Successful Substance Use and Therapeutic Program Elements for Young Children and Families in Child Welfare

The Sobriety Treatment and Recovery Teams Program

CWLA 2016 National Conference
August 1, 2016

START

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Objectives

1. Provide a national perspective on young children's involvement in child welfare, including for family substance use, and the landscape of programs designed to meet their needs.
2. Review the main intervention components of the Sobriety Treatment and Recovery Teams (START) model.
3. Describe outcomes of START model in a rural Appalachian county.
    I. Report on the process evaluation assessing fidelity to the START model.
    II. Report proximal and distal child abuse, neglect and treatment outcomes for START program participants and a matched comparison group.
4. Describe lessons learned about implementation, readiness work required, and adaptation of START in an area with a very limited infrastructure.

SAFE**STRONG**SUPPORTIVE

CASEY FAMILY PROGRAMS

VISION A nation where supportive communities nurture the safety, success and hope of every child

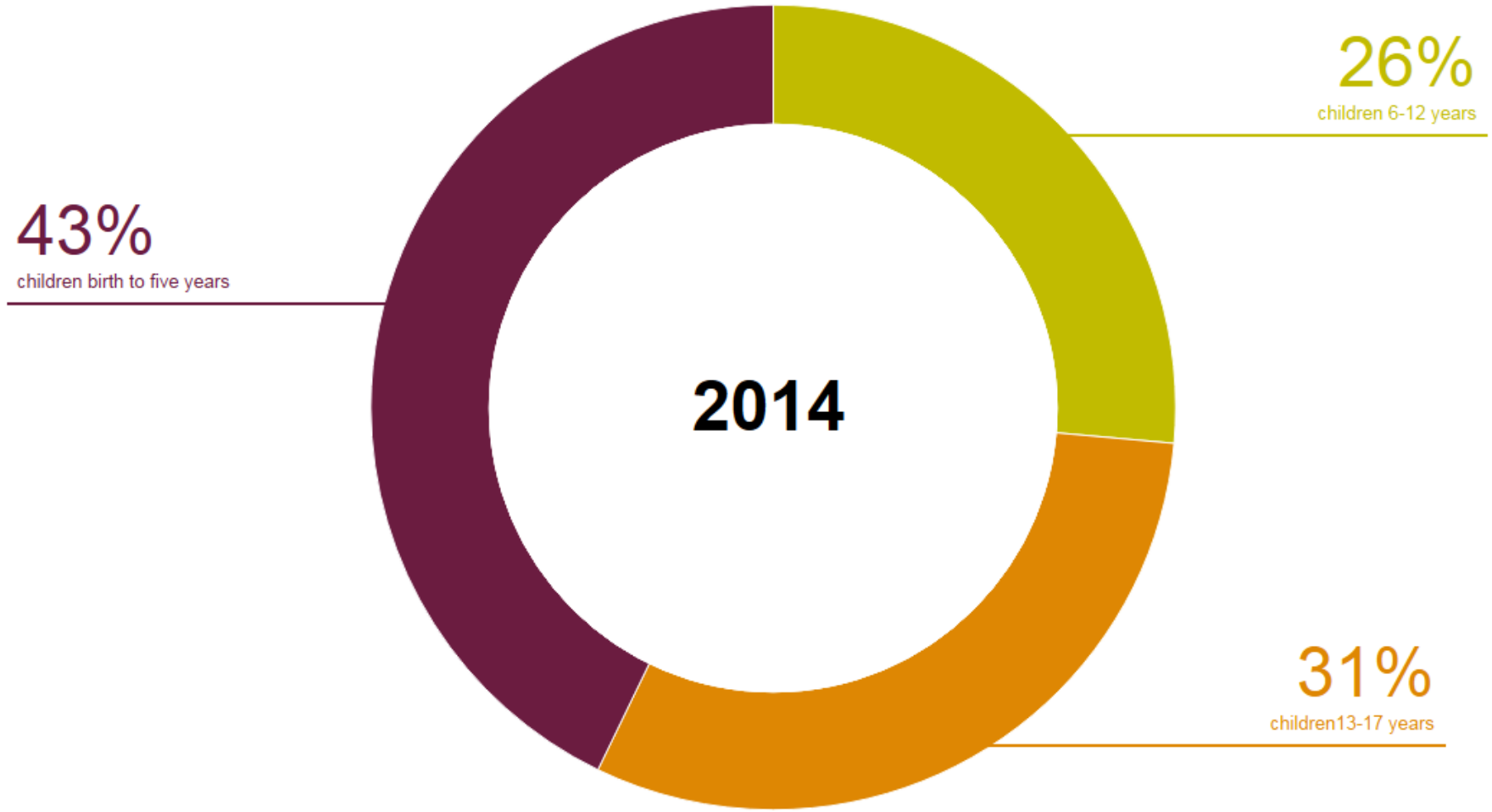
MISSION Our mission is to provide and improve – and ultimately prevent the need for – foster care

