



CW360^o

a comprehensive look at a prevalent child welfare issue



Safety



Permanency



Well-Being

Understanding Substance Use and Interventions in Child Welfare
Spring 2019

From the Editors

Each year 8.7 million (SAMHSA, 2017) children and families are impacted by substance use and misuse in the United States. Many families become involved in the child welfare system due to substance use-related safety and parenting concerns. Child welfare and substance use professionals intersect in many ways, yet these fields of study, formal training, and prevention and intervention services remain very siloed. With conflicting philosophies, priorities, policies, funding streams, and timelines, communication and collaboration between the child welfare and substance use communities is essential in supporting the complex needs of families.

For this issue of *CW360°* we have partnered with our colleagues at the Minnesota Center for Chemical and Mental Health (MNCAMH). This issue explores the impact and implications of families' co-occurring involvement in the child welfare and substance use disorder treatment systems. Local, state, and federal efforts to support families impacted by substance use are evolving and we are seeing more promising policy and practices emerge. It is imperative that we learn from these efforts

while drawing upon families' experiences and resilience, to think critically about how professionals within these two areas of practice can integrate services, and work collaboratively to best serve children and their families.

Preparation for each issue of *CW360°* begins with an extensive literature review and an exploration of best practices in these fields. Both centers identified individuals who have emerged as leaders or have a unique contribution to write articles that offer insights on a range of policies, programs, and strategies to inform the intersection of child welfare and substance use.

CW360° is divided into three sections: overview, practice, and perspectives. The overview section explores the latest evidence on addiction and recovery and the prevalence of substance use in families involved in child welfare in the U.S. Additionally, it explores key contributing factors for involvement and the systemic barriers that impact families, including stigma, poverty, and other social determinants of risk. The practice section includes articles on evidence-informed, innovative, and promising practices, including family drug treatment courts, medication assisted therapy,

multisystemic therapy, and much more. The perspectives section presents articles from a variety of individuals involved with and/or impacted by substance use and child welfare, highlighting key experiences and lessons learned.

We have included information and tools throughout this publication that will help you apply the research, practice, and perspectives to your own work setting. Please refer to the discussion questions at the end of the publication to guide conversations with staff and administrators at your agency. Please note that we have removed the reference section from the printed editions of *CW360°* in order to make space for additional content. You can find a full listing of the citations in PDF format on our website at z.umn.edu/2019cw360.

We hope you find this issue informative and useful in your work. We'd like to express a great appreciation for our partners at MNCAMH and for the dedication and hard work that professionals in our fields give every day to support children and families.



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As part of the School of Social Work family, we at the **Minnesota Center for Chemical and Mental Health** (MNCAMH) were thrilled when CACSW, 21 years our senior, asked us to partner with them on creating training materials related to co-occurring substance use disorders for the child welfare workforce. Over these past three years of collaboration, we have come to appreciate the necessity for collaboration to address the complex needs of families with substance use problems. We have seen how significantly our work and mission overlap. Like CACSW, our mission is to improve lives by bringing research to practice and providing training and consultation that inspires, challenges, and motivates practitioners toward exceptional, empirically informed and effective recovery-oriented care. What

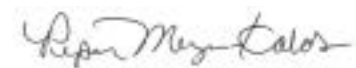
distinguishes our centers, somewhat, is our focus. For CACSW the focus is on children and families involved in the child welfare system, and for us, the focus is on individuals affected by mental illness, substance use problems, and co-occurring disorders. We say somewhat because, as this special issue demonstrates, our two areas of expertise intersect in significant ways. Really, what separates our two centers is a single flight of stairs. In planning this issue, we have worn a path from our center on the first floor to CASCW on the second. Each time we ascended the stairs for a meeting, we were always reminded about the overlap in our work and excited by the opportunities ahead of us.

At MNCAMH, we came into this project knowing that over 80% of families involved in child welfare have experienced challenges

related to substance use. As we put together the articles for this issue, however, we came to fully understand and appreciate the depth and diversity of the many facets that make up this staggering statistic. We quickly realized we couldn't possibly address everything, and we had to make some very difficult decisions about what to highlight. Our partnership on this project proved humbling and in many ways fulfilling and hopeful. While the issue shines an unflinching light on broken parts of the substance use disorders and child welfare systems, many of the authors provide us with examples of significant and inspiring progress in understanding, empathy, policy, and practice. This issue not only shines a light, but lights a way forward.



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Glossary

Definitions of commonly used terms in this edition.

A

Abstinence: Not using drugs or alcohol, in any form.¹

Addiction: According to the American Society of Addiction Medicine, addiction is a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. Addiction is characterized by behaviors that include: impaired control over drug use, compulsive use, continued use despite harm, cravings.²

C

Case Plan: A living document that describes the outcomes, goals, and tasks concerning a child's care while in placement.³

Child Maltreatment: Sometimes referred to as child abuse and neglect, includes all forms of physical and emotional maltreatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child's health, development, or dignity. Within this broad definition, five subtypes can be distinguished – physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse, and exploitation.³

Child Protective Services: The social services agency designated (in most States) to receive reports, conduct investigations and assessments, and provide intervention and treatment services to children and families in which child maltreatment has occurred.³

Child Welfare Services: A continuum of services designed to protect children, strengthen families to care for their children, and promote permanency when children cannot remain with or return to their families.³

D

Drug Court/Treatment Court(s): Drug courts are problem-solving courts that operate under a specialized model in which the judiciary, prosecution, defense bar,

probation, law enforcement, mental health, social service, and treatment communities work together to help non-violent offenders find restoration in recovery and become productive citizens.²

E

Evidence Based Practice: Patient care informed through the integration of clinical expertise and best available clinical evidence from systematic research.²

F

Foster Care: (see out-of-home care)

I

Illicit Substances: Illegal or forbidden by law.¹

K

Kinship Care: Kinship care refers to those arrangements that occur when child welfare agencies take custody of a child after an investigation of abuse and/or neglect and place the child with a kinship caregiver who is an approved placement based on the assessment standards developed by the agency.³

O

Out-of-Home Care: Also called foster care, including family foster care, kinship care, treatment foster care, and residential and group care. Out-of-home care encompasses the placements and services provided to children and families when children must be removed from their homes because of child safety concerns, as a result of serious parent-child conflict, or to treat serious physical or behavioral health conditions that cannot be addressed within the family.³

R

Recovery: The process of improved physical, psychological, and social well-being and health after having suffered from a substance use disorder.²

Relapse: Relapse often indicates a recurrence of substance use. More technically, it would indicate the recurrence and reinstatement of a substance use disorder and would require an individual to be in remission prior to the occurrence of a relapse.²

S

Sober/Sobriety: Sober is a state in which one is not intoxicated or affected by the use of alcohol or drugs, sobriety is the quality or state of being sober.²

Substance Abuse: This refers to a less serious drug or alcohol use disorder in which substance use causes distress and problems. However, the problem has not progressed to addiction, which is a more serious form of the disorder.¹

Substance Use Disorder (SUD): A medical illness caused by disordered use of a substance or substances. According to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), SUDs are characterized by clinically significant impairments in health, social function, and impaired control over substance use and are diagnosed through assessing cognitive, behavioral, and psychological symptoms. An SUD can range from mild to severe.¹

Stigma: An attribute, behavior, or condition that is socially discrediting. Known to decrease treatment seeking behaviors in individuals with substance use disorders.²

T

Treatment: The management and care of a patient to combat a disease or disorder. Can take the form of medicines, procedures, or counseling and psychotherapy.²

W

Withdrawal: Physical, cognitive, and affective symptoms that occur after chronic use of a drug is reduced or abruptly or stopped among individuals who have developed tolerance to a drug.²

¹ National Institute on Drug Abuse (NIDA). (2018). Glossary. Retrieved from <https://www.drugabuse.gov/publications/media-guide/glossary>

² Research Recovery Institute. (n.d.). Dictionary – Glossary of Substance Use Disorder Terminology. Retrieved from <https://www.recoveryanswers.org/addiction-ary/>

³ Child Welfare Information Gateway. (n.d.). Glossary. Retrieved from <https://www.childwelfare.gov/glossary/glossarya/>

Addressing Substance Use Disorders in Child Welfare: A Perennial Challenge with Reasons for Optimism

Laura F. Radel, MPP

For decades, parental substance use has been a significant factor in the lives of many children who come to the attention of the child welfare system. Child welfare professionals consistently identify substance use among the key concerns in the families they support. In 2017, drug and/or other substance abuse was identified as a factor associated with the placement of 37% (96,700) of children in foster care nationally (Administration for Children and Families (ACF), 2018). However, many believe this is a significant undercount and that much of the increase is a result of better reporting rather than higher incidence. There is substantial variation in the rates reported among states, which may reflect inconsistencies in measurement, such as assessment practices and how information is captured in states' information systems (Seay, 2015). Substance use and how it is identified to the child welfare system are also entwined in complex ways with issues of poverty, neglect, and racial disproportionality, making it difficult to isolate the phenomenon in data and practice.

While problematic substance use is common among families involved in the child welfare system, training for child welfare professionals rarely includes much content on the issue (Quinn, 2010). This year's CW360° makes it a focus. Following this introduction,

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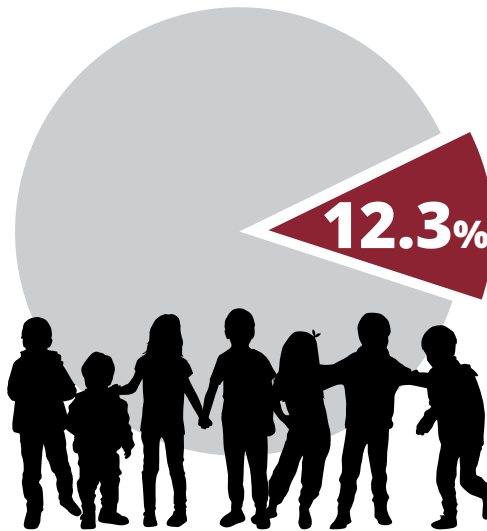
readers will find articles discussing an array of issues relating to the intersection of child welfare practice and substance use and use disorders (SUDs). This includes overview information about these conditions and their treatment, implications for parents and children, and the best information available on models of working with affected families.

Policy and practice look different among and within states in terms of whether and how substance use is addressed in child welfare. As of 2015, 19 states had laws requiring child maltreatment reporting of infants with symptoms of drug exposure and 34 states had criminal statutes that address exposing children to illegal drug activity (Child Welfare Information Gateway, 2015). Also, many states identify chronic, untreated substance use as justification for involuntary termination of parental rights (Child Welfare Information

Gateway, 2017). In addition to particular statutory requirements, states may address the issue less systematically in policy and practice (Radel et al., 2018a). There are wide differences across the country in how foster care placement rates relate to local indicators of substance use (Ghertner et al., 2018).

While substance use and use disorders are less common in women than in men, women's use has seen more pronounced growth. Past year use of heroin among women doubled between 2002-2004 and 2011-2013 (Jones et al., 2015). Similarly, opioid use among

pregnant women quadrupled between 1999 and 2014 (Haight et al., 2018) and the number of infants treated for Neonatal Abstinence Syndrome (NAS) increased more than five-fold between 2000 and 2012 to 5.8 per 1,000 births (Sanlorenzo et al., 2018). Federal data reveal that 8.7 million U.S. children live with a parent who has an alcohol or other substance use disorder. Of these, 2.1 million live with a parent using illicit drugs (Lipari et al., 2017). While most users have a preferred or primary substance, it is common for individuals with severe SUDs to use multiple substances in combination, depending on availability or to balance out the effects of the substances used (Jarlenski et al., 2017). Changes to the legal status of marijuana in some states have made addressing parents' misuse of that drug more complex (Silverstein, Wilcox, & Woodard, this issue; Stott & Gustavsson, 2016; Ng &



of all children in the country, live with a parent who has a substance use disorder

Tung, 2016). It is important to acknowledge that while child welfare practice has typically focused on maternal substance use, fathers' use is also important to consider and address (Stover, this issue).

Prenatal drug exposure has received renewed attention as the opioid epidemic has increased the number of children born with NAS, in which the infant experiences withdrawal symptoms following birth (Jansson & McConnell, this issue; Grossman, this issue). While limited data on extended outcomes of these children suggest that some may experience relatively subtle long-term effects (Behnke et al., 2013), the serious deficits associated with Fetal Alcohol Spectrum Disorders are often overlooked by the child welfare system (Chasnoff et al., 2015). States are required by the Child Abuse Prevention and Treatment Act to develop Plans of Safe Care for infants born substance-exposed to ensure their safety. States take a range of approaches to implementation of this requirement including how they define the population of children for whom such plans are developed, who develops them, what they include, and how they are monitored (Lloyd, this issue; Lloyd, Luczak & Lew, 2019; National Center on Substance Abuse and Child Welfare, 2018).

Substance use among youth in foster care is also of significant concern. Studies have found that while use rates for alcohol and marijuana are similar between youth in foster care and their same age peers in the general population, use of hard drugs such as opiates, amphetamines, cocaine, and hallucinogens are substantially higher among youth in care, as are SUDs (Braciszewski & Stout, 2016). Substance use prevention for youth in care is an important but under-researched topic, though recently the subject has received increased attention as



program developers seek to adapt evidence-based prevention programs to this population (Traube, this issue; Buchanan, this issue; Barkan et al., 2014; Haggerty et al., 2016).

Research has shown that children in foster care from families with substance use issues remain in care longer than children from other families (Brooks et al., 2010). Child welfare professionals report that such cases are more challenging than others (Jedwab, 2018),

fundamentally, there is a mismatch between the nature of SUDs as chronic, relapsing conditions, and a child welfare system that seeks short-term engagements with the families served. Add to that little accountability across systems for outcomes families experience and the result is limited progress.

