

# Working Across Systems to Improve the Outcomes of Child Welfare Involved Parents with Substance Use Disorders

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# Agenda

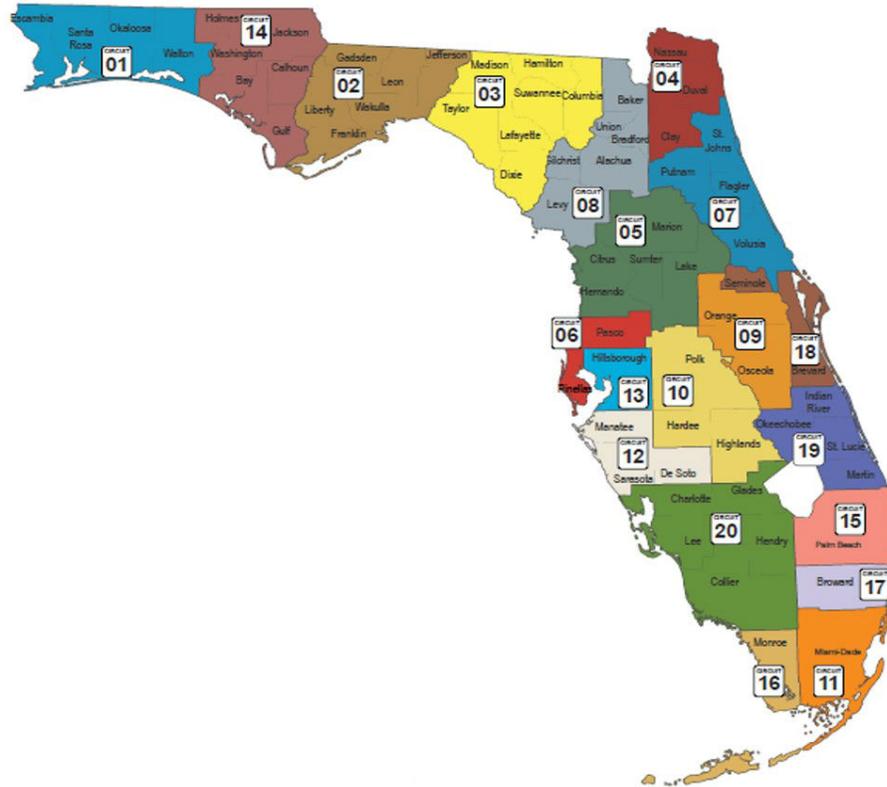
- ▶ Introductions
- ▶ Review of learning objectives
- ▶ Background information on both jurisdictions
- ▶ Discussion of key concepts
- ▶ Accomplishments and Outcomes
- ▶ Lessons learned
- ▶ Questions and Comments

# Learning Objectives

By the end of this presentation participants will:

- ▶ Understand the process Polk County, Florida, and Allegheny County, Pennsylvania, underwent to improve collaboration between their respective child welfare and drug and alcohol systems.
- ▶ Learn about strategies to increase early identification of substance use disorders and improve timely access to treatment.
- ▶ Become aware of ways to institute a sustainable evaluative structure.