Young Children in Foster Care

Substance use and neglect as key factors

CHILDREN ENTERING OUT-OF-HOME CARE IN KENTUCKY

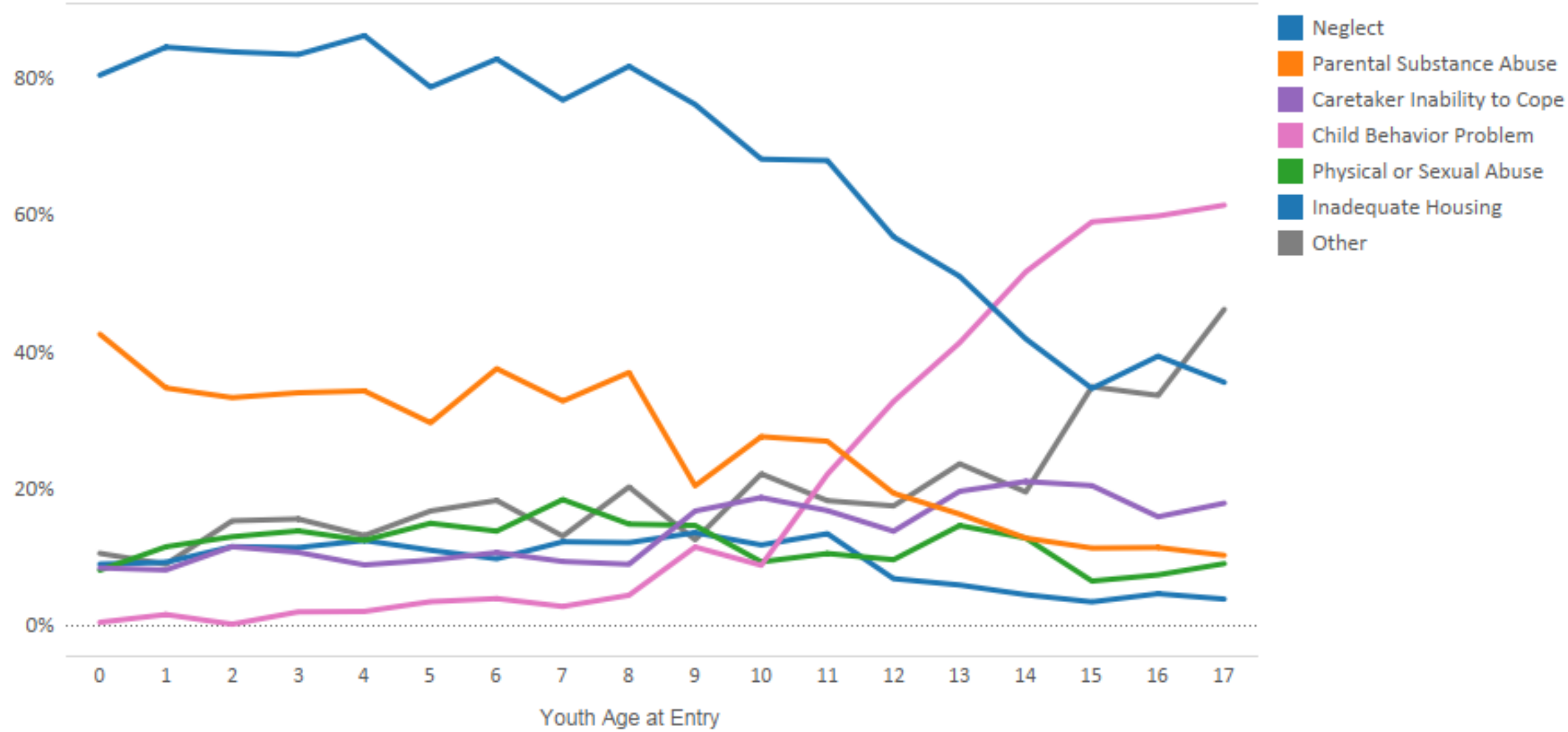
By age group at entry, FY2014



Produced by Casey Family Programs, Data Advocacy. Data source: AFCARS national file.

REASONS CHILDREN ENTER CARE IN KENTUCKY

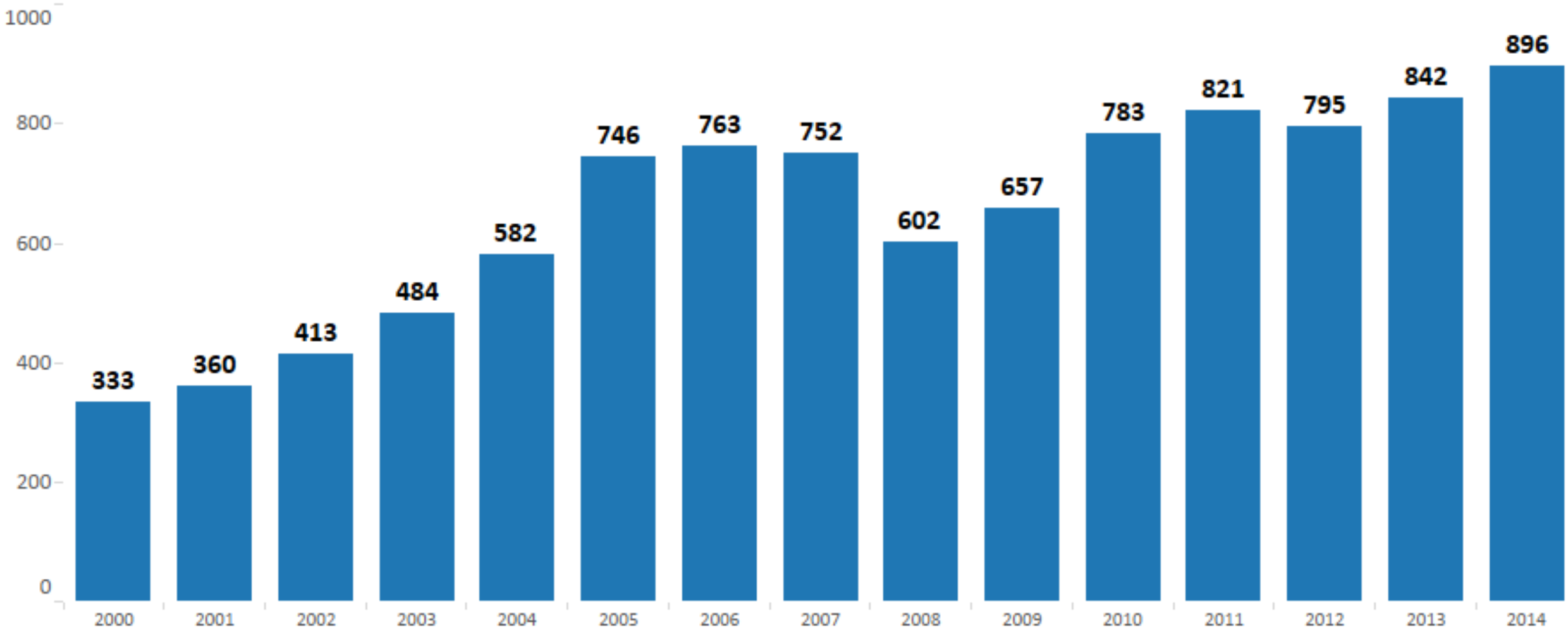
By age at entry, FY2014



Produced by Casey Family Programs, Data Advocacy. Data source: AFCARS national file.

of children entering care with parental substance abuse as a removal reason, 0-5 years old in Kentucky*

(alone or in combination with other reasons)



* Children enter care for many reasons. These categories represent the standard removal reasons states provide as part of their required AFCARS submission. How states utlize these standard fields, and whether or not they use all fields, is impacted by two key things: 1) how the removal reasons in their case management system are mapped to these categories; and 2) how caseworkers are instructed to determine removal reasons for a child. State policy and practice vary.