Today, there is more widespread recognition of addiction as a disease that responds best to treatment rather than moral outrage or

And fundamentally, there is a mismatch between the nature of SUDs as chronic, relapsing conditions, and a child welfare system that seeks short-term engagements with the families served. Add to that little accountability across systems for outcomes families experience and the result is limited progress.

requiring more time prior to reunification, more gradual reunification, and more post-reunification follow up. The issue of parental substance use challenges child welfare, in part, because the field reflects broader unresolved national differences about whether SUDs are primarily a health issue, a moral issue, or a criminal issue. These complex attitudes add to the stigma felt by families, making it less likely that they will come forward voluntarily for treatment or that their situations will be noticed and addressed in early stages (Gonzalez, this issue).

The findings of a 1999 report to Congress on substance use and child maltreatment remains remarkably relevant two decades later (HHS, 1999). It observed that most substance use treatment programs are not family focused and access is limited. Engagement and retention of parents in treatment is challenging and recovery is neither quick nor linear. And

criminal penalties (Associated Press-NORC Center for Public Affairs Research, 2018). In addition, there are more services in place to address the needs of families. The number of Family Treatment Drug Courts have expanded from 10 in 1999 to 370 in 2016 (National Drug Court institute, 2018) and the expansion of Medicaid has made SUD treatment more available to many Americans who were previously uninsured (Relevant Federal Policy Timeline, this issue; Wen et al., 2015). Federal demonstration grants have seeded the field with efforts to address parental substance use and its effects on children. These include grants to improve collaborative practice among child welfare, substance use treatment, and family court professionals and grants from the Substance Abuse and Mental Health Services Administration to provide SUD treatment for pregnant and postpartum women. Finally, the National Center on Substance Abuse and

Child Welfare continues to develop training materials and provide technical assistance to communities on the interrelated issues of substance abuse and child protection.

Important advances have offered pathways for continued progress in meeting the needs of families. Medication-assisted treatment (MAT) combines behavioral therapy and medications to treat SUDs, including opioid use. MAT demonstrates significant success in treating opioid use disorder (Connery, 2015) yet some research suggests that a minority of clients using opioids are receiving this treatment (Sandoe, Fry, & Frank, 2018). Initial investigation of MAT for child welfare-involved parents shows associations between receipt of MAT and permanency outcomes for children (Hall, this issue; Hall et al., 2016), though there are serious challenges to providing such treatment in the child welfare system (Radel et al., 2018b).

Sober housing and post-treatment recovery supports as keys to long-term sobriety have received increased attention. There is also more attention to early intervention with the recent Family First Prevention Services Act putting both SUDs and mental health conditions at the forefront of the child welfare system's efforts to prevent the need for foster care (Barry, Walthour, & LaLiberte, this issue). The opportunity for child welfare agencies to become purchasers of SUD treatment is a significant opportunity for the field to improve the effectiveness of services for families with SUDs. Taking best advantage of this opportunity will require agencies to become knowledgeable and discerning of treatment services. They will also need to accept and operationalize joint accountability with SUD treatment providers of outcomes for families and children.

For many years our child welfare programs have too often watched families fail rather than help them succeed. Hopefully, improved understanding of SUDs as health conditions, expanded opportunities for effective treatment, and earlier intervention opportunities will allow us to build on the progress that has been made and intervene with families more constructively and successfully in the years to come. While not all families will succeed in achieving a stable recovery and effectively parenting their children, the knowledge exists to improve outcomes considerably for the children and families we serve today.

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Addiction: The Brain Disorder that Responds to the Social Environment

Lanae Staab, BS, Nikki Tillman, BS, & Amy R. Krentzman, PhD

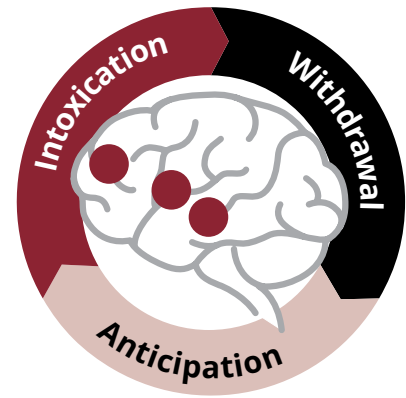
Addiction baffles and bewilders us. Why would anyone do something so hurtful and harmful? Once sober, why would anyone relapse? This is one of the hardest aspects of human behavior to understand. However, recent research shows that in addiction, small changes take place in the brain over time. These neurological changes account for the perplexing behaviors we observe. Moreover, changes in the social environment can account for the maintenance of long-term successful recovery.

When people start using substances, they experience pleasure and satisfaction. As time goes on, the person requires more of the substance to experience the same level of pleasure. The individual begins to crave the substance. Craving as it relates to addiction is more than a casual urge; it has been described as a kind of fury in the mind that demands attention. Kevin

ing off the craving and is vulnerable to relapse (HHS, 2016).

Because of these brain changes, individuals with addiction may transition from intermittent and controlled use to prolonged, uncontrollable misuse. Unfortunately, these brain disturbances have lasting impact even after substance use stops and recovery begins (HHS, 2016). This can make recovery a challenge, but many individuals do recover. While the brain is deeply involved in the onset and exacerbation of addiction, it can be surprising to learn that the social environment has a significant role in furnishing the positive elements that can govern successful recovery.

McIntosh and McKeganey (2000) surveyed 70 individuals in recovery from addiction and asked them how they stayed sober. The individuals in recovery described a range of



disconnecting from drug-using networks. New activities provide value, purpose, and renewed hope for the future. When new activities, especially paid employment, feel purposeful and meaningful, they can dramatically improve self-esteem and validate and reinforce a person's transformed identity. With the restoration of meaning and purpose through healthy activities and relationships, a substance-free identity becomes more rewarding. This "renewed sense of self" strengthens resistance to relapse because there is too much to lose (McIntosh & McKeganey, 2000, p. 190).

Addiction, and therefore recovery, involve the whole person in their environment. The detrimental changes to the brain as a result of addiction can last into sobriety and can result in relapse. The brain recovers with abstinence, but recovery efforts must also involve psychosocial changes that support recovery. It is imperative for child welfare professionals to understand that a holistic mind-body, bio-psycho-social approach is a means through which recovery can begin and be sustained throughout the lifespan.

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While the brain is deeply involved in the onset and exacerbation of addiction, it can be surprising to learn that the social environment has a significant role in furnishing the positive elements that can govern successful recovery.

McCauley, a physician and filmmaker, defines craving as "a ruminative, emotional, and involuntary process that many would describe as a form of suffering" (2010, p. 63).

The route to addiction, or this steadfast craving, is a three-stage cycle of binge/intoxication, withdrawal/negative affect, and preoccupation/anticipation. Over time, this cycle becomes more entrenched and inflexible and transforms the way the brain functions. This change in brain function impairs the power to control substance use (U.S. Department of Health and Human Services [HHS], 2016).

Where does this change happen in the brain and how does it impact a person's power of choice? Addiction causes disturbances in three important areas of the brain: the basal ganglia, the extended amygdala, and the prefrontal cortex. These regions are central to the onset, progression, continuation, and relapse to addiction. The disturbances in these areas of the brain create a heightened sensitivity to environmental cues associated with substance use that generate craving. These disturbances decrease the brain's sensitivity to pleasure and increase the brain's stress system. Finally, these changes weaken the brain's control system, which is essential to decision-making and regulating actions, emotions, and impulses. This culminates in easily triggered, prolonged, and persistent craving in a brain that has been biologically impaired when it comes to control. Therefore, the person has a terrible time fend-

ing off the craving and is vulnerable to relapse (HHS, 2016).

strategies for success that clustered around two primary recommendations: "(1) individuals have to distance themselves from their former life and, in particular, their drug-using network and (2) they have to develop a range of new activities and relationships" (p. 181).

To avoid temptations and triggers, individuals in McIntosh and McKeganey's study found it helpful to distance themselves from the culture that accepted and encouraged active substance use. This required dissolving relationships with those still using, which can be a challenge if the relationships are close (e.g., relatives or partners). Some individuals suggested picking up and moving to sever these ties. However, people in recovery often experience difficulties obtaining financial security, developing new supportive friendships, and finding meaningful sober activities if they make this move. These circumstances and barriers can be exacerbated for families navigating recovery that are child welfare-involved. Nevertheless, if a person successfully achieves distance, engagement in new sober activities and relationships can make sobriety meaningful, enjoyable, and reinforcing (McIntosh & McKeganey, 2000).

Building new ties while finding sober activities can create a transformed substance-free identity. Developing relationships that support sobriety creates feelings of social acceptance. It brings opportunities for participation in a substance-free world while decreasing the loneliness and isolation that often comes with

The Family First Prevention Services Act's Impact on Substance Use in Families

Korina Barry, MSW, LGSW, Kate Walthour, MSW, LISW, & Traci LaLiberte, PhD

The five major goals of the Family First Prevention Services Act of 2018 (Family First) include: 1) keeping children safe with their families through prevention services and treatment, 2) promoting kinship involvement, 3) reducing the overreliance on group care, 4) addressing the opioid crisis, and 5) supporting youth transitioning out of foster care (Sprow, n.d.).

Several of these goals directly impact child welfare-involved families who are affected by substance use. As a significant piece of legislation, the Family First Prevention Services Act expands existing reimbursements under Title IV-E of the Social Security Act. Historically, Title IV-E funds have primarily focused on reimbursement to states for the cost of foster care. In this way, Title IV-E funds subsidize foster care costs for children who live in extreme poverty (families with income at or below the 1996 AFDC requirements). Under Family First, services and programs eligible for Title IV-E reimbursement will include those that provide substance abuse treatment and

prevention. They will also need to be trauma-informed and provide approved evidence-based programming, either as a promising, supported or well-supported practice. The U.S. Department of Health and Human Services (HHS) has begun work to identify an approved list of these services and programs, however it is expected to take some time to review and approve all nominated interventions. HHS will also provide technical assistance, best practices and a clearinghouse for approved interventions and resources for Family First implementation. It is important to note that all reforms and new funding in prevention services and programs are optional for states and tied to requirements present within the legislation.

Families eligible for prevention services through Title IV-E funds will include “candidates” for foster care, including children at risk of re-entry into foster care, and their parents and relative caregivers. Each state is responsible for defining what a “candidate” is in their state. Importantly, *all children and families* are eligible for these services regardless of family income (a difference from the long-standing

funding of Title IV-E which is a means tested program).

Another aspect of this legislation is its emphasis on family-based substance abuse treatment. Effective October 1, 2018, Title IV-E foster care reimbursement funds are now available for a child's placement in a trauma-informed, residential, family-based treatment program with the parent, for up to 12 months in duration (see Everts, this issue).

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CAPTA Compliance and Noncompliance: Implications for Mothers with Substance Use Disorders

Margaret H. Lloyd, PhD

The Comprehensive Addiction and Recovery Act of 2016 was passed in response to the increasing incidence of prenatal opioid exposure and to promote early intervention services and post-natal stability (CARA; Pub. L. No. 114-198, § 130 Stat. 695). It amended our primary federal child welfare law, the Child Abuse Prevention and Treatment Act in three key ways (CAPTA; P.L. 111-320). One, CAPTA now mandates a notification to child protective services (CPS) of births affected by legal and illegal drugs. Two, CAPTA now specifies that plans of safe care, developed for all identified infants, must address the health and substance use treatment needs of both the infant and the mother. And three, CAPTA now requires data collection and monitoring on referrals and receipt of needed services for infant and mother.

A 2018 evaluation of the extent to which states' policies were consistent with CAPTA across its key domains was done by obtaining and analyzing 179 administrative, legislative, and policy documents from 49 states plus Puerto Rico and D.C. (Lloyd, Luczak, & Lew, 2019).

Only two states' (3.9%) policies comply with CAPTA across all domains. Thirty-two

states (62.7%) use language consistent with at least one domain of CAPTA. Nineteen states' (37.3%) policies are inconsistent with CAPTA on all domains. The domain that states most commonly follow is that plans of safe care be developed for all identified infants (16 states; 31.4%) and that plans of safe care address the needs of infants and mothers (15 states; 29.4%). However, only seven states (13.7%) correctly use the term “notify” to describe the process of contacting CPS regarding identified infants. The remaining 40 states (78.4%) use the term “report” or “refer.” Moreover, of these, 16 states (31.4%) have implemented a new reporting mandate because of CAPTA even though the Administration for Children and Families (2016) have clarified that, “such notification need not be in the form of a report of suspected child abuse or neglect.”