# Florida Overview



# Circuit 10 Data

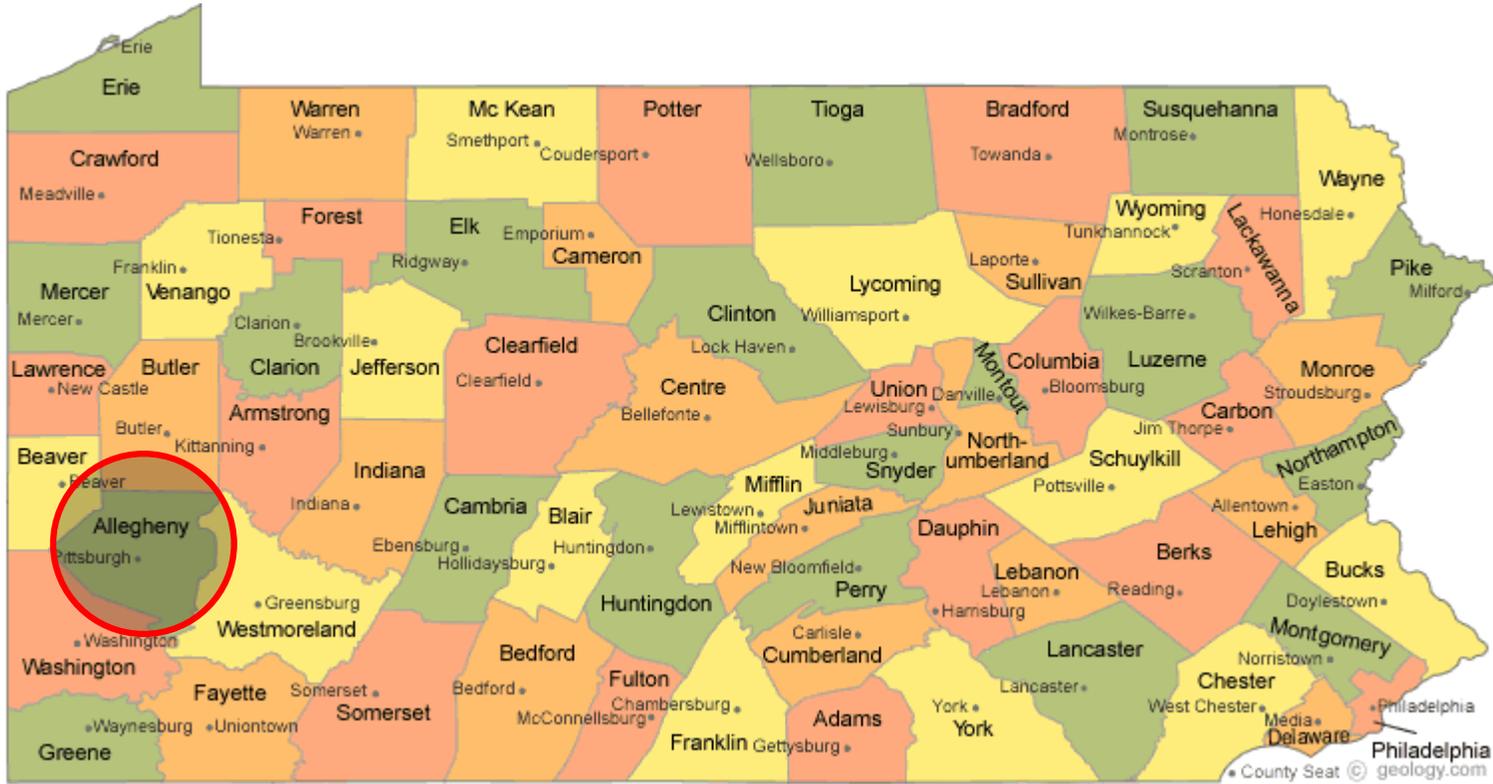
- ▶ Parental substance abuse is a major contributing factor in cases of child abuse and neglect in Circuit 10.
- ▶ Our district (Circuit 10) ranks 11<sup>th</sup> in the state in percentage of investigations due to substance abuse - above the Miami, Palm Beach, and Tampa areas. Polk County named as one of Central Florida's "High Intensity Drug Trafficking Areas" (US Department of Justice National Drug Intelligence Center's Drug Market Analysis, 2011).
- ▶ From March 2012 through February 2013, a total of 14,103 children were participants of an investigation in Circuit 10; of those, 3,482 were involved in an investigation where substance misuse was at least one of the reasons for the investigation. At any given time, approximately 750 children under child welfare care are the victims of some type of substance misuse by their parents.
- ▶ Approximately half of all children 0-5 years old in out-of-home care are the children of parents alleged to be misusing substances.
- ▶ Children whose parents misuse substances have experience an additional three months length of stay in the system compared to the overall census of children under supervision. These children encompass half of all children in care nine months or longer, and for children 0-5 years old, that statistic rises to 56%.