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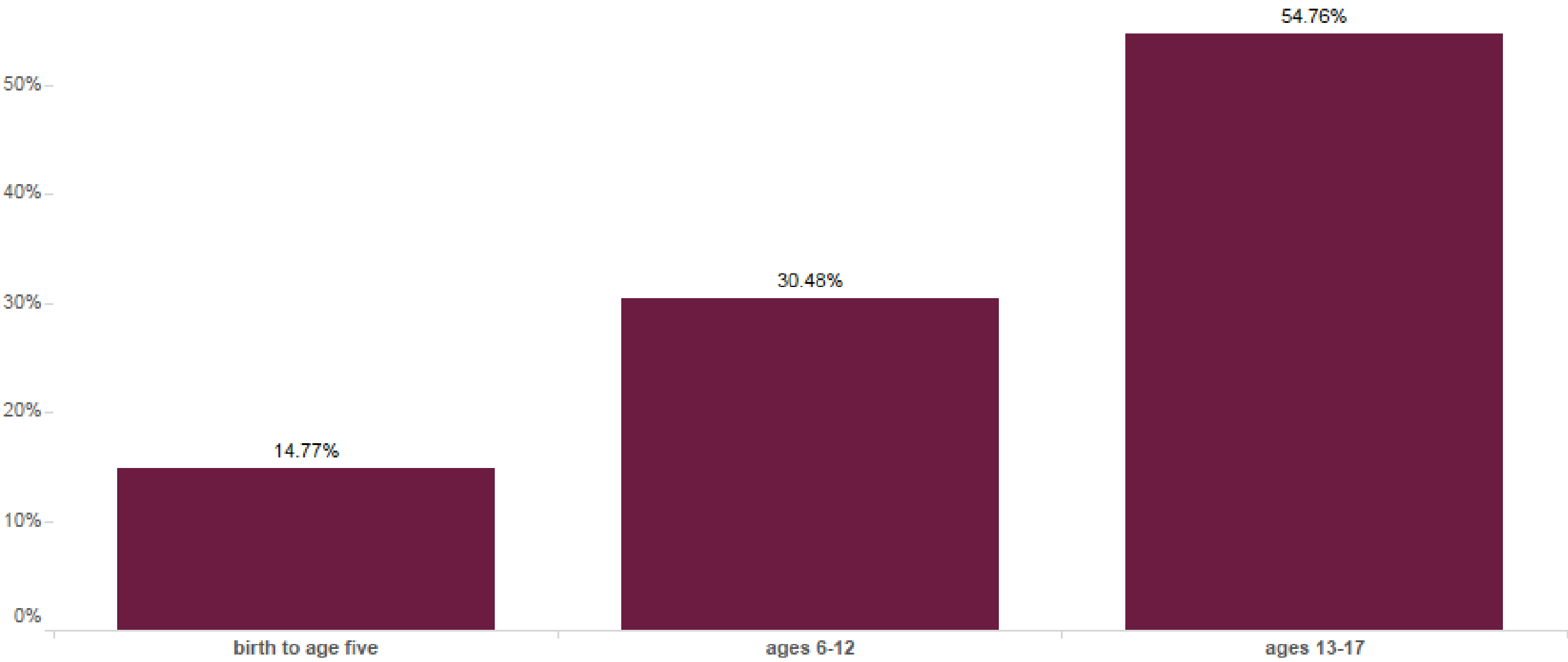
AGE AT FIRST ENTRY INTO CARE IN KENTUCKY

For all teenagers currently in care, FY2014



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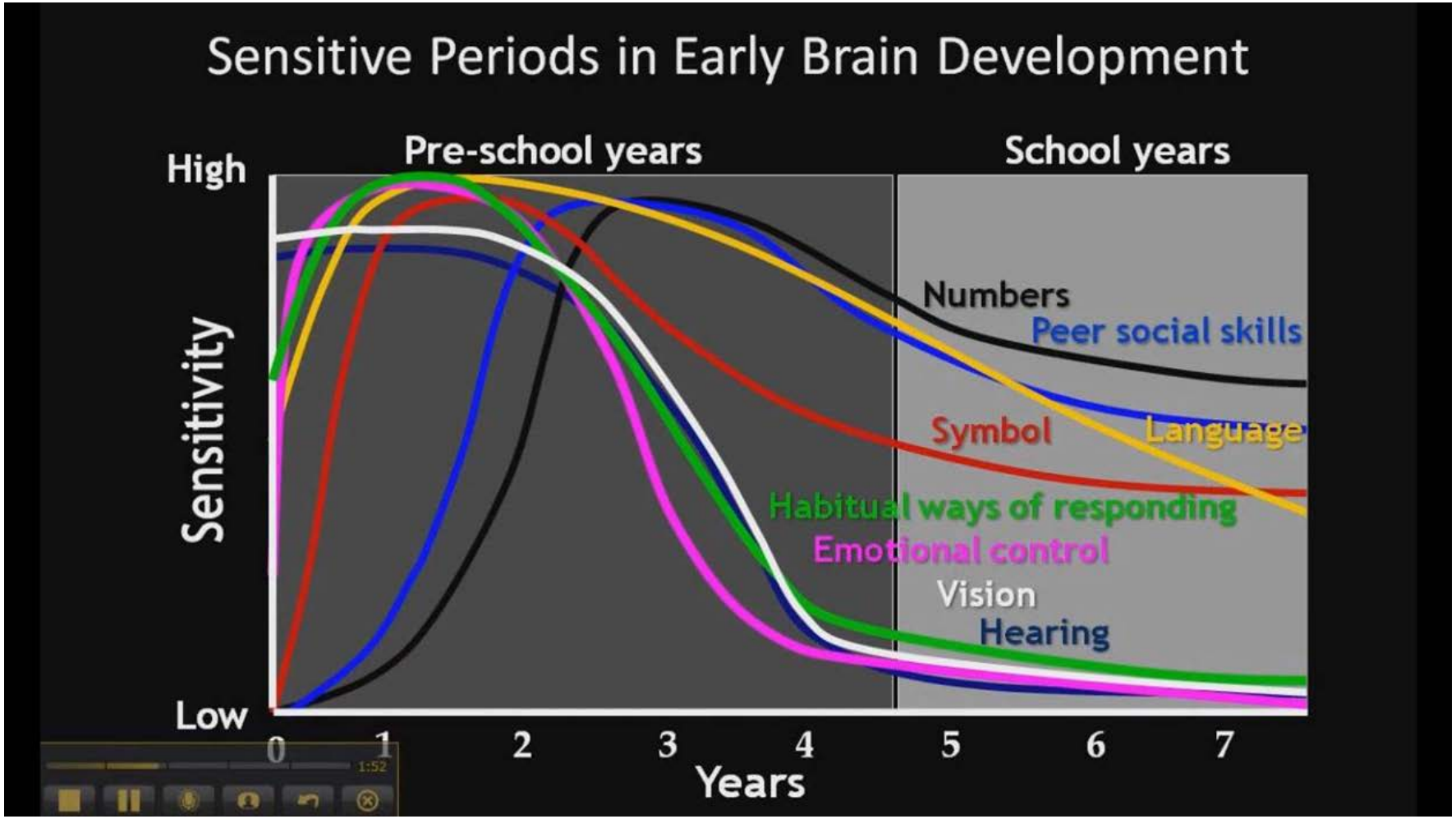
Early Childhood Matters…A Lot