The implementation of new reporting mandates is concerning as it likely increases the number of infants, particularly infants of color, encountering the child welfare system (Kerker, Horwitz, & Leventhal, 2004; Prindle, Hammond, & Putnam-Hornstein, 2018; Chasnoff, Landress, & Barrett, 1990). Unfortunately, these infants are then at heightened risk for out-of-home placement

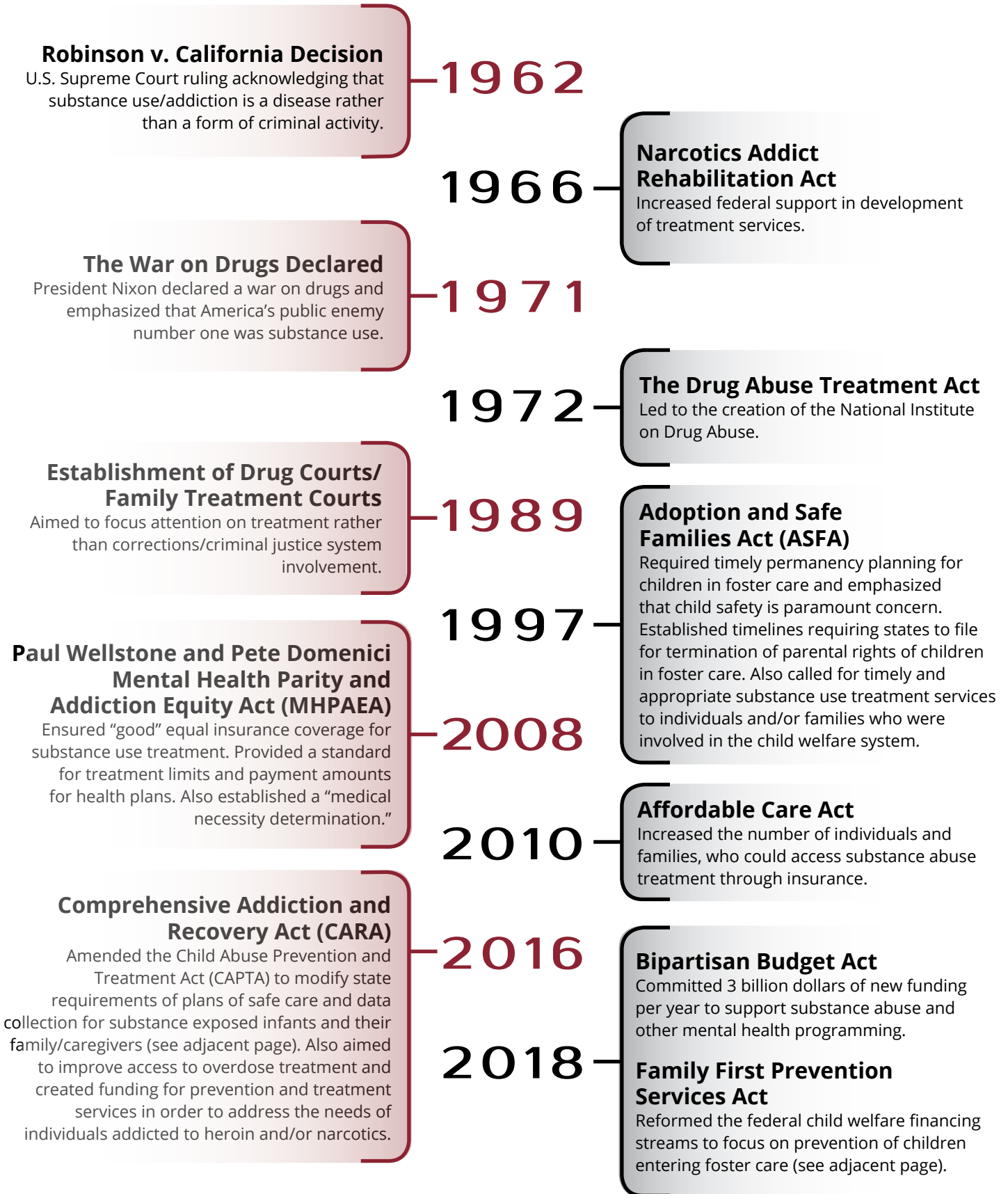
because child welfare workers inflate their assessments of child risk when they know the parent has a substance use issue (Berger, Slack, Waldfogel, & Bruch, 2010). These infants also spend more time in care and are less likely to achieve permanency compared to infants without substance-related removals (Lloyd, Akin, & Brook, 2017).

Due to its focus on early intervention and maternal-child health, the potential for CAPTA to improve the well-being of women with substance use disorders and their newborns is significant. Unfortunately, very few states have changed their policy to reflect its mandates. Continued efforts to provide in-depth technical assistance (e.g., Center for Children and Family Futures, 2017) hopefully will change these findings in the coming years. In the meantime, child welfare professionals must maintain a close eye on the potential for this policy to widen the net without concurrently changing the systemic response to these families.

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Relevant Federal Policy Timeline

Federal policies relevant to the intersection of child welfare and substance use.



Addressing Stigma of Substance Use Disorders in Child Welfare Settings

Lucien Gonzalez, MD, MS, FAAP

Stigma is a condition or status that is subject to prejudice and discrimination by others. There are several ways in which child welfare system involvement can be stigmatizing for a parent. These are compounded for both child and caregiver when substance use disorder (SUD) is an additional factor in the family. It is valuable to understand the different types of stigma, how they may be encountered in practice, and

and discrimination and status loss. In the case of substance use, affected individuals are often characterized as blameworthy for their illness, and if they are parents, they may be shamed for “choosing” alcohol or other drugs over their children. This represents a fundamental attribution error, or correspondence bias – a tendency to draw inferences about a person’s unique and enduring dispositions from

self-efficacy, and decreased confidence in one’s future. For example, a parent’s hesitancy in engaging with their child’s service providers or school can be construed as detachment or inaction, when frequently parents are unclear on their rights and are reluctant to ask clarifying questions.

Structural stigma is prejudice and discrimination by law, policy, and/or constitutional practice. For example, a person with a substance-related illness may experience discrimination in housing and employment. They may also experience barriers to treatment (Hart Research Associates, 2001). This can include lack of insurance or trouble obtaining insurance, prohibitive cost of treatment, and/or lack of access to treatment programs. How legislation such as the Americans with Disabilities Act is implemented and awarding of federal disability benefits can be more restrictive for people with SUD compared to those with non-substance use-related mental illness (Join Together, 2003; Committee on the Science of Changing Behavioral Health Social Norms, 2016; Kenny & Barrington, 2018).

This represents a fundamental attribution error, or correspondence bias — a tendency to draw inferences about a person’s unique and enduring dispositions from behaviors – without factoring in the context in which the behaviors occur.

methods for addressing stigma when working with families.

The three main spheres of stigma are public (social), self, and structural. Public stigma is the public reaction to persons with mental health and substance-related diagnoses. It consists of three components: stereotype generation, emotional reaction and prejudice,

behaviors – without factoring in the context in which the behaviors occur (Gilbert & Malone, 1995).

Self-stigmatization occurs when a person with a SUD becomes aware of public stigma, agrees with stereotypes, and internalizes them by applying them to themselves. Consequences of self-stigma can include low self-esteem, low

Person-Centered Language

The language providers use to describe individuals they work with matters. Language not only describes our reality, but also designs it. Professionals’ words can be harmful or healing and we need to pay attention to what we say. Below are some examples of deficits-based and strengths-based terms used in substance abuse and child welfare settings. Note that person-centered language is constructed with the use of post-modified nouns (e.g. person with a substance use disorder) literally putting the person first in the sentence structure.

Deficits-Based

Addict

Frequent Flyer

Hostile, Aggressive

Helpless/Hopeless

Mentally ill

Lazy

Manipulative

Unfit parent

Resistant

Suffering with

Abuses the system

Weaknesses

Strengths-Based

Person with a substance use disorder

Utilizes services and supports when necessary

Protective

Unaware of capabilities/opportunities

Person with a mental illness

Ambivalent; working to build hope

Resourceful

Person experiencing barriers to successful parenting

Chooses not to; isn’t ready for; not open to

Working to recover from; experiencing; living with

Good self-advocate

Barriers to change or needs

Tips for Practice

- **Acknowledge and name stigma.** Although social and structural stigma may not always be directly mitigated, name it, and do not underestimate the value of your support and validation.
- **Use person-centered language** (see sidebar, and Kelly, Wakeman, & Saitz, 2015).
- **Remember** that child removal, or the threat of it, is traumatic for parents and children.
- **Avoid guilt and shame tactics.** Confrontation and shaming are not only dehumanizing and disrespectful, they are not effective approaches to SUD treatment.
- **Emphasize caregiver strengths and promote resilience.**
- **Honor the parental role.** Even in cases where permanent removal becomes necessary, the child will need help resolving that relationship. Disrespecting that bond is not helpful to the child.

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Source: MNCAMH Person-Centered Language Clinical Tip
z.umn.edu/MNCAHMPersonCenteredTip

Poverty, Parental Addiction, and Family Reunification

Margaret H. Lloyd, PhD

For families who come into contact with the child welfare system, those with parental substance use disorder (SUD) can expect to experience worse outcomes at every measure compared to families with no parental SUD (e.g., Dubowitz et al., 2011; Testa & Smith, 2009; Donohue, Romero, & Hill, 2006; Maluccio & Ainsworth, 2003; Brook, McDonald, Gregoire, Press, & Hindman, 2010; Akin, Brook, & Lloyd, 2015; Wolock & Magura, 1996). Some might argue that given the dismal statistics for these families, termination of parental rights (TPR) is the best option. However, it is a complicated issue. Research shows that mothers struggling with addiction who lose parental rights of one child are highly likely to have another child, and that child is at increased risk of being substance-exposed in utero (Grant, Graham, Ernst, Peavy, & Brown, 2014). Subsequently, that child is then at high risk of becoming involved with the child welfare system (Smith & Testa, 2002). Because the cycle of untreated addiction and child welfare involvement is not halted by TPR, focusing on safe and stable reunification is a critical research priority if we hope to ensure child well-being in the long term.

Advancing child welfare practice requires two things: we must understand differences among the population of substance-involved families and we must account for the effect of other factors beyond the substance use. Because addiction is a health problem, it is useful to adopt one of the primary frameworks in the field of public health, social determinants of health, in understanding the problem. With attention to social justice and interest in identifying root causes of inequality, this framework calls for examination of ways that discrimination directly and indirectly affects health and well-being.

A recent study focused on the effect of several socioeconomic status (SES) risk factors among mothers with SUD seeking reunification (Lloyd, 2018). We know from earlier work that women are less likely to access treatment in the presence of economic disparities (Greenfield et al., 2017). We also see treatment completion associated with several types of SES factors including income, insurance coverage, and family size (Greenfield et al.).

Applying this framework led to hypothesize that reunification likelihood would decrease and time in foster care would increase as families experience more SES risks. The SES risks assessed were: 1) < \$15K annual income, 2) unemployment, 3) single parent household, and 4) out-of-home placement due to housing-related factors. In the sample of 325 mother-child dyads, 4% of cases had zero risks, 24% had one risk, 36% had two risks, 31% had three risks, and 4% had four risks.

examined (see Figure 2). It took nearly twice as long for 50% of the mothers in the three-risks group to reunify compared to those in the zero-risks group.

Risk level affected the amount of time families were given to attempt reunification as well as the likelihood that they would reunify at all. Based on these findings, it appears that a couple of tipping points exist. At three risk factors, families were at significantly reduced likelihood of reunification and spent hundreds more days in foster care compared to the one-risk group. However, the three-risks group also spent 200 days longer in care compared to the four-risks group. At four risk factors, the courts appeared to make faster decisions to terminate parental rights.

Despite several limitations, these findings provide valuable implications for direct child welfare practice. First, findings suggest that families with SUD in child welfare are a varied

Families with SUD in child welfare are a varied population. Simply treating the substance use disorder or monitoring abstinence through drug tests is insufficient for ensuring a safe and stable reunification.

Further analysis found that differences in likelihood of reunification between zero, one, and two risks were not significant. There was a significant effect when a family accumulated three risk factors (see Figure 1). Compared to cases with one risk, cases that had three risks were nearly 40% less likely to reunify. Families with four risks were over 50% less likely to reunify compared to the one-risk group, though this finding is not as significant due to a low number of families with four risks.

Length of time that passed before 50% of the group achieved reunification was also

population. Simply treating the substance use disorder or monitoring abstinence through drug tests is insufficient for ensuring a safe and stable reunification.

In addition, a multi-faceted approach to overall risk reduction seems to be more important than addressing specific, individual risks. It appears beneficial to reduce a family's risk load to two or fewer risk factors to mitigate problems. Child welfare workers need to rely on varied assessments and gauge multiple dimensions of SES to accurately understand a family's circumstances.

Continued on page 33

Figure 1: Difference in Reunification Likelihood Compared to One-Risk Cases (n = 325)

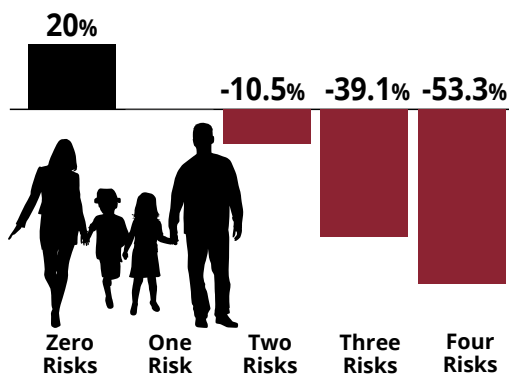
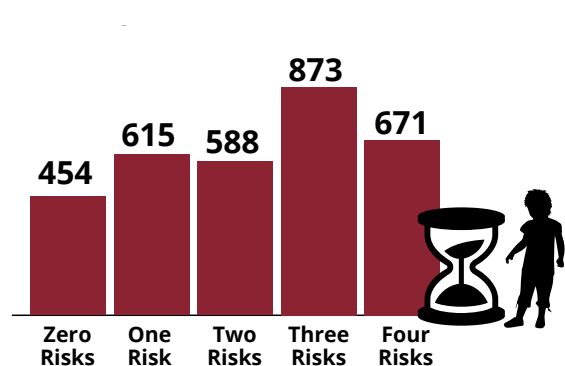


Figure 2: Median Days in Foster Care for Each Risk Group (n = 325)



Implementing Systems Change: Opportunities for Collaboration between Child Welfare and Substance Use Disorder Treatment Systems

Amy S. He, PhD

When child welfare (CW) organizations collaborate with substance use disorder (SUD) treatment systems to better serve caregivers dealing with SUD, positive outcomes emerge such as improving connection to and delivery of SUD services (He, 2017; Grace, Coventry, & Batterham, 2012; Green, Rockhill, & Burrus, 2008; Osterling & Austin, 2008). Collaboration practices vary, but can include activities such as co-location of staff, interdisciplinary training, joint case planning, and data linkages (He, 2015; Wells & Chang, 2012; Young & Gardner, 2002).