# Information on what FITT teams are

*The Family Intensive Treatment (FIT) team model is designed to provide intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance abuse. The goals of the program include:*

- ▶ Increase safety and reduce risk of children in the child welfare system whose parents have a substance use disorder;
- ▶ Develop a safe, nurturing and stable living situation for these children as rapidly and responsibly as possible (as part of safety services);
- ▶ Participate as a provider in an in-home safety plan (as part of safety services);
- ▶ Reduce the number of out-of-home placements; and
- ▶ Reduce rates of re-entry into child welfare system.

# Allegheny County



# Allegheny County DHS Overview

## Allegheny County Department of Human Services (DHS)

DHS is responsible for providing and administering publically funded human services to Allegheny County residents

DHS is an integrated social services system which includes the following offices:

- ▶ Area Agency on Aging
- ▶ Office of Behavioral Health
- ▶ Office of Children, Youth and Families
- ▶ Office of Community Services
- ▶ Office of Intellectual Disabilities

### Support Offices:

- ▶ Office of Administrative and Information Management Services
- ▶ Office of Community Relations
- ▶ Office of Data Analysis, Research and Evaluation

# Allegheny County Overview

## DHS Clients

220,000 or 1 in 5 County residents served by Department of Human Services

## Child Welfare Clients

Calls Logged 2014 total (families)

- ▶ 10,353 calls of suspected child abuse/neglect were received by CYF
  - ▶ 47% (4,865) were referred to community-based services
  - ▶ 53% (5,488) were assessed for child welfare services.
    - ▶ 30% of these (1,620) were accepted for child welfare services
- ▶ Passage of new Child Abuse Laws January 1, 2015
  - ▶ 25,626 calls received in 2015
  - ▶ 1,300 children in placement on any given day

# DHS Substance Use Data

- ▶ **12,455** – Number of drug and alcohol clients served by DHS
- ▶ **1461** – Number of CYF referrals with substance use as a factor
- ▶ **POWER Connections** –offer treatment and recovery support to individuals with substance use disorders

*POWER's mission is to help women reclaim their lives from the disease of addiction and to reduce the incidence of addiction in future generations.*

- ▶ POWER was founded in 1990; opened our doors in 1991. This year, POWER is celebrating 25 years of serving women in recovery and their families.
- ▶ Mid-size private, non-profit organization with a **\$3.5 million budget**, about **55 employees** (most of whom are full-time), and we serve approximately **1,200 - 1,400 clients** (mostly women) each year.
  - ▶ About half of our operating budget goes to recovery support services, primarily those offered to child welfare-involved families
- ▶ We offer a range of **gender-responsive, trauma-informed treatment and recovery support** services designed for women. All of our services reflect the lives of women and we incorporate our deep understanding of trauma into all of our programming.
- ▶ POWER values employees with lived experience. Approximately half of our staff is in recovery from a substance use disorder. Employees are required to have a minimum of 5 years in recovery and, currently, the average length of time in recovery is 18 years!

# Goals of Integration

- ▶ Identify gaps and barriers
- ▶ Implement effective strategies
- ▶ Improve *collaboration* across systems
- ▶ Increase access to *timely assessment, treatment, and supports*
- ▶ *Increase involvement* in treatment and recovery services
- ▶ *Increase abstinence*, program retention and completion rates
- ▶ *Decrease absenteeism* from scheduled treatment sessions
- ▶ Ensure *safety and reduce risk* of child welfare involvement
- ▶ Develop *safe, nurturing, and stable living situations* for children as rapidly and responsibly as possible
- ▶ *Reduce the number of out-of-home placements and re-entry rates*

# Steps Toward Integration

- ▶ Phase I -Site outreach and engagement
- ▶ Phase II -Strategic planning and capacity building
- ▶ Phase III -Implementation and evaluation
- ▶ Phase IV -Dissemination, evaluation and sustainability planning
- ▶ Phase V -Follow up, monitoring and aftercare