Source: Human Early Learning Partnership (HELP), University of British Columbia.

https://www.youtube.com/channel/UC45uY3htHCOBKkqjxQxIHIA

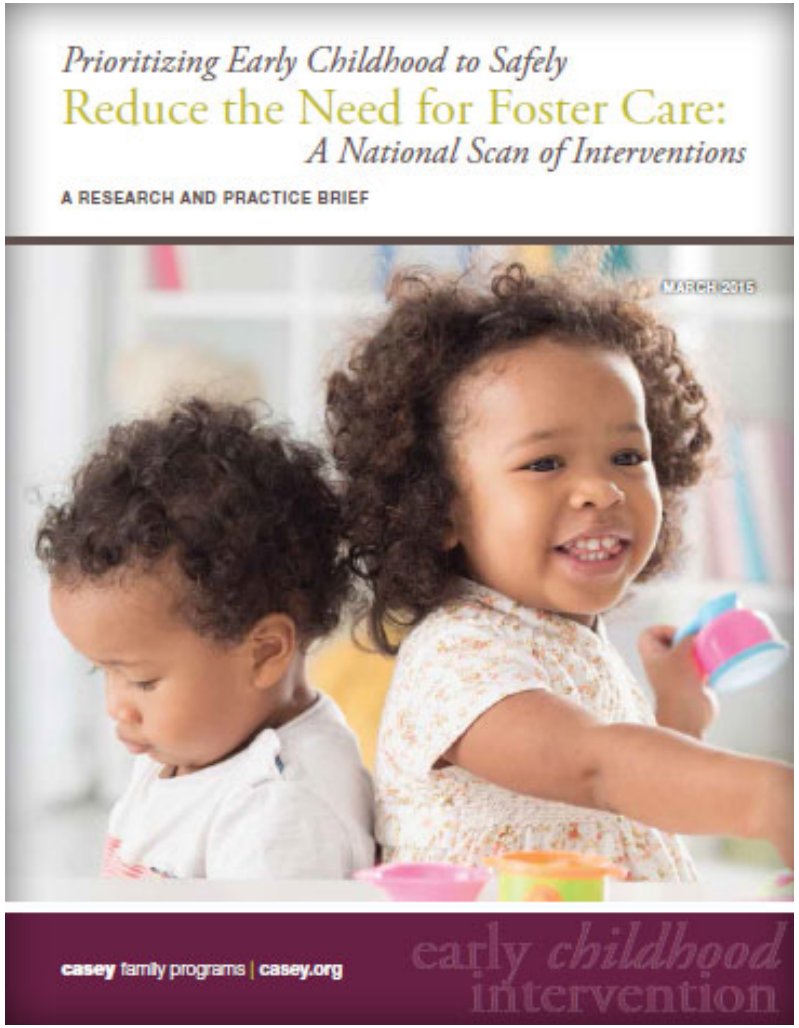
And, yet, young children…

- experience longer stays in out-of-home care
- are more likely to experience repeat maltreatment
- have an enduring pattern of long-term system involvement

Young Children are Vulnerable

- Almost 44% of all *fatalities from maltreatment* are infants

- CPS contact during infancy predicts greater likelihood of intentional and unintentional injury deaths



Need for Effective Interventions

- Eastern Band of Cherokee Indians: Safe Babies Program
- Parent Child Assistance Program (PCAP)
- Juvenile Dependency Wellness Court (DWC)
- Childhaven
- Developmental Repair

http://www.casey.org/prioritizing-early-childhood-safely/

Sobriety Treatment and Recovery Teams

Program Overview

Substance Use and Child Maltreatment

- **Research shows that children with parents who abuse alcohol or drugs are more likely to experience abuse or neglect than children in other households** *(Dube et al.,2001; Hanson et al., 2006).*

- **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).*

- **Nationally, one-third to two-thirds of child maltreatment cases involve some type of substance use.** *(Childwelfare.gov, 2013).*

Substance Use and Child Maltreatment

- Nationally, 8.3 million children live with at least one parent who has abused or was dependent on alcohol or drugs *(NSDUH, 2007).*
    - 13.9% of these children ages 0-2
    - 13.6% of these children ages 3-5