Research examining barriers and pathways to collaboration between the two systems is expanding (Drabble, 2010; He, 2015; Young and Garner, 2002), especially as it relates to the various stages of intervention in the SUD treatment process (Arria & Thoreson, 2007; Belenko et al., 2017; He, 2017; Traube et al., 2015). Other research has explored factors at various service levels that influence collaborative efforts for the delivery of SUD treatment services (He, 2015; Wells & Chuang, 2012). To further expand this research and to address current trends and policies related to caregiver SUD in the CW system, there are two additional opportunity areas for CW-SUD collaboration – systematic data collection and a standardized SUD assessment tool.

Although it is widely acknowledged that caregiver SUD is a prevailing issue in CW, there is a lack of systematic and ongoing data collection on the prevalence and trends of SUD impacting CW-involved caregivers. Moreover, most CW agencies and research on this topic do not capture information on the different types of SUD (e.g. opiates, methamphetamine, etc.) that impact CW-involved families (Child Welfare Information Gateway, 2014; Young, 2016). While this data may be collected by SUD treatment systems, this information is oftentimes not relayed back to the CW system. This makes it challenging for these two systems to collaborate on the development of targeted prevention/intervention services and funding opportunities that address specific SUD needs impacting their shared clientele. For example, despite recent calls from social service systems to address the opioid crisis and the enactment of related federal policies, there is a dearth of information regarding the prevalence of caregiver opioid use problems (OUP) within the



CW system. While there is growing research suggesting that OUP are indeed increasing among CW-involved families (Quast, Storch, & Yampolskaya, 2018; Radel, Baldwin, Crouse, Ghertner, & Waters, 2018), emerging research indicates that this prevalence is mainly increasing among white caregivers and not among other racial/ethnic groups (Mowbray et al., 2017). These findings are mirrored in the general population. Therefore, without available data to inform decision-making processes, CW and SUD organizations may work together to prioritize OUP treatment needs, all the while diverting resources from treatment programs and services that address other SUD (e.g., methamphetamine and cocaine). This in turn could disproportionately and negatively affect services and resources for CW-involved caregivers of color who may be struggling with other SUD.

Collaboration between CW and SUD organizations to ensure current data on prevalence and trends of SUD is crucial in informing practices and policies that reflect the current needs of CW-involved families. Therefore, CW and SUD treatment systems and federal policymakers need to provide guidelines for developing data-sharing agreements, as well as establish protocols for the systematic collection of SUD-related data at the local, state, and national level. Once the data is collected, CW and SUD systems could then collaborate to create data management tools such as data dashboards to provide real-time data that informs decision-making processes related to SUD programs and services.

Another CW-SUD collaboration opportunity is a standardized SUD assessment tool for CW workers. Given the high number of families coming into contact with the CW system because of caregiver SUD, it is imperative that workers have resources to identify SUD needs in a timely manner. However, the limited expertise of CW workers in dealing with SUD and limited SUD resources available to them often inhibits their ability to accurately assess for caregiver SUD (Chuang, Wells, Bellettiere, & Cross, 2013; Feit, Fisher, Cummings, & Peery, 2015). This likely contributes to the challenge of early identification of caregiver SUD needs in child welfare investigations (Chuang et al., 2013; Schroeder, Lemieux, & Pogue, 2008).

The use of a standardized SUD assessment instrument has been found to better equip CW workers with the tools necessary for accurate identification and assessment of caregiver SUD (Feit et al., 2015, Traube et al., 2015). Adoption of a national and uniform psychosocial assessment tool such as the Addiction Severity Index (ASI), an evidence-based instrument that assesses for SUD needs (McLellan et al., 1992), could serve as a platform to systematically capture data on SUD and other psychosocial problems impacting CW-involved caregivers. Given that these caregivers often deal with co-occurring problems related to SUD (e.g. mental health, and legal and health issues), national implementation of a standardized assessment instrument that assesses for these needs can equip workers to more quickly identify various treatment needs. Additionally, use of the same national assessment tool by both CW and SUD treatment systems could serve to establish a common language between siloed CW and SUD treatment systems.

Implementation of systems-level collaborative practices such as systematic collection of SUD data and use of a standardized SUD assessment tool could serve to inform practice and policy, provide workers with tools to better serve families, and bridge the interdisciplinary gap between systems.

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Understanding the Impact of Prenatal Substance Use on Mother and Child

Krystle McConnell, MPH, Martha L Velez, MD, CAC, & Lauren M. Jansson, MD

It is estimated that 9.4% of pregnant women use alcohol regularly, 2.3% binge drink, 15.4% smoke cigarettes, and 5.4% use illicit drugs (SAMSHA, 2014). Opioid use during pregnancy has increased in tandem with the opioid epidemic (Haight, 2018), and gestational cannabis use is increasing following legalization in several states (Young-Wolff et al., 2019). Generally, women use and/or misuse substances during pregnancy because they are unaware of their pregnancy, unaware of potential fetal/infant effects of prenatal exposures, or because they have a substance use disorder (SUD) and cannot abstain.

Effects of prenatal substance use include a variety of complications. Changes in the development of the fetus/child depend on the type of substance(s) used and the timing, dose, and patterns of use. Alcohol exposure has been



Long-term effects of prenatal substance exposure are difficult to identify due to conflicting research and multiple confounding factors typically present in this population, but include effects on growth, behavior, cognition, language, and achievement.

linked to birth defects (e.g., heart, kidney) that can be identified prenatally, but nicotine, alcohol, opiates, cocaine, and amphetamines are all linked to low birth weight. Many substances can produce neurobehavioral dysregulation (e.g., tremors, sleeping difficulties) in the neonatal period and beyond, such as cocaine and marijuana. Neurobehavioral deficits (e.g., difficulty with staying alert or paying attention due to sensory overstimulation) can occur at any point when a mother lacks the ability to sensitively handle the infant or to understand the symptoms the infant is demonstrating.

Neonatal abstinence syndrome (NAS) occurs when in-utero substance exposure ceases at birth. NAS is typically described in opioid-exposed infants, but signs of neurobehavioral dysfunction consistent with withdrawal after delivery can also be caused by alcohol, marijuana, nicotine, benzodiazepines, and psychiatric medication exposures. NAS-affected infants typically have central and autonomic nervous system problems that can affect sleep/awake patterns, movement/muscle tone control, sensory over- or under responsiveness, and autonomic functioning such as breathing and diges-

tion. This can result in difficulties with feeding, sleeping, growth, and the ability to manage environmental stimulation and interactions.

Long-term effects of prenatal substance exposure are difficult to identify due to conflicting research and multiple confounding factors typically present in this population, but include effects on growth, behavior, cognition, language, and achievement. Several studies suggest that many effects of prenatal exposures are not exhibited until childhood or adolescence (Behnke & Smith, 2013). Studies of school-age children found that between 2-5% of the general population may be affected by Fetal Alcohol Spectrum Disorder, ranging from mild to severe impairment (May et al., 2014).

Prenatal exposure to nicotine, alcohol, marijuana, opiates, and cocaine has been tied to behavioral problems including hyperactivity,

impulsivity, lack of inhibition, poor sensitivity to social cues, and substance abuse. Prenatal exposure to nicotine, alcohol, marijuana, and cocaine have been linked to cognitive deficits, including attention difficulties, sensory processing deficits, perceptual problems, and executive functioning deficits. Nicotine, alcohol, and cocaine have been linked to language delays. There is less consensus regarding the potential cognitive and language effects of prenatal opiate exposure (Behnke & Smith, 2013).

Effects may be exacerbated by a child's environment, including parental physical and mental health, substance use/misuse, incarceration, violence, poor education, unhealthy parenting styles, and poverty. Latent effects may make it difficult for healthcare providers and social workers to identify and address prenatal

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Resources

Early intervention services for children

CDC Early Intervention, Information by State
<https://www.cdc.gov/ncbddd/actearly/parents/states.html>

Policy recommendations related to pregnant and postpartum women, their infants and families

SAMHSA 2017 Policy Academy: Improving Outcomes for Pregnant and Postpartum Women With Opioid Use Disorders and Their Infants, Families, and Caregivers
https://ncsacw.samhsa.gov/files/Policy_Academy_Dissemination_Brief.pdf

Families affected by opioid use and neonatal abstinence syndrome

HRSA's Home Visiting Program: Supporting Families Impacted by Opioid Use and Neonatal Abstinence Syndrome
<https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/MIECHV-Opioid-NAS-Resource.pdf>

What about Dad? Engagement of Fathers to Improve Outcomes for Children

Carla Smith Stover, PhD

Approximately 40-60% of the 1.2 million men entering substance abuse treatment in the United States each year (SAMHSA, 2011) are fathers of children under 18 (Rubenstein & Stover, 2016; Stover, Hall, McMahon, & Easton, 2012; Stover, McMahon, & Easton, 2011). There is significant evidence of the negative impact paternal substance use can have on children. Fathers who misuse substances may have a more limited role in their children's lives and provide less financial support than non-substance using fathers (McMahon, Winkel, & Rounsaville, 2008), which may lead to child welfare providers making less effort to engage these fathers. However, involvement of fathers in child welfare cases may reduce the amount of time a child spends in care and increase the likelihood of reunification (Burrus, Green, Worcel, Finigan, & Furrer, 2012).

Men often do not know how to re-engage with their children after long absences due to addiction, incarceration, and/or treatment (Stover, Carlson, & Patel, 2017). They grapple with feelings of guilt about their behaviors while using substances. They have concern about the role model they have been and lack an understanding of how to reassume a fathering role (McMahon et al., 2008; Rubenstein & Stover, 2016). Further, although substance use treatment can reduce violence, it alone does not treat all problems related to violence and/or poor parenting (Murphy & Ting, 2010) seen in



ing concerns related to their children (Stover et al., 2012). Ninety-five percent of fathers in residential substance use treatment think about their children all the time, 70% agreed it would be helpful to discuss father-child issues as part of their treatment, and 77% indicated they would be interested in fatherhood and co-parenting sessions (Rubenstein & Stover, 2016). As part of their residential treatment, fathers reported a wish for individual and family therapy related to parenting and co-parenting, as well as a fatherhood-focused group (Stover et al., 2017). Fathers indicated a

Nurturing Parenting is an adaptable program offered as a one-to-one or group model (Bavolek, 2000). The program has been used with mothers and fathers struggling with addiction in combination with substance use treatment. It has shown significant reductions in child maltreatment risk and relapse for fathers in residential substance use treatment or jail (Palusci, Crum, Bliss, & Bavolek, 2008). Fathers for Change is an individual treatment program that has been successfully implemented in outpatient and residential substance use treatment settings (Stover, 2015; Stover et al., 2017; Stover, Carlson, Patel, & Manalich, 2018). It targets IPV, substance misuse, and child maltreatment risk simultaneously. The program has been shown to improve emotion regulation, reduce IPV, reduce substance use, and improve father-child interactions.

It would be beneficial for substance use programs to offer individual treatment programs such as Fathers for Change that address topics including how to talk with children about addiction, how to plan visits, and how to prepare for transitions. Programs could also include a group intervention component focusing on parenting practices and attachment such as Nurturing Parenting or Circle of Security (Cassidy et al., 2010; Cooper, Hoffman, Powell, & Marvin, 2011). Child welfare professionals should advocate for these services with treatment providers and include them as part of fathers' case plans. Such services would allow for improved coordination of care at a single treatment program.

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Despite evidence that fathers with substance use problems would benefit from interventions to improve their parenting, these services have not been readily available.

fathers who misuse substances. Substance using fathers are more likely to exhibit hostile-aggressive parenting (Stover, Easton, & McMahon, 2013), lower sensitivity and warmth (Eiden, Colder, Edwards, & Leonard, 2009), higher rates of negativity during interactions with children (Jacob, Krahn, & Leonard, 1991), more problematic disciplinary practices, and less appropriate oversight of their children (Fals-Stewart, Kelley, Fincham, Golden, & Logsdan, 2004). Additionally, there is significant evidence of the overlap of substance use, intimate partner violence (IPV), and child maltreatment (Foran & O'Leary, 2008; Hamby, Finkelhor, Turner, & Ormrod, 2011).

Despite evidence that fathers with substance use problems would benefit from interventions to improve their parenting, these services have not been readily available. Surveys of fathers entering outpatient substance use treatment indicated 27% hav-

ing concerns related to their children (Stover et al., 2012). Ninety-five percent of fathers in residential substance use treatment think about their children all the time, 70% agreed it would be helpful to discuss father-child issues as part of their treatment, and 77% indicated they would be interested in fatherhood and co-parenting sessions (Rubenstein & Stover, 2016). As part of their residential treatment, fathers reported a wish for individual and family therapy related to parenting and co-parenting, as well as a fatherhood-focused group (Stover et al., 2017). Fathers indicated a

desire for support in how to engage with their families in healthy ways in order to return to an active parenting role. Generally, men reported a lack of support in this area as a barrier to their continuation in treatment. Integration of parenting and co-parenting focused work could increase fathers' engagement in substance use treatment programs, reduce stress, and contribute to relapse prevention. This would also facilitate fathers' completion of child welfare case plans that include parenting interventions such as parenting classes or family therapy. Referring fathers to several agencies – with multiple intakes, providers, and requirements – increases the burden on parents compared to offering programs within the same treatment facility. Having to work with multiple agencies reduces the likelihood of success and impedes coordination of care that would benefit families.

Advancing Lessons Learned in Child Welfare and Recreational Use Marijuana Legalization

By Meredith Silverstein, PhD, Carole Wilcox, MSW, LLSW, & Jade Woodard, LSW, MPA

Thirty-three states and the District of Columbia have passed laws legalizing marijuana for medical or recreational use (Governing, 2019). Colorado led the way in 2012, becoming one of the first states to allow legal sales of recreational marijuana and the impact of legalization on the state's child welfare system is still emerging (Colorado Health Institute, 2015). Nevertheless, Colorado's experience has lessons to offer other states and child welfare systems where marijuana legalization may be on the horizon. The legalization of marijuana for recreational use caused reexamination of perspectives, partnerships, policies, and practices in Colorado's child welfare system. States are encouraged to advocate for family perspectives and actively represent the child welfare system as new legislation unfolds.