# Phase one

- ▶ Obtain MOA or MOUs between child welfare agencies and mental health/substance abuse agencies
- ▶ Meet with key personnel in the child welfare legal system for buy-in
- ▶ Educate key stakeholders regarding the program design, goals, and expected outcomes

# Ensure Buy-In From the Top Down

- Gather data and identify missing data elements
- Conduct case reviews, analyze and report findings
- Complete a walk-through and identify gaps, barriers and opportunities
- Identify practices, policies and decisions (local and state) that could support or impede this work
- Support the selection and implementation of effective programs, strategies, tools
- Facilitate cross-system communication through bi-weekly or monthly calls with partners
- Probe...prod...ask the hard questions...hold everyone accountable for results

## Phase Two

- ▶ Cross System competency
- ▶ Cross-training of staff

# Cross System Competency

- ▶ Understand and appreciate the parameters and culture within each sector and how they operate
- ▶ Understand requirements, limitations, and timelines of each system of care
- ▶ Gain basic knowledge of mental health and substance use disorders and appreciate the challenges that these disorders create for parents
- ▶ Implement a treatment based practice model designed to address behavioral health and parenting capacity issues while improving family functioning, caregiver capacities and strengthening related outcomes

# Cross-Training of Staff

All child welfare and mental health/substance abuse staff should be cross-trained in all of the following areas:

- Child welfare system of care
- Mental health/substance abuse system of care
- Proposed Integrated Program Core Competencies
- Access and use of a shared electronic health record and reporting networks
- Child legal services
- Trauma-informed care

## Phase Three

- ▶ Collaborative planning approach
- ▶ Establish effective communication between the two systems of care

# Collaborative Planning Approach

The vision of an integrated model is to ensure that every family involved in services is supported and engaged with *one team and one common planning process* so that the family will experience one community-wide system of care.

Through the integration of child welfare and behavioral health practice models, an integrated model is designed to:

- Collaboratively engage and assess the entire family at an intense level
- Integrate care to the entire family unit
- Treat behavioral health and parenting capacity issues and;
- Create a mechanism of *shared accountability* across the Provider Agencies, the Managing Entities and the Community Based Care organizations

# Establish an Effective Communication System

- The integrated model approach to cross system partnering seeks to **reduce communication barriers and enhance collaborative** planning between behavioral health and child welfare.
- One of the most effective core components for integrated collaboration is the **concept of Teaming**.
- Research shows that services that are provided in a **comprehensive** manner support both recovery and permanency for children.
- Whether teams are small or large, family planning for achieving safety, permanency, and well-being is more effective with genuine teamwork in place and guided by the central principle on achieving **unity of effort and commonality of purpose**.

# Phase Four

- ▶ Establish a network of diverse providers
- ▶ Ensure equal access to treatment for both men and women
- ▶ Provide *practice and resource guides* to child welfare and SAMH staff on working with the target population
- ▶ Use *takeaways* from local and national best practices to *improve* assessments and connections to service
- ▶ Increase capacity to *track progress* through uniform data entry, collection and evaluation
- ▶ Ensure staff are equipping program participants with developing *natural supports* for continued successful recovery beyond treatment

# Building Informal Supports

- The *successful transition* away from formal supports to informal supports is a critical juncture during the episode of care and is addressed as part of the Teaming process.
- Ensuring *long term recovery and stability* for the family requires that transition planning begin at intake, is family-centered, and continues throughout the family's stay.
- Referral processes with community providers occur in a timely, systematic fashion prior to discharge.
- *The process concludes with the coordination and implementation of services and transition to the least restrictive level of care regardless of transitioning from child welfare service or behavioral health services*

# Phase Five

- ▶ On-going monitoring/follow-up
- ▶ Recommendations for improvement

# On-going Monitoring of Progress

Continuous monitoring and evaluation of the effectiveness of the plan and interventions is critical to the integrated practice model.