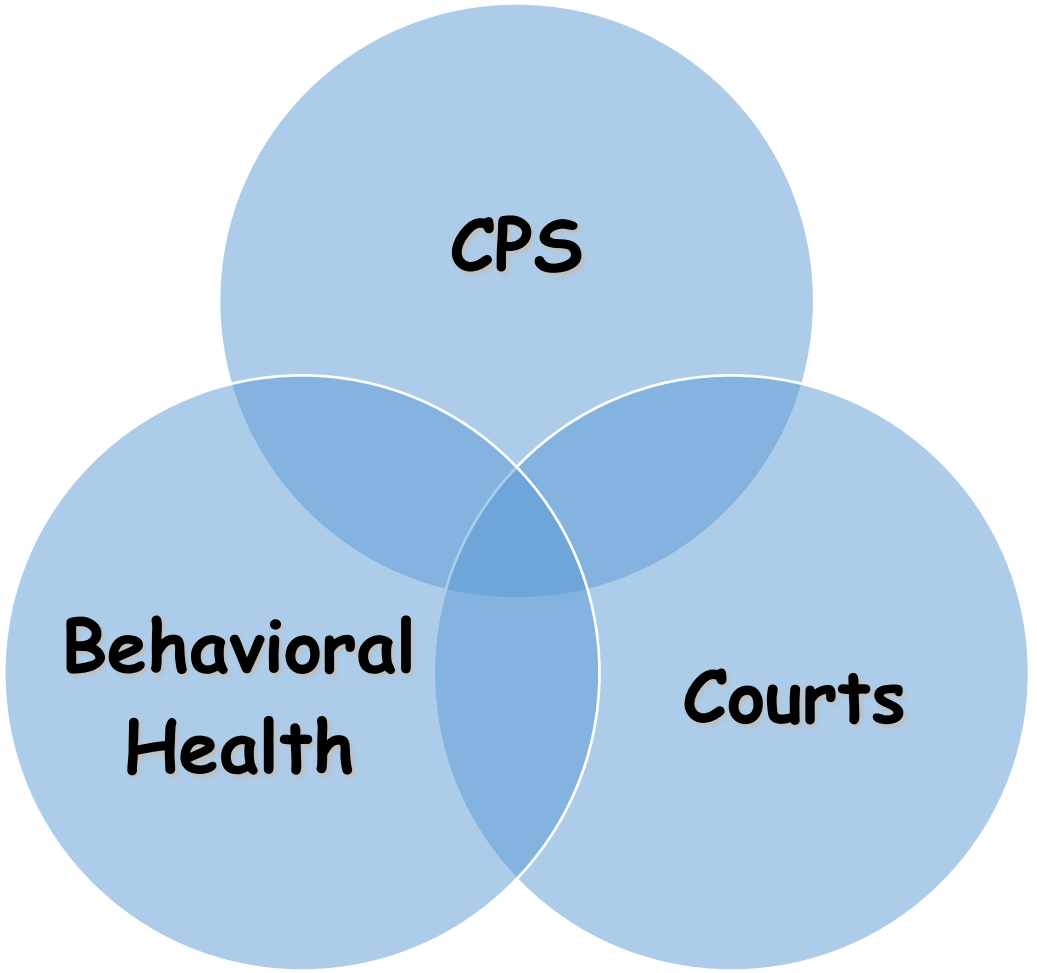
- Maltreated children of substance abusing parents remain in the child welfare system longer and experience poorer outcomes *(GAO, 2003).*

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 abuse treatment
- Time for staff to respond to the other four clocks

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.**

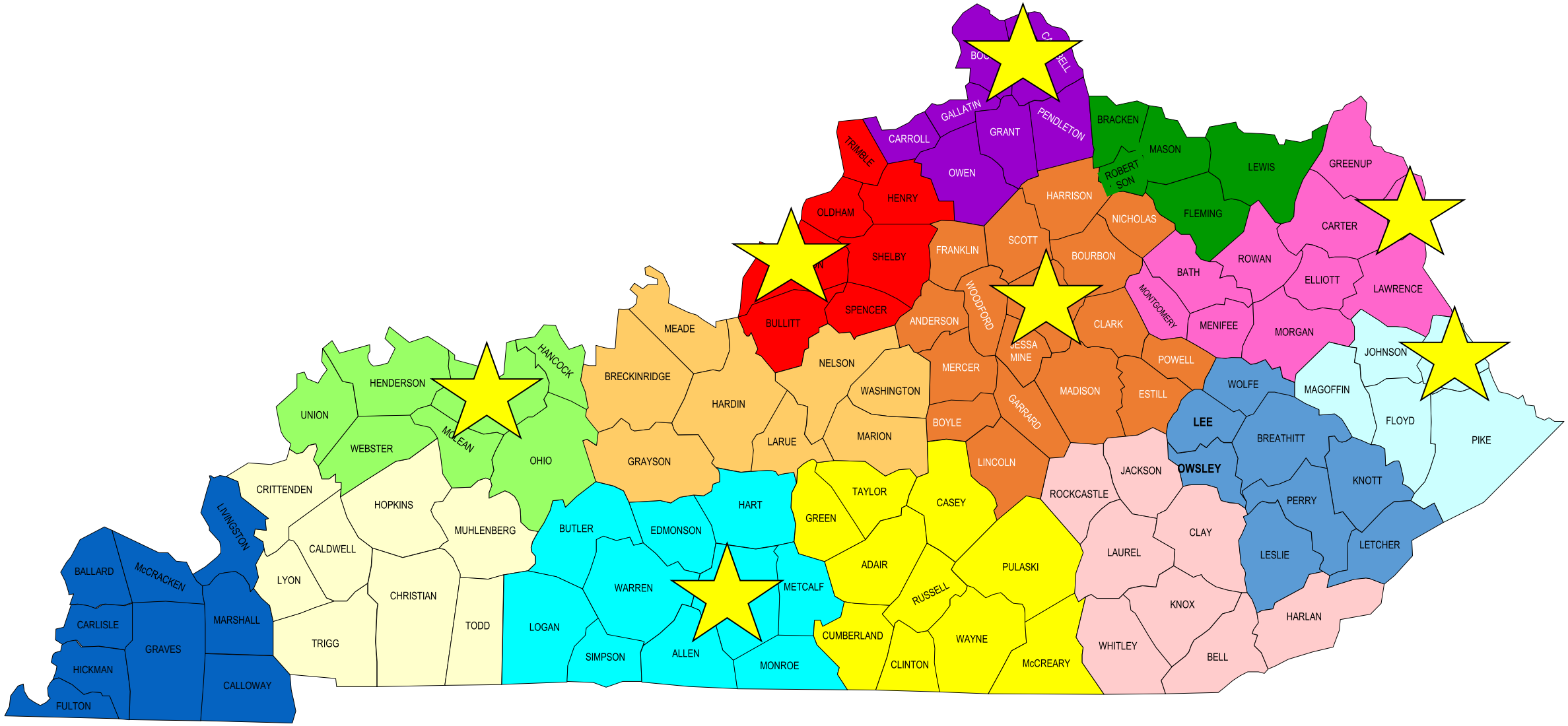


SAFERR Model, NCSACW

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 five unique counties in KY: Kenton, Jefferson, Boyd, Martin and Daviess
- KY START funding includes a federal RPG grant, TANF, Medicaid and state general funds.
- IN START in Bloomington and expanding to Terre Haute.
- START has also been piloted in Bronx, NY and NW GA.