At least 70% of parents involved in the child welfare system suffer from a substance use disorder (SUD) and many have a co-occurring mental health disorder (MHD) (Children Welfare Information Gateway, 2014). Nationally, marijuana is the most widely used illicit drug, with 40.9 million people reporting use in the past year. By comparison, 18.1 million report past year psychotherapeutic drug use such as prescription opioids, sedatives, and tranquilizers (SAMSHA, 2018). In 2017, Colorado ranked second for past 30-day illicit drug use and third for past 30-day use of marijuana and pain reliever misuse (SAMSHA, 2017). Yet, research on effects of marijuana and parenting is sparse and inconclusive. Similarly, research on marijuana's effects on fetal development suggests poorer birth outcomes, but this is limited by self-report data and confounded by use of tobacco and other substances (Ng & Tung, 2016).

Colorado, comprised of 64 counties, the Southern Ute Indian Tribe, and the Ute Mountain Ute Tribe, has a state-supervised and county-administered child welfare system. Thus, complex practice variations occur between counties. Most counties utilize a system of differential response (DR), providing multi-track child protection responses. Some counties have Dependency & Neglect System Reform across systems judicial and child welfare collaboration to improve outcomes for families affected by SUD and co-occurring MHD (Colorado Judicial Branch, 2019). These strategies are intended to strengthen a system's capacity to respond to child safety concerns.

Since the legalization of marijuana, Colorado has experienced increased child maltreatment reporting, presenting new screening challenges (Personal Communication, Solomon, 2019). Reports have included police



interventions on illegal cultivation activity with children present and medical concerns of prenatal exposure or marijuana exposure through breastfeeding. Home-based marijuana growing operations may pose greater risks to the health of children living in such homes due to risks of chemical exposures and mold associated with poor ventilation for children (Ng & Tung, 2016). Unfortunately, Colorado cannot quantify impact on reporting rates or separate

communication, Solomon, 2019). For example, reducing reliance on drug testing to measure child safety and instead conducting comprehensive assessments. Considering marijuana use as comparative to alcohol use is helpful when encouraging critical thinking about child safety impact. Similar to alcohol use, parents can legally use marijuana, yet the child must be cared for safely. Caseworkers should assess the parent-child relationship and use a child

Considering marijuana use as comparative to alcohol use is helpful when encouraging critical thinking about child safety impact. Similar to alcohol use, parents can legally use marijuana, yet the child must be cared for safely.

marijuana data from other substances due to lack of data (Ng & Tung, 2016). For counties utilizing DR, marijuana-related reports typically receive a family assessment response, an approach focusing on support and assistance rather than a traditional investigative approach that has no maltreatment substantiation. Therefore, Colorado has not seen an increase in child maltreatment substantiations since legalization was enacted.

Over the past seven years of legalized sales of marijuana in Colorado, child welfare workers have found it is critical to keep child safety as the paramount consideration, while understanding case plan compliance does not always equal child safety (Personal Com-

development lens to gauge the child's ability to protect or care for themselves in the event the parent is incapacitated (Personal Communication, Dossey, 2019).

Training will help child welfare professionals understand laws, regulations, and available research on marijuana and conduct holistic assessments, which supports evolving child welfare practice. Best practices include the application of screening, brief intervention, and referral to treatment protocols (SAMHSA, 2019). Motivational Interviewing (MI) can also be utilized to assess parental judgment and to identify behavioral indicators that create a safe environment.

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Mothers as Medicine: A New Approach to Neonatal Abstinence Syndrome (NAS)

Matthew Grossman, MD

Infants born to mothers using opioids often develop signs and symptoms of withdrawal in the first few days after birth. This collection of withdrawal signs is referred to as neonatal abstinence syndrome (NAS) and includes irritability, poor feeding, tremors, high-pitched cry, increased muscle tone, and loose stools. Infants with NAS have among the longest lengths of stay of any pediatric disorder and the number of infants born with NAS increased five-fold from 2004 to 2014 (Winkelman, 2018). The traditional approach to management of infants with NAS is focused

Until recently, this traditional model was almost universally accepted despite limited evidence of its benefits. In fact, this approach has several glaring problems. It produces extremely long lengths of stay and requires the utilization of large amounts of opioids (Patrick, 2015). Management of care is driven by evaluation tools that require the assessor to disturb the infant. This exacerbates signs of withdrawal. Perhaps most importantly, this approach often provides substantial barriers to maternal-infant bonding by separating the infant from the mother.

Second, in our approach infants are assessed by whether they can do things that infants should be able to do, specifically, eat, sleep, and be consoled. In the traditional model when infants became irritable and difficult to console, they were usually given powerful medications. In the new approach the infant would be picked up, held, and tended to like any other infant.

Lastly, the experience of mothers of infants with NAS has generally not been a positive one. Qualitative studies have reported that mothers feel judged by the staff and guilty because they know that whatever substance they were using, even if prescribed by a physician, has caused their baby to experience withdrawal (Cleveland, 2014). New mothers struggling with substance use disorder or in recovery are a vulnerable population. At Yale, we realized we were making an already challenging situation more difficult for these mothers. We were creating barriers to prevent mothers from bonding with their newborns, blaming them for putting their babies through this experience, and treating them with a lack of support and empathy. It seemed that positive outcomes would increase both in the hospital and after discharge if we empowered, encouraged and supported mothers. We found that mothers could develop pride in their parenting because they knew that they were the treatment for their baby and they went home with the confidence that they could continue to be successful at home. Even if child protection decided to place the infant in out-of-home care, the biological mother would often have the first several days of life to bond with her infant – a bond that is especially important for reunification.

The results of our approach were dramatic. The infant hospital length of stay decreased from 22.5 days, which was about the national average, to 5.9 days, and the percentage of opioid-exposed infants treated with morphine decreased from 98% to 14% (Grossman, 2017). This new approach relies on the empathy and goodwill that is found in abundance in pediatric care providers and has produced outstanding results in the hospital. Though studies addressing the long-term outcomes of infants with NAS are lacking, continuing with the same intention of supporting and empowering the family is likely to have a positive benefit.

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We found that mothers could develop pride in their parenting because they knew that they were the treatment for their baby.

on reducing symptoms of withdrawal. Infants typically spend weeks in the hospital being cared for by medical staff with little priority on the family experience.

In the traditional approach to care, infants are managed in neonatal intensive care units (NICU). Signs of withdrawal are measured using a standardized tool and infants are treated with medications, usually either morphine or methadone. Non-pharmacologic interventions are listed as first-line treatment and can include a low stimulation environment, feeding on demand, swaddling, and rooming a parent and infant together to provide skin-to-skin care and minute-to-minute tending. However, there is little ability to deliver these treatments in most NICU settings (Hudak, 2012). In the traditional model of care, staff members are responsible for the care of the infant. While parents may visit, they are not always made to feel welcome.

A new model developed at Yale-New Haven Children's Hospital shifts NAS management to a family-centered approach. The goal of this approach was to provide families with a positive experience while in the hospital and better equip them for success at home. We initiated a multi-year quality improvement project that essentially de-medicalized the care of infants with NAS and was based on three simple concepts: the mother is medicine, treat the infant like an infant, and treat the mother like a mother (Grossman, 2017).

First, after substantial improvement in outcomes when the focus was placed on keeping the mother and infant together, we began to view the role of the mother in the treatment of an infant with NAS as similar to that of antibiotics for pneumonia. Once this connection was made, it became unreasonable to manage infants with NAS in our NICU where parents could not room with them.

De-medicalized care is based on three simple concepts

1



The mother is medicine

2



Treat the baby like a baby

3



Treat the mother like a mother

Mothering from the Inside Out: A Mentalization-based Therapy for Mothers in Substance Abuse Treatment

Nancy E. Suchman, PhD

Neuroscientific evidence suggests that alterations in the brain's reward system associated with chronic substance use can affect a mother's response to her infant (Rutherford, Williams, Moy, Mayes, & Johns, 2011; Kim, Iyengar, Mayes, Potenza, Rutherford, & Strathearn, 2017). In response, clinical scientists have increasingly developed parenting interventions that target psychological vulnerabilities associated with early stages of addiction recovery, including emotion dysregulation and discontent, compromised impulse control, and the absence of pleasure associated with caregiving. Many of these efforts target the parent's capacity to mentalize, or make sense of the emotional distress associated with pregnancy and parenting (Pajulo, Pajulo, Jussila, & Ekholm, 2016; Paris, Herriott, Holt, & Gould, 2015; Stover, Carlson, & Patel, 2017).

Mothering from the Inside Out (MIO) is a 12-session evidence-based individual parenting therapy for mothers with histories of substance abuse. It was developed to address the psychological challenges associated with addic-

ated state. The third objective is to foster the mother's capacity to mentalize for her child. Once the therapist has helped the mother restore her capacity to mentalize for herself, she pauses the conversation again and encourages the mother to imagine the thoughts, wishes, intentions, and emotions that her child might be experiencing during the stressful interaction. The therapist maintains an inquisitive and non-expert stance toward the mother's experiences while exploring what the mother imagines the child's experiences to be. Maintaining the mentalizing stance is probably the most important and most difficult component of MIO to implement and maintain (see Allen, Fonagy, & Bateman, 2008; Bers, 2016).

The mother determines the focus of each session. Maintaining focus on what is on the mother's mind is more likely to lead directly to sources of emotional arousal where mentalizing is lost. Stressful situations, particularly those where the mother's capacity for reflective functioning is challenged, are considered in detail. If the child is not the immediate topic, the therapist will bring the child into mind when



MIO has demonstrated efficacy in two randomized controlled clinical trials. When compared with an active 12-session individual psychoeducational intervention, MIO demonstrated greater efficacy for improving parental reflective functioning, mother-child interactions, and maternal substance use (Suchman, DeCoste, McMahon, Rounsaville, & Mayes, 2011; Suchman et al., 2017). In the second trial, attachment security improved in children of MIO-completing mothers who had severe addiction histories (e.g., family histories, early onset). MIO is now being tested throughout the northeastern U.S. as a prelude to early childhood and dyadic interventions (e.g., Child-Parent Psychotherapy) for its potential to strengthen amenability to treatment and outcomes for mothers with substance use disorders and their young children. MIO is also being tested when delivered by addiction counselors as part of addiction treatment (Suchman, Borelli, & DeCoste, 2018).

Introducing a mentalization-based approach to parenting treatment that focuses on the mother's own internal experiences and reactions to parenting can support the mother in knowing and understanding her child in a deeper way. If this approach continues to be brought to scale, children in the child welfare system may be more likely to experience their mothers in recovery as a secure attachment base.

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The mother determines the focus of each session. Maintaining focus on what is on the mother's mind is more likely to lead directly to sources of emotional arousal where mentalizing is lost.

tion (Suchman, DeCoste, McMahon, Dalton, Mayes, & Borelli, 2017). MIO targets two components of a mother's parental reflective functioning: 1) the capacity to make sense of and manage one's own strong emotional states during stressful moments of parenting, and 2) the capacity to accurately perceive and make sense of a child's emotional needs through a developmental attachment lens (Suchman, DeCoste, Leigh, & Borelli, 2010).

The MIO approach involves fostering a process rather than delivering specific content. The first and most important objective in this process is to form and maintain a therapeutic alliance between the therapist and mother. Without this alliance, other intervention strategies will likely fail. The second objective is to foster the mother's capacity to mentalize for herself. The therapist listens for moments when the mother has become affectively aroused and has experienced a limited capacity to recognize her own internal mental states. The therapist pauses the conversation and helps the mother uncover and make sense of the thoughts, wishes, emotions, and intentions that accompanied events which led to her affectively-

the timing seems appropriate. The therapist is careful not to shift the focus to the child too early.

Developmental guidance about the child's emerging cognitive, language, and social capacities can be provided when the mother's expectations for the child appear to be unrealistic. Strategies for promoting a secure attachment (e.g., managing transitions and separations) can also be provided when the mother expresses uncertainty about what to do or how to interact with her child in specific situations.

MIO was designed to supplement addiction treatment programs, ensuring that mothers have access to the many resources they need. Most mothers who are battling chronic addiction require assistance in multiple areas including relapse prevention, housing, clothing, food, transportation, healthcare, psychiatric services, victim services, education, and vocational training. MIO, therefore, provides case management for assistance with various family and child needs such as developmental assessment, child care and preschool registration, and follow-up family-child therapy.

Child Welfare Practices of the Sobriety Treatment and Recovery Teams (START) Model

Tina Willauer, MPA

Child welfare agencies across the nation are struggling to identify effective strategies to address the needs of families with child-welfare involvement, particularly those with young children and parents with substance use disorders. In 2002 for example, 13% of children who entered foster care were infants under age one (Children’s Bureau, 2006) compared to 19% in 2017 (Children’s Bureau,

standards that specify the number of days from the CPS report to parents engaged in at least five treatment sessions (See Figure 1). START research shows that more rapid access to treatment is associated with higher rates of parents achieving early recovery and children remaining with their parents throughout the child welfare case (Huebner, Posze, Willauer, & Hall, 2015). It may take two to three years to establish the

ment; 3) the needs of each family member are assessed and addressed; and, 4) relatives are included in the case plan. The team provides intensive oversight and support for parents and children that match the higher service delivery guidelines of START. The family mentor, who is a person with at least three years of sustained recovery, ensures that parents are engaged in treatment and community recovery supports and they coach parents on sober parenting and living skills (Huebner, Hall, Smead, Willauer, & Posze, 2018).