- ▶ This includes:
  - ▶ Evaluating the fidelity to the motivational interviewing model
  - ▶ Ongoing assessment
  - ▶ Continually revisiting progress or lack of progress, adjusting measurable indicators and frequency of interventions
  - ▶ Providing continuous engagement and encouragement
  - ▶ Celebrating milestones
  - ▶ Maintaining current and appropriate documentation
  - ▶ Soliciting feedback from family to express their views on identified goals, etc.

# Accomplishments/Outcomes

- *Family-centered practice* - engages the whole family to identify strengths and needs and partners in identifying resources and strategies for addressing challenges.
- *Community based practice* - mobilizes formal and informal supports for families in the community with the goal of keeping the child in the community to maintain connections.
- *Individualized services* - works to understand the unique interests and cultural perspectives of child, youth and family and identifies and accesses services and supports that are appropriate in meeting individual needs.
- *Strengthen parental capacity* - enhances parental capacity so families can adequately care for their children and ensures their child's safety, permanency and wellbeing.
- *Streamlined assessment processes* through data management
- *Improved intra- and inter-agency collaboration*

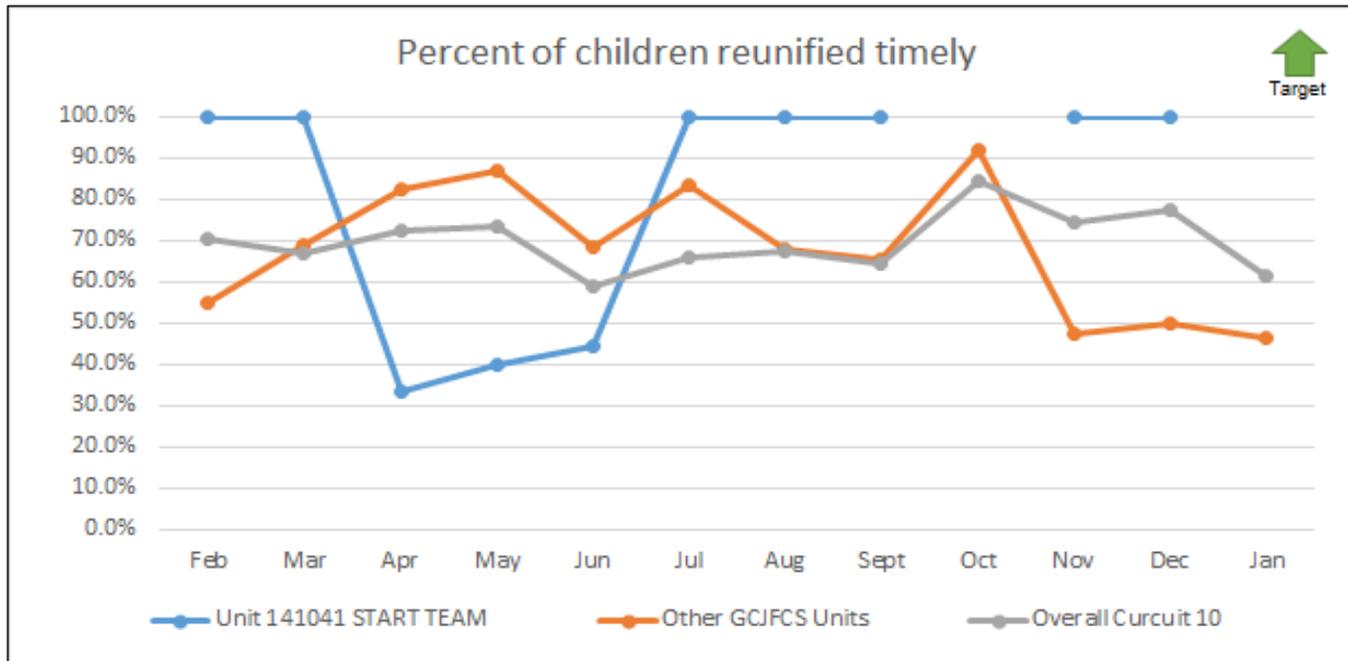
# Pennsylvania Outcomes

- ▶ During FY 15-16 there were an estimated **926 unduplicated referrals** from CYF to the POWER Connection Program.