Kentucky – CMHC Districts and START Sites



What is START?

- **Child Protective Services (CPS) program for families with parental substance abuse 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 new 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 and 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

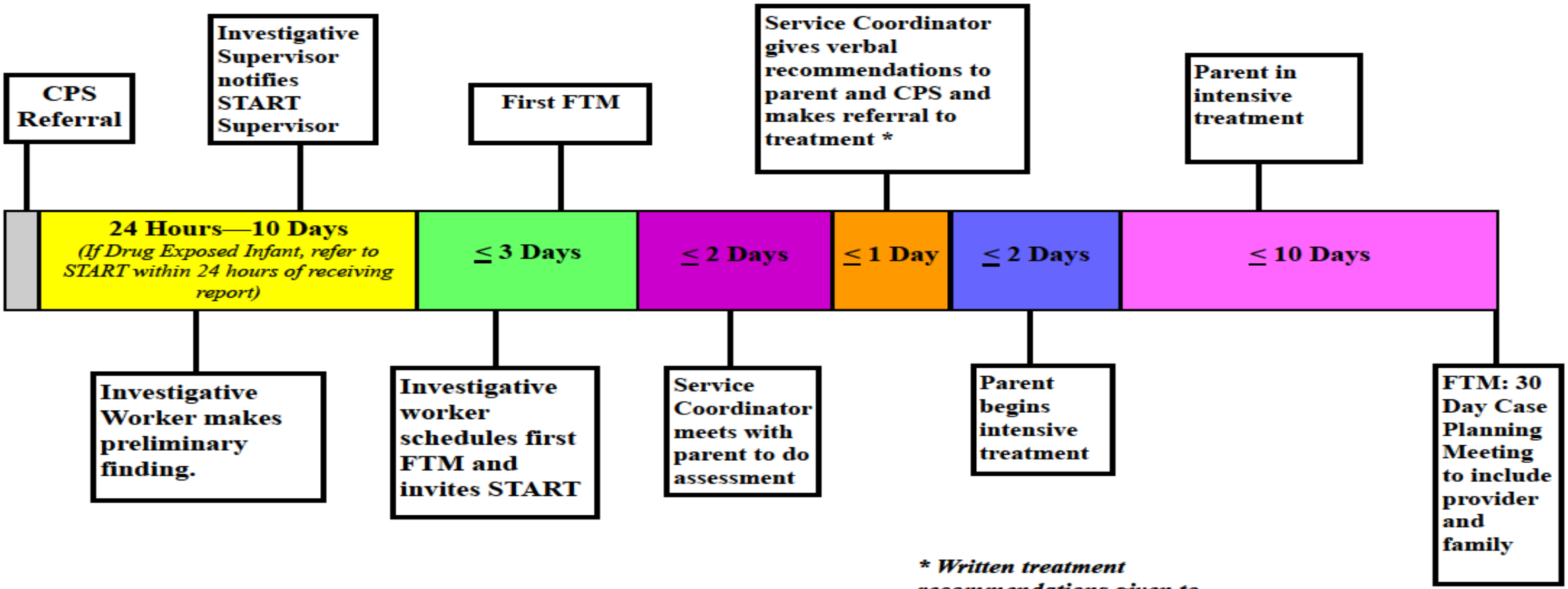
- Preventing foster care entry
- Child Safety and Well Being
- Parental Sobriety
- Permanency for children
- Family stability and self sufficiency
- Improved system capacity for addressing co-occurring addiction and child abuse.

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

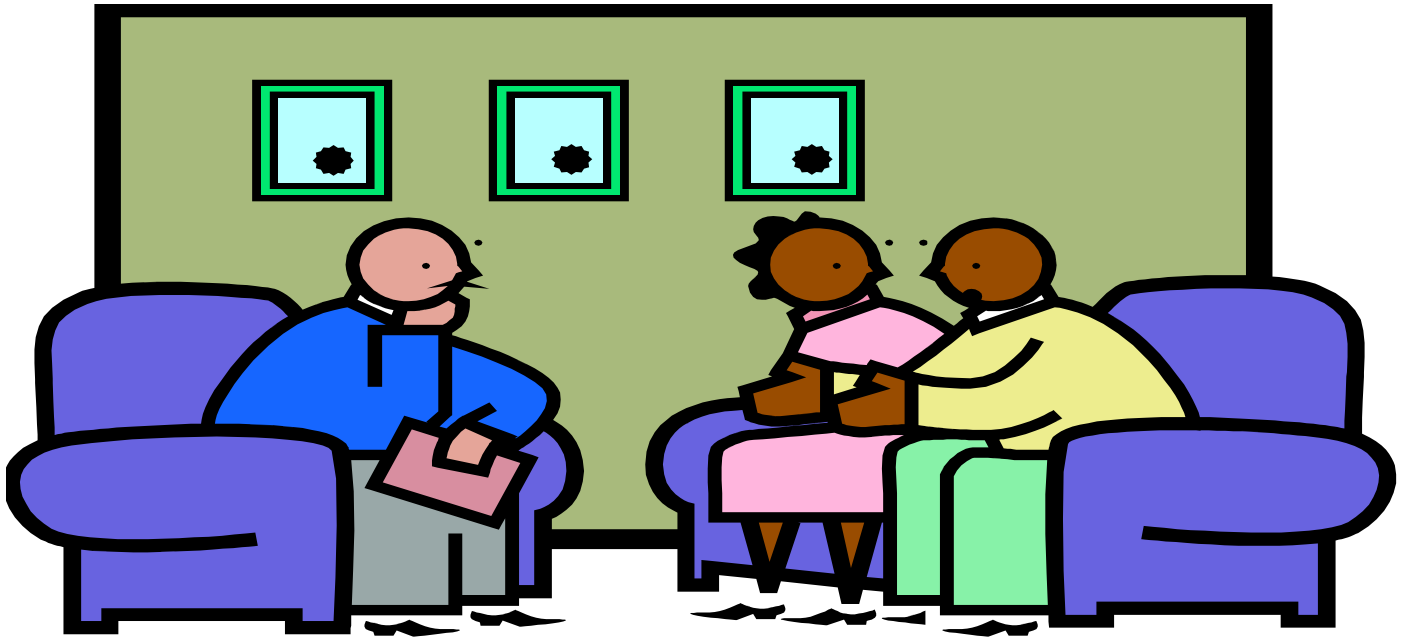
First 30 days of a START Case



Note: All days listed are work days.