Together this team ensures that a family-centered approach is used, including: 1) the family has a voice in decisions; 2) children are kept safely with their parents or have frequent and extended visitation to learn parenting skills and attachment; 3) the needs of each family member are assessed and addressed; and, 4) relatives are included in the case plan.

The collaboration of START with SUD treatment providers is a cornerstone of START strategies. In addition to working together toward mitigating barriers to achieving quick access to treatment, the collaborative team at the local and state level engages in system change efforts. Traditionally, SUD treatment has focused on the parent while child welfare has focused on the child. In the START model, both systems must share responsibility for parent and child outcomes. SUD treatment providers begin to address adult behaviors that may threaten child safety while the CPS worker/family mentor dyad make sure that parents attend treatment sessions. Both agencies participate with the family in decision-making regarding treatment needs, child safety, child placement, family logistics (e.g. child care and transportation), and implementing a case plan agreed upon by all. Also, they examine program outcome indicators together and identify ways to improve service delivery. When a parent relapses, the collaborative team decides on a response that is most likely to reengage the parent and keep the children safe. Achieving this level of collaboration and shared responsibility requires persistent efforts and professionals who understand each agency’s values, priorities, and business practices and then agree on new shared values, priorities, and business practices.

2018). An estimated 61% of those infants may be affected by parental substance use disorders (SUD) (Wulczyn, Ernst, & Fisher, 2011).

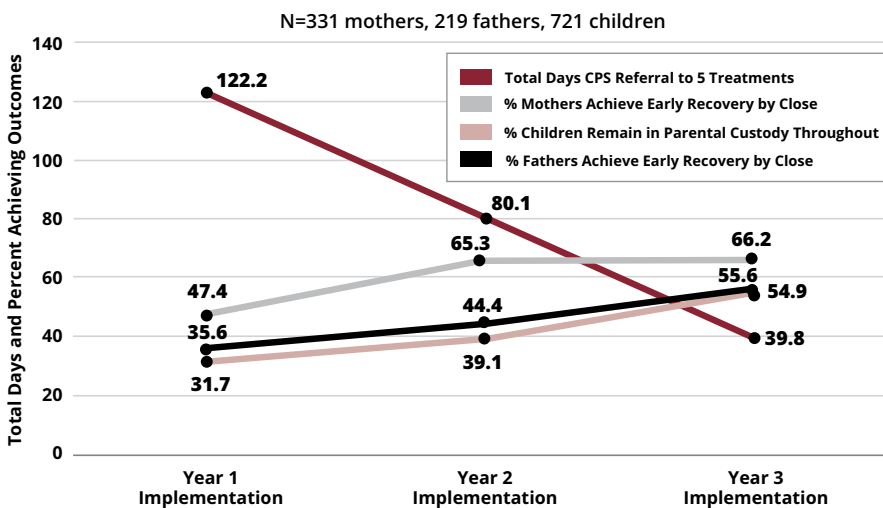
The Sobriety Treatment and Recovery Teams (START) model, which falls under the national nonprofit Children and Family Futures, is a child welfare-led intervention specifically designed to transform the system-of-care within and between child welfare agencies and substance use disorder (SUD) treatment providers. START reduces barriers to treatment service delivery and promotes rapid access and retention in intensive treatment services. This is in adherence with the model’s timeline

START practices that support rapid access to treatment services.

Quick access and retention in intensive treatment services matched to the parent’s needs however, is achieved only as a culmination of several START practice strategies. A specialized child protective services (CPS) worker is paired with a family mentor and is assigned a reduced caseload. Together this team ensures that a family-centered approach is used, including: 1) the family has a voice in decisions; 2) children are kept safely with their parents or have frequent and extended visitation to learn parenting skills and attach-

When implemented with fidelity, the START model shows promise as an evidence-based practice. When measuring parental early recovery using indicators of engagement and progress in SUD treatment, progress on CPS goals, and progress in engaging in other recovery-oriented activities such as attending community meetings, finding a job, or securing housing, START is associated with nearly double the rates of parental early recovery (66% vs. 37%) and half the rates (21% vs 42%) of children under 5 being placed in state custody (Huebner et al., 2012, 2015). It is associated with three times lower rates of recurrence of child abuse and neglect (4.2% vs. 11.3%) than similar matched children (Huebner, et al., 2017).

Figure 1: The Relationship of Number of Days to Parents Receiving 5 SUD Treatment Sessions to Outcomes Across Years of Implementation.



(Huebner, Posze, Willauer, & Hall, 2015)

Continued on page 33

Supporting Medication-Assisted Treatment in Child Welfare

Martin T. Hall, PhD

Among families in child welfare experiencing problems with substance use, families with caregiver opioid use tend to have poorer outcomes than those with other types of substance use (Choi & Ryan, 2007; Grella, Needell, Shi, & Hser, 2009). The explanation for this is two-fold. First, opioid use is associated with somewhat unique risks and harms. Opioids are highly intoxicating and highly reinforcing and they are associated with exceptional personal (e.g., overdose) and social (e.g., infectious disease) harms (Nutt, King, Saulsbury, & Blakemore, 2007). Combined, these factors pose considerable challenges to child welfare and other public services. Second, relatively few individuals with substance use disorders actually receive evidence-based treatments. Only 10% of people in the U.S. who need addiction treatment actually receive it (Substance Abuse and Mental Health Services Administration, 2017). Furthermore, the quality of treatment varies widely.

Medication-assisted treatment (MAT) refers to the use of medications in conjunction with other evidence-based psychosocial services in the treatment of opioid use disorder. MAT, which is also referred to as opioid-replacement therapy or substitution therapy, involves the use of prescribed medications (e.g., methadone, buprenorphine, naltrexone) under medical supervision to alleviate symptoms of intense craving and withdrawal associated with opioid use disorder. As early as 2004, the World Health Organization (2004) described MAT as one of the most effective treatment options for individuals with opioid use disorder. In the U.S., the National Institutes of Health's National Institute on Drug Abuse (2016) maintains a similar position based on evidence showing MAT reduces illicit opioid use, fatal overdoses, and disease transmission, and increases retention in addiction treatment. In spite of the positive outcomes associated with MAT, few individuals with opioid use dis-

order actually receive it (Jones, Campopiano, Baldwin, & McCance-Katz, 2015).

In response to a lack of studies describing MAT use and related outcomes among families in child welfare, our research team conducted a study of families receiving services through Kentucky's Sobriety Treatment and Recovery Team (START) model (Hall, Wilfong, Huebner, Posze, & Willauer, 2016). START is a child welfare-based intervention focused on families with co-occurring substance use and child maltreatment that actively promotes

that nearly half of U.S. drug courts disallow it (Matusow et al., 2013).

Our study with families in START also included an important finding related to child outcomes. When holding adult demographic variables (e.g., gender, age, race) constant, each additional month of MAT increased the odds that parents retained custody of their children by 10%. If parents in this study received MAT for 14 months, the average length of a START case in Kentucky, that increased the odds of retaining custody of their children by 140%.

MAT providers typically do not have a seat at the table in child welfare and to improve outcomes for families with opioid use in the system, this will need to change.

use of MAT when clinically appropriate (see Willauer, this issue). Of the 596 individuals with a history of opioid use in START, only 55 (9.2%) received MAT at any point during their involvement in the program. There were no differences among those who received MAT and those who did not on gender, age, county of residence, or other drug use, though individuals who identified as White were more likely to participate in MAT than individuals of other races. The low rate of MAT use in a program that actively promotes it is concerning and raises questions about rates of MAT use among families in child welfare nationally. Low utilization of MAT is likely due in part to availability (Jones et al., 2015) as many parts of the country still lack MAT providers. However, individuals who use MAT are often stigmatized (Earnshaw, Smith, & Copenhagen, 2013). For example, because of their expectations of abstinence, Narcotics Anonymous meetings may limit the ways in which individuals receiving MAT participate in meetings (White, 2011). Additionally, courts may prohibit use of MAT. One study found

Previous research has also shown that duration of MAT improved outcomes for individuals with opioid use disorder (Condelli & Dunte-man, 1993; Greenfield & Fountain, 2000; Simpson & Sells, 1982). Though there is no standard length of time individuals should receive MAT, these studies suggest that individuals who receive it (along with their service providers) should not feel urgency to discontinue medications.

To better serve families struggling with opioid use in the child welfare system, the child welfare workforce may need better education about the brain disease model of addiction and the benefits of MAT. Addiction shares much in common with other chronic health conditions (McClellan, Lewis, O'Brien, & Kleber, 2000), though this finding is generally not reflected in the types or duration of treatment people with substance use disorder receive. Additionally, the child welfare system, the courts, and addiction treatment providers will need to create or strengthen relationships with MAT providers. MAT providers typically do not have a seat at the table in child welfare and to improve outcomes for families with opioid use in the system, this will need to change.

Low rate of MAT use stems from



Availability



Stigma



Court Prohibition

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10 Element Framework for Improving Service Linkages to Prevent Substance Use Among Child Welfare-Involved Youth

Dorian E. Traube, PhD

There is a dearth of models that facilitate the selection, implementation, and dissemination of prevention strategies for mitigating substance use among child welfare (CW)-involved teens. This gap is primarily related to the substance abuse and child welfare fields having different perspectives and philosophies that may impede cooperation, engender mistrust, and cause agencies to hamper one another's efforts. This can include differences in definitions of "the client;" expected outcomes and timelines; and legal and policy environments which constrain agencies'

operations (He, 2015). The "10 Element Framework for Improving Linkages between Alcohol and Drug Services, Child Welfare Services, and Dependency Court Services" (<https://z.umn.edu/10elementframework>) (National Center on Substance Abuse and Child Welfare, 2003) has become an important model that fills the previously mentioned gap related to selecting, implementing, and disseminating evidence based, cross-system collaborative efforts between CW and substance abuse treatment providers for adults and caregivers with substance use dis-

orders and difficulties. The following describes adaptations necessary to make the 10-element framework an efficacious model for serving youth involved in CW.

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<p>Element 1: Collaboration increases organizational capacity to effectively serve youth at risk for substance abuse.</p>	<p>In youth-serving organizations it is often difficult to agree on who the client is, and a tension persists between focusing on parents, families, classrooms, foster care environments, etc. An adolescent-focused framework for prevention and intervention must serve as a foundation in which all entities can agree on whom they serve and the ultimate purpose of the collaboration. This clarifies that the client is the youth and that all parties in the collaboration are participating to increase the community's overall capacity to support the youth's needs.</p>
<p>Element 2: Screening and assessment for primary, secondary, and tertiary prevention should occur at discrete developmental time points of risk based on CW case changes, age of the youth, and family stressors.</p>	<p>There is an intractable problem of engaging teens in substance use treatment because of lack of access to services and services only being available to those in foster care. This is despite the fact that placement stability might be enhanced if they received services while in kinship care or under supervision at home. This gap is perpetuated by the siloing of service organizations, many of which claim that assessment is not part of their mission. Effective screening and assessing youth for substance use and abuse requires a public health perspective of primary, secondary, and tertiary prevention that moves beyond simple reliance on self-report.</p>
<p>Element 3: Increase access and engagement by utilizing creative strengths-based prevention and treatment options in multiple youth serving sectors.</p>	<p>One of the greatest challenges of providing treatment services to CW-involved youth is the volume of service sectors in which they are engaged. Increasing service options, embracing creativity, and removing legal penalties on youth could effectively impact the scarcity of services and the long timeline to access them.</p>
<p>Element 4: Family-centered approach to treating CW-involved adults and youth.</p>	<p>Given the complexities of substance use among CW-involved adolescents, it is unlikely that a family centered approach alone will be sufficient to meet the prevention and treatment needs of all youth. Therefore, a family centered approach to treating parents is an important element of youth treatment and prevention.</p>
<p>Element 5: Joint accountability and shared outcomes on the prevention and treatment of risky substance use.</p>	<p>As with any collaboration, there is the potential for each partner to measure progress based on its own industry-centric outcomes. Educational success, physical or mental well-being, absence of future criminal justice involvement, safety and permanency, and decreased relapse are laudable and important for healthy youth development, but they are all secondary outcomes that are contingent upon youth avoiding substance dependence.</p>
<p>Element 6: Information sharing and data systems that are centrally collected and organized.</p>	<p>As most youth interfacing organizations are county or state level government entities, it would be ideal for these entities to create data warehousing units where data can be linked and analyzed (see He, this issue).</p>
<p>Element 7: Training and staff-development should include multiple youth-serving sectors.</p>	<p>When training only incorporates child welfare or substance abuse treatment professionals, peripheral providers miss significant opportunities to assist. For example, schools often refer for any services that are not educationally related or impacted. However, youth spend more time in school than almost any other sector and there is less stigma attached to attending school than attending outside services. Therefore, teachers and administrators are in a prime position to assess and potentially provide direct support to CW-involved youth.</p>
<p>Element 8: Joint budgeting to support collaborative sustainability should be required by funders and service organizations.</p>	<p>Because of the long-term impacts of CW involvement and the remitting and relapsing nature of substance use disorder, organizations need long-term funding sources. Given the importance of cross-systems collaboration for improved client outcomes, funders would benefit from tying their funding to collaborative efforts.</p>
<p>Element 9: Collaborative efforts that are inclusive of multi-sector youth organizations will close the gaps where CW-involved youth are often lost.</p>	<p>All youth-serving service providers have an opportunity to catch youth who fall through the cracks, due in part to the sheer volume of sectors with which they interface. CW-involved youth-serving collaboratives must make concerted efforts to include education, public health, health, mental health, and delinquency-related services in addition to child welfare and substance abuse treatment. All youth-serving sectors should be given a seat at the table once they have agreed upon the shared outcome to prevent and treat risky substance use (element 5).</p>
<p>Element 10: Communities are the epicenter for a continuum of care to prevent and treat youth substance use and should be committed to protecting the most vulnerable youth.</p>	<p>CW-involved youth will only have the potential to break the cycle of addiction when communities commit to prevention and intervention services.</p>

Intervention to Break Cycles of Abuse and Addiction in Families

Shirley N. Sparks, MS and Rosemary Tisch, MA

The societal burden of child abuse is exorbitant and it is of vital importance to find effective interventions to prevent its recurrence.