- ▶ POWER Connection **provided services to 850 unduplicated** (527 assessments and 323 mentoring services).
- ▶ This number excludes clients withdrawn by CYF, clients who refused services, clients scheduled for services in the following fiscal year, and clients who are in assertive outreach.
- ▶
- ▶ Of the 527 assessments conducted, 373 clients were recommended to treatment.
- ▶ At the **7 day follow up**, 282 clients accepted our help with **linkage to a treatment provider**.
- ▶ At the **30 day follow up**, 158 clients were verified to have been **active in treatment**.
- ▶ At the **60 day follow up**, 144 clients were verified to have been **active in treatment**.
  - ▶ 7 clients had multiple treatment episodes.

# Florida Outcomes

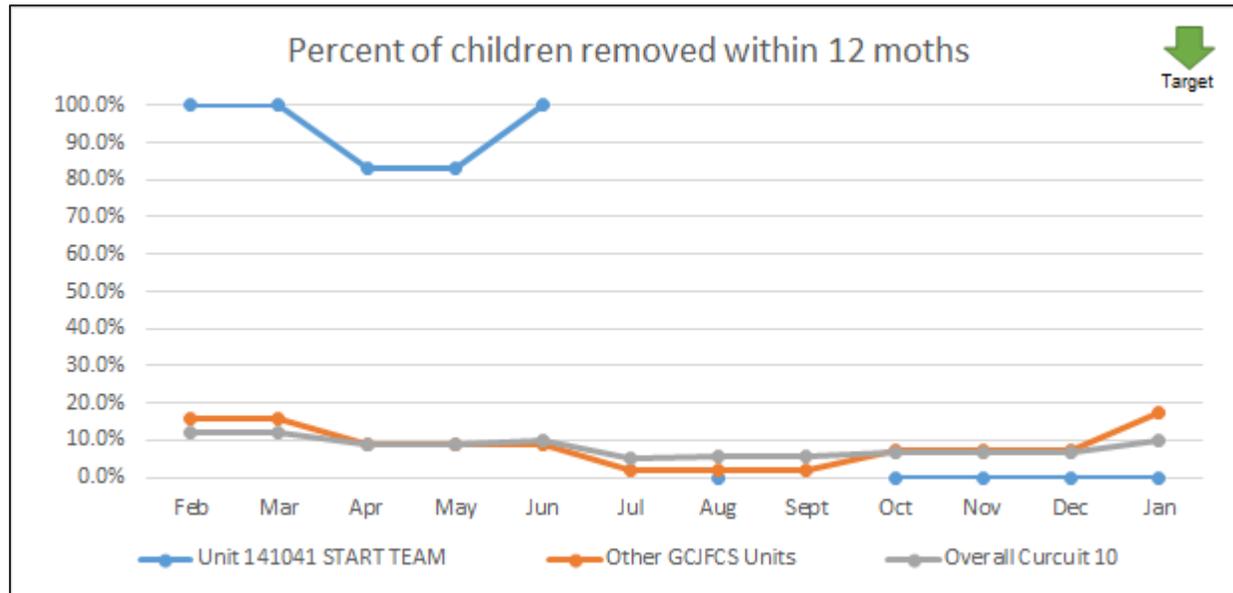
## ▶ Timeliness To Permanency (FS 301)

Percent of children reunified within 12 months of latest removal episode – Target: 75.2%



# Children Returning to Care (FS 302)

Percent of children removed within 12 months of prior reunification – **Target: 9.9%**



# Lessons Learned

- ▶ It is imperative to have support and commitment from leadership.
- ▶ Implementing system improvements requires cross-system collaboration.
- ▶ Referral and treatment pathways need regular assessment and enhancement.
- ▶ Clearly articulated goals and objectives are necessary to improve practice and outcomes.
- ▶ Communication between systems of care should be frequent and effective
- ▶ Collaborative planning approach is imperative.

Recommendations

Panel Discussion

# Contacts

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