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

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:

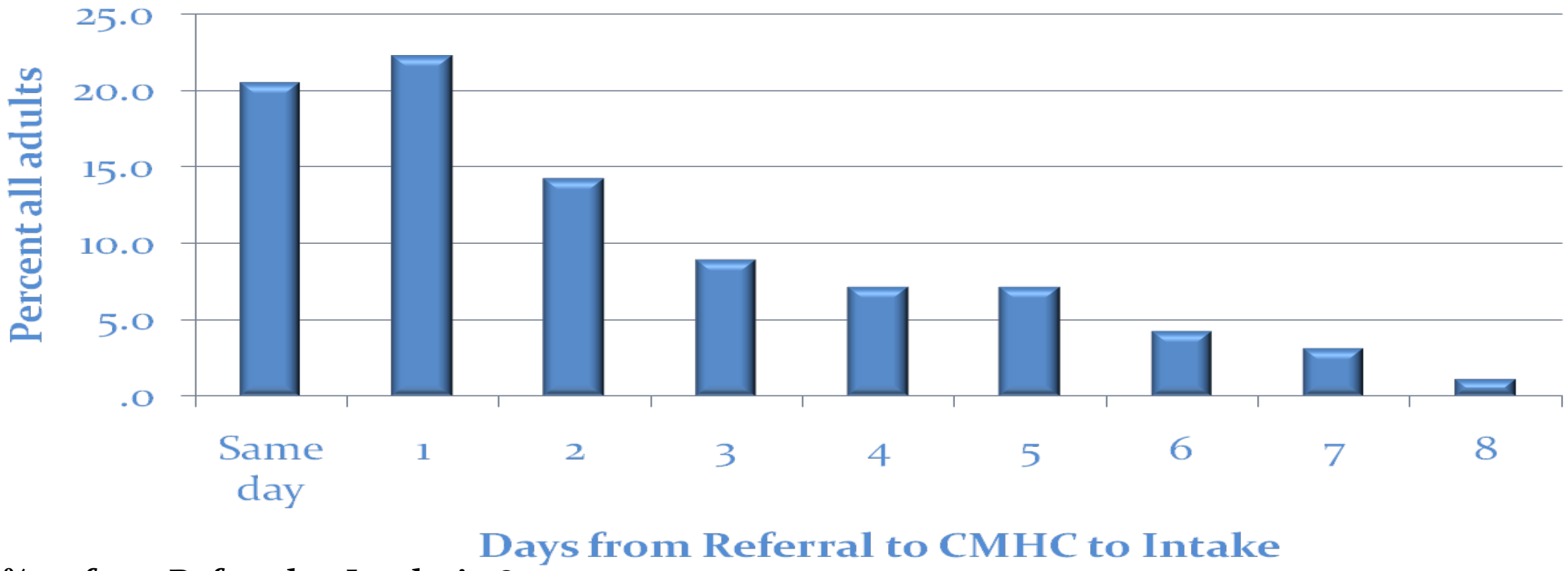
- START attempts to maintain the children in the home whenever possible while working with the parents:
  - Protective factors
  - Safety planning
  - Wraparound supports
  - Quick access to treatment
  - Sober caregiver/supervisor
  - Weekly visits; close monitoring

Child Placement Philosophy

- This should be 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.

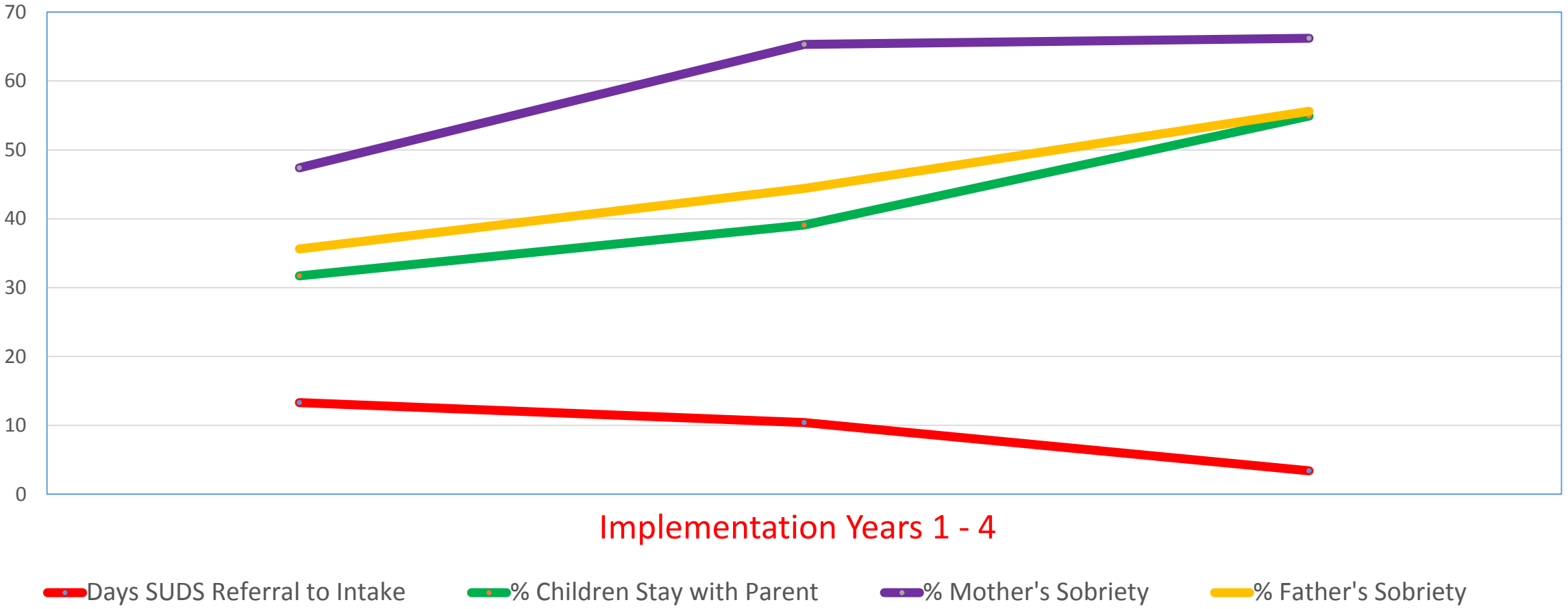
Quick Access to SUD Treatment



90% go from Referral to Intake in 8 days

Quick Access to SUD Treatment and Parent and Child Outcomes

(*N* = 550 adults; 717 children)



- 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.