Children living with caregivers dealing with substance use disorder (SUD) are more likely to experience lengthier stays in out-of-home placement, recurrent involvement with child welfare services, and lower rates of family reunification than other child welfare-involved children (Brook & McDonald, 2007; Traube, He, Zhu, Scalise, & Richardson, 2015).

Caregiver SUD can have long-term impacts on children's mental and physical health and affects every member of the family, often impacting multiple generations. Children of parents with SUD are four times more likely than other children to develop problems with addiction (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). However, these children are not predestined to develop problems with substance abuse, and family-focused treatment can be an effective prevention strategy.

There is much evidence that family skills training programs decrease the risk of child abuse and decrease the time children spend in out-of-home placement by providing interventions for parents/caregivers and preventing the cycle of addiction for children. They do this by strengthening protective factors in families, thereby reducing the probability of risks. *Celebrating Families!*[™] is one of the few family skills training programs that engages family members in learning healthy living skills while addressing child maltreatment, family violence, and substance use disorders. The program utilizes a multi-family skill-building model that engages every member of the family (age birth through adult). Several aspects of the program make it distinctive: It uses strength-based, trauma-informed strategies to increase healthy living skills; it adapts teaching to be appropriate for

families dealing with (or at risk for) substance use, learning differences, and mental health challenges; and it addresses substance use and mental health challenges in every session, helping parents/caregivers comprehend the critical importance of basic healthy behaviors.

Sessions are provided weekly for 16 weeks. Each two-and-a-half-hour session begins with a family meal served by group leaders followed by separate 90-minute, age-appropriate instructional sessions for children age birth-17, and another for parents and caregivers. Session topics cover substance use; education facts about alcohol, tobacco, and other drugs; addiction as a disease; the effects of addiction on the whole family; and the impact of in-utero exposure to alcohol and other drugs. Other subjects include well-being related topics such as healthy living, nutrition, communication, feelings and defenses, anger management, goal setting, and healthy friendships and relationships. Parents then reunite with their children for a 30-minute family activity.

Parents of children age 0-3 have a half-hour session preceding the meal that focuses on parent-child interaction. Transportation to the site can be a barrier, but trained and dedicated staff members are ready to help with solutions. Attendance is usually excellent because families are motivated to participate by being reunited with their children when they graduate. Appropriate sites must have enough space for the separate groups and facilities to serve the meal.

Celebrating Families impacts families in three ways. First, it gives parents/caregivers skills to stay sober, to heal, and to build healthy, non-violent relationships with their children. Second, it decreases risks of child abuse and repeated family cycles of addiction. Lastly, the program serves as an intervention for parents/caregivers who are in early recovery and focuses on prevention for children.

Celebrating Families is provided throughout the United States by over 100 organizations and serves approximately 4,000 families each year. The curriculum is effective with diverse cultural, racial, and socio-economic populations (Coleman, 2006; Sparks, Tisch, & Gardener, 2013). It has been adapted for Spanish-speaking families (*Celebrando Familias*), Native American families, and women in residential treatment facilities with young children. Evaluation outcomes from multiple studies show significant positive results with very large effect sizes. Independent evaluators have documented that the curriculum:

- Doubles the rate of family reunification, while decreasing reunification time for families in Dependency Drug Court (Quittan, 2004; Brook, Akin, Lloyd, & Yan, 2015).
- Significantly increases family cohesion, communication, strengths, resilience, and organization, and impacts positive parent involvement, supervision, efficacy, and positive parenting style (LutraGroup, 2007).
- Significantly increases positive growth for youth in knowledge and use of resources, coping skills, and ability to avoid delinquency involvement (Jrapko, Ward, Hazelton, & Foster, 2003).

Agencies serving families dealing with (or at risk for) child welfare involvement and SUD can reduce out-of-home placement of children and help families to prevent children's future SUD by providing family-skills training programs, such as Celebrating Families. Programs should emphasize strengthening protective factors such as healthy attachments between caregivers and children. Programs can decrease risk factors by educating caregivers about the importance of relationships and decreasing substance use, violence, and abuse in the home. Family drug courts may offer it as an alternative to incarceration and child removal. However, any institution that serves families is appropriate, such as schools, churches, community centers, and rehabilitation facilities.

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Independent evaluators have documented that the Celebrating Families![™] curriculum:

Doubles the rate of family reunification

Decreases reunification time for families in Dependency Drug Court

Significantly increases

- family cohesion
- communication
- strengths
- resilience
- organization



Significantly increases

- family cohesion
- communication
- strengths
- resilience
- organization

Impacts

- positive parent involvement
- supervision
- efficacy
- positive parenting style

Empowering Parents and Improving Outcomes in the Dependency Arena: The Mentor Parent Program

Hilary Kushins, MSW, JD, Edward Cohen, PhD, Laurie Drabble, PhD

The Mentor Parent Program (MPP) is a peer-mentoring program in Santa Clara County, California, designed to provide guidance to child welfare-involved parents with substance use disorder. The mentor parents provide a unique level of peer support based on their own personal experiences. All mentors have completed substance abuse treatment services and experienced dependency drug court. Their legal cases have been dismissed, they have successfully reunified with their children, and the court no longer has jurisdiction over their families.

Parents mentoring other parents is grounded in the theory of stress and coping (Thoits, 1986). Mentors' "sameness of experience" allows parents to identify with other parents who have succeeded, which increases hope and facilitates engagement and coping. In such a relationship, advice and concrete support will be more meaningful (Berrick, Young, Cohen, & Anthony, 2011). There is evidence that parent mentor programs can improve engagement in the juvenile dependency court process (Summers et al., 2012). They also have been shown to increase reunification rates (Berrick, Cohen, & Anthony, 2011; Bohannon, Gonzalez, & Summers, 2016). Within a dependency welfare court, parents tend to take full advantage of parent mentors and have high rates of service completion (Golan et al., 2011). For parents with substance use problems, such engagement strategies are very important in the long-term success of the case. While research on the specific reunification rates of the MPP is still in progress, hopefully the program will show positive child welfare outcomes that confirm the insights of parents who have been through the experience (Drabble et al., 2011). We do know that the program is associated with high rates of client satisfaction, especially in the areas of client-centered support, empowerment, and help with systems navigation (Drabble, Haun, Kushins, & Cohen, 2016).

The MPP is administered by the Dependency Advocacy Center (DAC), a non-profit law firm that represents parents in the Santa Clara County child welfare court system. By embedding this program within a law office, the relationships between mentors and clients is protected under attorney-client privilege. This is crucial to maintaining the confidential and special relationship a client has with his or her mentor, and enables clients to feel comfortable sharing critical information.

DAC strives to utilize an interdisciplinary model of attorneys, mentor parents, and social workers. The mentor works as an integral part of the legal advocacy team on behalf of a cli-



ent who is struggling with substance use and who is attempting to reunify with their child. Whenever there are allegations of substance use disorder by Santa Clara County Department of Family and Children's Services (DFCS), an attorney and mentor meet the client in court for the first dependency proceeding. The mentor is crucial in helping to engage the client in the process, participate in services as early as possible, connect with the attorney in a meaningful way, and provide hope by sharing their own experience.

Ultimately, a mentor continues working with a client if the client decides to voluntarily enroll in Santa Clara County's Dependency Wellness Court (DWC). This is the county's dependency drug treatment court. Also known as family drug treatment court, it is a therapeutic, collaborative court designed to address the needs of parents with substance use disorder involved in the child welfare system using a family-centered approach. The mentors are a critical part of the holistic dependency drug treatment team and participate in the staffing of the cases and support the clients during the drug court hearings. Mentors support clients in various ways, including by attending drug court and legal hearings, meeting parents in the community, facilitating drug and alcohol assessments to access treatment, assisting parents in navigating the complex child welfare system, supporting productive communication with their social worker, attending meetings facilitated by DFCS, connecting parents to recovery supports in the community, and, most importantly, providing hope and being role models. As one parent noted, "One of the main things that I realized is I hadn't done this alone, I had somebody who had experienced the exact same thing supporting me. I truly feel that this was a major benefit in helping me develop a strong bond with my parent mentor. I will forever be grateful for the mentor program

because without that I wouldn't have survived this journey."

Currently, MPP employs seven mentor parents – five women and two men – with plans to expand. Each mentor has 15 to 25 clients on their caseload. An MPP supervisor manages the program and a part-time clinical supervisor provides clinical support to mentors in group settings and individually.

Finally, mentor parents play a key role in systems change. Representing the parents' perspective, mentors serve on various committees that direct policy regarding DWC, child welfare, and the courts. They sit at the table with directors of agencies, judges, and community-based organizations in effecting change. They also provide input on the training curriculum for key stakeholders such as social workers at DFCS, court-appointed special advocates (CASAs), and foster parents. This allows the parents' perspective to influence a wider audience and helps to shift the practices of those working directly and indirectly with parents in the child welfare system.

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Multisystemic Therapy-Building Stronger Families (MST-BSF): Comprehensive Treatment for Maltreatment and Substance Abuse

Cindy M. Schaeffer, PhD and Cynthia Cupit Swenson, PhD

Among families involved in the child welfare system, parental substance abuse is the single greatest risk factor for a range of negative outcomes. Parental substance abuse significantly raises the odds of child removal, results in longer out-of-home placement stays, and decreases the odds of family reunification (Doab, Fowler, & Dawson, 2015). These generally poor outcomes are due primarily to low substance abuse treatment completion rates for parents in need (Staudt & Cherry, 2009) and a failure to integrate substance-

abuse services with interventions that address broader parent and family needs such as mental health treatment, trauma treatment, and case management services (Choi & Ryan, 2007). Indeed, evidence is emerging that high-quality integrated care results in better outcomes across a range of indicators (Marsh, Smith, & Bruni, 2011; Niccols et al., 2012).

The treatment model Multisystemic Therapy-Building Stronger Families (MST-BSF) integrates behavioral substance abuse treatment (Tuten et al., 2012) with other evidence-based

interventions matched to family needs. It comprehensively serves families involved with child welfare who are experiencing severe parental substance abuse. This intensive approach, which involves a minimum of three hours per week of services delivered by a master's-level clinician, a home-based service delivery model, and 24/7 crisis response capability (see Table 1), is best suited for families for whom there is a high risk of child removal or a goal of family reunification.

MST-BSF builds upon decades of research establishing the effectiveness of the core Multisystemic Therapy (MST) approach for clinically-complex families with public system involvement.

MST-BSF builds upon decades of research establishing the effectiveness of the core Multisystemic Therapy (MST) approach for clinically-complex families with public system involvement. This includes families with children involved in the juvenile justice system (standard MST; Henggeler et al., 2009) and families involved in child welfare for child physical abuse and/or neglect for whom severe parental substance abuse is not the primary concern (i.e., MST-CAN; Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010). In a pilot study, families who received MST-BSF had significant reductions pre- to post-treatment in maternal self-reported alcohol and other drug use, depressive symptoms, and use of inappropriate disciplinary techniques. In addition, children reported significant reductions in anxiety symptoms (Schaeffer, Swenson, Tuerk, & Henggeler, 2013). Relative to families who received MST-BSF, a comparison group of matched families receiving treatment as usual were three times more likely to have another substantiated child maltreatment report and experienced a significantly higher number of new reports across a 24-month follow-up period (Schaeffer et al., 2013).

MST-BSF uses a social-ecological framework to conceptualize problems. Presenting problems are viewed as being caused by poor functioning within and between the multiple, interconnected systems in which parents and families are embedded. Thus, MST-BSF assesses for drivers of problems across individual,

Continued on page 34

Table 1: Multisystemic Therapy-Building Stronger Families (MST-BSF) Service Characteristics		
Clinical Team	<ul style="list-style-type: none"> 1 full-time supervisor with no caseload 3 master's-level therapists 1 full-time family case manager 	<ul style="list-style-type: none"> 20% dedicated time of a psychiatrist or psychiatric nurse practitioner Close working relationship with Child Protective Services
Service Characteristics	<ul style="list-style-type: none"> Interventions delivered in home and community settings 24-hour on-call support to families, 7 days/week Flexible hours for treatment appointments to match family's needs 	<ul style="list-style-type: none"> Supporting families in court processes Quality assurance process Caseload = four families/therapist Treatment length = 6-9 months

Table 2: Multisystemic Therapy-Building Stronger Families (MST-BSF): Interventions Provided to All Families		
<ul style="list-style-type: none"> Functional assessment of abusive incidents Safety planning to prevent maltreatment incidents Safety planning for substance relapses Functional assessment of substance use Urine drug testing and breathalyzer testing (minimum of three times per week) 	<ul style="list-style-type: none"> Reinforcement-based treatment (RBT; Tuten et al., 2012) for parental substance misuse <ul style="list-style-type: none"> Motivational interviewing and use of feedback Use of graphs to monitor sobriety and sobriety-supporting behaviors Monetary voucher system and other tangible incentives for negative drug screens Recovery support group with other parents 	<ul style="list-style-type: none"> Assessment of traumatic events and trauma symptoms (caregivers and children) Clarification of the abuse

Table 3: Multisystemic Therapy-Building Stronger Families (MST-BSF): Interventions Provided as Clinically Warranted		
<ul style="list-style-type: none"> Prolonged exposure and Cognitive Behavioral Treatment for adult and child post-traumatic stress disorder and trauma symptoms 	<ul style="list-style-type: none"> Structural-strategic and behavioral family and couple therapy Behavioral family therapy – family communication skills training 	<ul style="list-style-type: none"> Anger management training (caregivers and children) Behavioral parent training

KEEP SAFE: Supporting the Caregiver-Teen Relationship to Improve Health Outcomes for Teens in Child Welfare

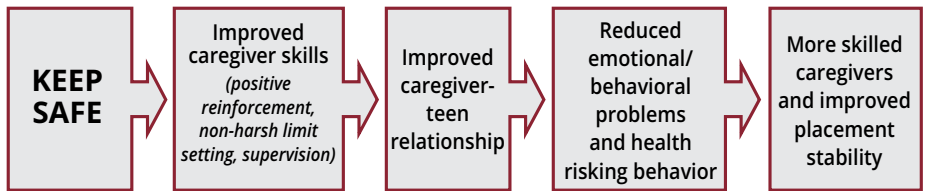
Rohanna Buchanan, PhD, Kathleen Bennett, MS, & Patricia Chamberlain, PhD

Teens in foster care engage in a trifecta of health-risking behavior including delinquency, substance use, and health-risking sexual behavior. Research shows that teens in foster care are at higher risk for serious delinquency and juvenile justice system involvement than their non-foster peers (Ryan & Testa, 2005; Widom, 2000). Likewise, the National Household on Drug Abuse Survey states that 15- to 17-year-olds with foster care histories were 1.5 times more likely to use alcohol, 3.8 times more likely to have alcohol dependence, and 2.4 times more likely to have drug dependence than their non-foster care peers (Pilowsky & Wu, 2006; Substance Abuse and Mental Health Services Administration, 2005). There is strong evidence linking childhood maltreatment and trauma to sexual risk-taking in adolescence and adulthood (Berenson, Weimann, & McCombs, 2001). There is also clear evidence linking these and other behavior and mental health problems in teens to placement disruptions in foster care; the most frequently cited explanation for failed placements is the inability of the foster/kinship parents to manage a particular teens' behavioral and mental health problems (Brown & Bednar, 2006; James, 2004).

