Collaboration: A Primer on Child Welfare, Alcohol and Other Drug Services, and Courts



An essential reference providing an introduction to each of the child welfare, substance abuse, and court systems. It helps professionals become familiar with the operations of the other organizations that also serve their clients.

NCSACW demonstrates the importance of cross-system collaboration among the child welfare, substance abuse treatment, and court systems by providing materials that document current best practices and policies from across the country. The following products are all available FREE online or via the U.S. mail.



National Center on Substance Abuse and Child Welfare
Visit our Web site at
<http://www.ncsacw.samhsa.gov>
For assistance, call 866-493-2758.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Administration for Children and Families



*Improving
Family
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