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 work 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.

Engaging Fathers

- Persistence in finding and involving biological fathers in the case plan for service referrals, visitation, etc.
- Consider dad or his extended family as a placement if mom is not able to provide safety.
- Insist that both mom and dad/paramour must be in stable recovery before children are returned.

Behavioral Health Services

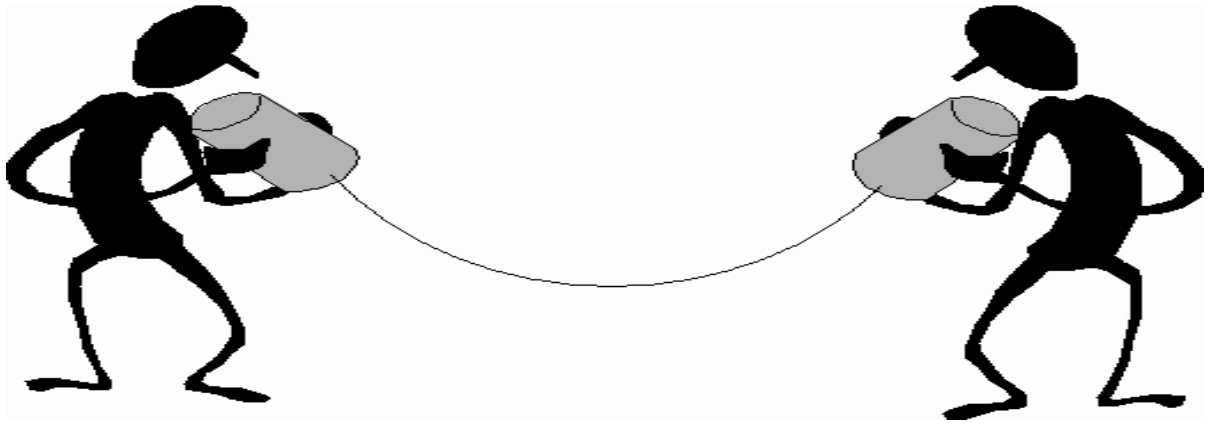
- **Strong partnership between behavioral health service providers and CPS at state and local levels.**
- **Team works collaboratively to improve service delivery, overall practice and outcomes for families.**
- **Team and other community partners participate in ongoing joint and cross training.**
- **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 or email if client no-shows or has a positive drug test or other child safety concern
- Family Team Meetings – being on the same page in front of the client/family
- Cross Training
- Case consults
- Service Coordination
- Direct Line meetings
- Advisory and/or contract meetings
- Team building



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!

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 in Rural Appalachia

Implementation and Outcomes

Background

- 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, cont.

- 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

Method, cont.: 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 recovery mentor contacts
- Fidelity to quick-access service delivery standards
- Analysis of meeting and training notes

Method, cont.: 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

Method, cont.: 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

Selected Results: 5 year changes in collaborative capacity based on CCI

Domain and Item	% Agree year 1 (n=18)	% Agree year 5 (n=14)
Our RPG has developed coordinated AOD treatment and CPS case plans.*	38.9%	84.6%
Our RPG supplements child abuse/neglect risk assessment with an in-depth assessment of AOD issues and their impact on each of the family members.*	33.3%	92.3%
CWS staff provides outreach to clients who do not keep their initial AOD appointment or drop out of treatment.*	27.8%	84.6%
In our RPG, client relapse typically leads to a collaborative intervention to re-engage the client in treatment and to re-assess child safety.*	22.2%	92.3%

*Note. * = $p < .05$.*
RPG = Regional Partnership Grant; CWS = child welfare services; AOD = alcohol or other drug; CPS = child protective services.

Selected Results: 5 year changes in collaborative capacity based on CCI

Domain and Item	% Agree year 1 (n=18)	% Agree year 5 (n=14)
Our RPG ensures that all children in CWS are screened for developmental delays associated with parental substance abuse.*	22.2%	84.6%
Our RPG is using data that can track CWS-AOD clients across information systems to monitor system outcomes.*	33.3%	84.6%
CWS ensures that all managers, supervisors and workers receive training on working with AOD-affected families.*	61.1%	100.0%
CWS staff know how to identify and link families with the support services that are frequently needed by CWS-AOD involved clients and makes effective referrals to those agencies.*	55.6%	100.0%

*Note. * = $p < .05$.*
RPG = Regional Partnership Grant; CWS = child welfare services; AOD = alcohol or other drug

Selected Results: 5 year changes in collaborative capacity based on CCI

Domain and Item	% Agree year 1 (n=18)	% Agree year 5 (n=14)
Our RPG has AOD support/recovery groups that include a special focus on CWS and child safety issues.*	22.2%	84.6%
Consumers, parents in recovery and program graduates have an active role in planning, developing, implementing and monitoring services for families with substance abuse problems in the child welfare system.*	22.2%	84.6%
Youth and former foster children/youth have an active role in planning, developing, implementing and monitoring services for families with substance abuse problems in the child welfare system in our RPG.*	5.6%	53.8%

*Note. * = $p < .05$.*
RPG = Regional Partnership Grant; CWS = child welfare services; AOD = alcohol or other drug

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

	n (%)	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 *(M, SD)*	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 (χ^2 (1) = 166.2, p < .001).

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

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

Note: CA/N = child abuse/neglect.

Out of Home Care (OOHC) Cost Avoidance

- Of 153 children served by START, 49 (32%) were place 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

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.
- Additional funding came from the Kentucky Department for Community Based Services (DCBS).
- 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.

Thank you!

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