KEEP SAFE was developed on the premise that improving the caregiving environment and enhancing caregiver skills plays a critical role in preventing and reducing problem behaviors for teens in foster care. KEEP SAFE, a foster/kinship parent support group, consists of 16 weekly 90-minute sessions led by two trained facilitators for approximately 10 foster/kinship parents. The KEEP SAFE curriculum includes research-based parenting techniques aimed at preventing teen delinquent behaviors, substance use, and risky sexual behaviors. Facilitators integrate curriculum content into group discussions and include opportunities for foster/kinship parents to practice skills in session and at home. KEEP SAFE is a responsive program where weekly group sessions focus on the teens' current emotional and behavioral challenges through increased positive reinforcement, consistent use of non-harsh limit setting methods (e.g., brief privilege removal), and an emphasis on parenting skills to increase supervision of teens' whereabouts and peer associations.

The Parent Daily Report (PDR; Chamberlain & Reid, 1987), a repeated measure of teens' problem behaviors, is used to tailor the weekly sessions to the unique needs of the teens in the KEEP SAFE group (Kim, Buchanan, & Price, 2017) as reported by the parents. The PDR is collected once per week via a

Figure 1: KEEP SAFE Logic Model



brief phone call from the group facilitators. The PDR data includes information on teen behavior and associated foster/kinship parent stress in the past 24 hours. The PDR is a strong predictor of placement disruption for children in foster care (Chamberlain et al., 2006) and provides an indication of teens' placement stability.

A recent study examined whether participation in KEEP SAFE improved the caregiver-teen relationship. Our findings demonstrated that teens in KEEP SAFE homes showed a decrease in high-risk behaviors. They had fewer associations with deviant peers and were less likely to use alcohol and other drugs

(Kim, Buchanan, & Price, 2017).

The KEEP SAFE model is currently implemented in New York City, San Diego, Portland, OR, the United Kingdom, and Denmark. The KEEP SAFE curriculum and foster/kinship parent materials are available in English, Spanish, and Danish. We have worked with international stakeholders and practitioners to adapt the KEEP SAFE curriculum for the cultural context of each implementation site. Although the core parenting skills in KEEP SAFE remain the same, the curriculum content related to alcohol and other drug use and sexual behavior reflects the cultural norms and laws of each country.

KEEP SAFE was developed on the premise that improving the caregiving environment and enhancing caregiver skills plays a critical role in preventing and reducing problem behaviors for teens in foster care.

compared to their peers in a services-as-usual (SAU) control condition (Kim, Buchanan, & Price, 2017). Results from this study reinforce findings from prior studies that teens in KEEP SAFE homes had fewer emotional and behavior problems, including decreased substance use and decreased health-risking sexual behaviors, compared to their peers in the SAU condition (Chamberlain, Leve, & Smith, 2006; Kim & Leve, 2011; Kim, Pears, Leve, Chamberlain, & Smith, 2013; Roberts, Glynn, & Waterman, 2016).

These studies also demonstrate that the caregiving environment is a critical intervention target for communities seeking to reduce risky behaviors (and increase normative behaviors) for teens in foster care. Living in a stable home with skilled caregivers provides teens opportunities to experience supportive relationships, which then makes them more comfortable seeking out and accepting help from their caregivers (Guibord, Bell, Romano, & Rouillard, 2011). Specifically, teens in KEEP SAFE homes identified that they were more likely to feel close to their caregiver and discuss sensitive topics such as substance use and sexual behav-

ior. KEEP SAFE outcomes illustrate how foster/kinship parents can serve as powerful therapeutic change agents for teens in foster care. Foster/kinship parents as change agents shifts the focus in child welfare from "care as maintenance" to "care as an active intervention" (Chamberlain et al., 2008; Kerker & Dore, 2006). Given that youth in foster care are at significantly increased risk for health-risking behaviors, it is critical to focus services for foster/kinship families on strategies that have been shown to be effective in preventing the initiation and escalation of such behaviors.

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Peer Support: A Personal and Professional Journey toward Recovery

Valerie Gustafson, interviewed by Kate Walthour

Valerie Gustafson is a woman in long-term recovery, free of problematic substance use since July 2008. As a single mother of young children living in the suburbs of Minneapolis, Valerie had never heard of a recovery coach, though based her journey she could certainly understand the value of one. Through recovery meeting attendance, Valerie met her sponsor who became critical for her success in moving beyond addiction. She now has a personal mission for everyone to have access to what she had in that sponsor.

Peer Recovery Support Specialists (PRSSs), also known as recovery coaches, provide non-clinical substance abuse recovery support and are free agents of recovery, supporting their recoverees on individual pathways to meaningfully improved lives. “Addiction is a disease of isolation,” Valerie explains. “It feeds on itself and pushes you away from healthy behaviors. Having a PRSS doesn’t give you a new best friend, but helps you find new friends and connections in a new world.” The PRSS begins by using motivational interviewing to listen to their recoverees as they formulate specific goals and plans to reach those goals and then supports that process. The PRSS



more of her personal passion and intention to support others. She applied to attend the Recovery Coach Academy training at Minnesota non-profit Minnesota Recovery Connection to become a PRSS. A PRSS receives compensation and supervision for their peer recovery coaching services. The training is 46 hours and includes content in motivational

on the brain, it takes a lot of hard work to develop new neurological pathways post-treatment. According to Valerie, “A person will always need to be mindful of how to successfully manage recovery maintenance and may require extra support at any time.” She emphasizes that recovery is not defined as abstinence, and that relapse is a manifestation of the chronic disease of addiction’s symptoms and should not be seen as personal failure. In fact, measuring recovery by days of abstinence, only to have to “restart the clock” after a relapse, can be emotionally harmful to some in recovery. Instead, Valerie defines recovery by building recovery capital (Cloud & Granfield, 2001). Recovery capital can include having a plan and goals for your recovery, living in a safe place, having friends who are in recovery, completing activities that support recovery, and having employment that supports recovery. The PRSS can be an integral component in helping build recovery capital. She says, “Connection to the outside recovery community is critical and that is where the peer has the most leverage.”

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Addiction is a disease of isolation...It feeds on itself and pushes you away from healthy behaviors. Having a PRSS doesn’t give you a new best friend, but helps you find new friends and connections in a new world.

accompanies their recoveree to support groups and other appointments. The PRSS introduces their recoveree to a network of new healthy relationships and behaviors. Finally, the PRSS is a resource connector, assisting their recoverees in accessing employment, housing, education, and advocacy services. Throughout the lifetime of the professional relationship, which will ebb and flow as needs arise, the PRSS serves as a role model and inspiration for what is possible. As Valerie describes her relationship with her sponsor: “By how much fun she was, existing in her happy life of recovery, I could see it was possible, and that maybe I could do it too.” Importantly, the relationship is tailored to the unique needs of the person in recovery. No other professionals, including social workers, are positioned with the kind of connections, expertise and time to dedicate to a person in recovery. The PRSS profession is a growing one. The model is spreading and in some states, including Minnesota, CPRS can now bill health insurance for peer services.

When her youngest child graduated from high school in 2017, Valerie was ready to begin a career that she hoped would incorporate

interviewing, cultural competency, ethics, and boundaries. After completing the necessary training, the PRSS can apply to become a certified peer recovery specialist (CPRS) by passing an exam issued by the International Certification and Reciprocity Consortium. Minnesota Recovery Connection has been offering its recovery coach training since 2010 (Minnesota Recovery Connection, 2019).

Eventually, Valerie became employed as a recovery coach and currently serves to support and grow the Peer Support Alliance, which is a supportive network of the PRSS workforce. Because her employment is through Minnesota Recovery Corps (under the umbrella of the federal program AmeriCorps), Valerie has earned educational stipends that have enabled her to begin a master’s degree program in addiction counseling.

Valerie explains that, historically, there has been a lot of emphasis on treatment as the beginning and end of substance abuse recovery. “Though we know addiction is chronic, it has been treated as acute,” she says. The PRSS model emphasizes that treatment is not the complete answer. Because of addiction’s effects

Investing in Women as Mothers: Family-Centered Residential Treatment

Jessie Everts, PhD, LMFT, interviewed by Natalie Prater and Myra Shevchenko

Wayside Family Treatment Center understands the importance of maintaining and nurturing the family system. It is designed so women in recovery from substance abuse are able to live with their children while in a residential treatment facility. Wayside also works to reunify child welfare-involved mothers with their children and enhance their parenting skills. Many of the women who participate have experienced a pattern of losing custody of their children due to substance use; the program is designed to break this cycle. Founded in 2011, the center is in Minneapolis and can accommodate up to 19 mothers with their children.

Wayside does not utilize a singular treatment approach in their programming but rather incorporates parts of many approaches in an effort to fit the needs of a variety of women. At the center is a core value of the importance of human connection and the efficacy of treating substance use disorders from this framework. This is seen in the way Wayside invests in the women as mothers, moving away from models that can isolate people during treatment.

Residents participate in programming for a large part of their day. The type of programming offered includes addiction education classes, relapse prevention classes, therapeutic



cant barriers. For example, having children as residents creates liability requirements that are very different than adult-only residential treatment. While mothers are in programming, older children are attending school and Wayside assists in arranging child care for younger children with one of their offsite partners. Wayside covers the cost of child care while mothers are in treatment. Although fathers cannot stay at the residence, Wayside seeks to involve

Notably, the Family Treatment Center has better success rates, completion rates, and longer lengths of stay than Wayside's single Women's Facility.

Wayside Family Treatment Center will be affected positively by the new Family First Prevention Services Act of 2018 (see p.8, this issue). They are now eligible to receive Title IV-E reimbursement for children who are living with their mothers while they complete inpatient treatment. Despite not being able to currently accommodate more women at their facility, the number of referrals they receive from child protection social workers is also expected to increase, although most of their residents are already child welfare-involved. Most of all, Wayside staff are hopeful that the new legislation will create a shift in the child welfare system, including more investment in whole families affected by substance use. This includes mothers and children remaining together at the beginning of treatment, rather than taking custody of children and working toward reunification as treatment progresses.

Finally, Wayside emphasizes the importance of the child welfare system and professionals within it understanding the nature of substance use disorders. This includes being realistic about recurrence of use and knowledge of how trauma contributes to addiction. It is crucial that even though moms can slip up on their recovery journey, it does not mean they should not have custody of their children. With proper safety measures in place, Wayside shows the possibility and benefits of a mother remaining with and parenting her children while receiving treatment for substance use.

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At the center is a core value of the importance of human connection and the efficacy of treating substance use disorders from this framework. This is seen in the way Wayside invests in the women as mothers, moving away from models that can isolate people during treatment.

processing groups, life skills classes, parenting skills education, and mindfulness groups. In addition, Wayside provides family-focused weekend programming, assisting mothers in learning about free and/or low-cost activities they can participate in with their children. The center also has a client-led parenting support group and a perinatal group focused on providing education on attachment to pregnant women and new mothers.

Along with treatment for substance use and parenting support, women at Wayside are also offered mental health services, housing supports, physical health services, and more. From the moment the women begin treatment, Wayside works to prepare them for life outside of the program, including linking them with outside parenting skills classes, connecting them to stable housing, arranging recovery supports, linking the family with health services, and providing them with access to an in-home family therapist.

Providing family-centered treatment does not happen without overcoming some signifi-

them by offering family therapy, assessments to fathers, and referrals to services. They hope by pointing fathers in the direction of appropriate services to meet their own needs, they can help strengthen the entire family system.

The program and services described and operated within Wayside are referred to as "Rise Up in Recovery." Wilder Research (2019) completed an evaluation of Rise Up in Recovery by surveying the women who were served from June 1, 2017, until May 31, 2018. The findings showed that in addition to treatment and recovery, mental health and parenting were the areas of programming women found most beneficial. Additionally, 92% of women in the Rise Up in Recovery program reported their relationship with their children as "good" or "excellent" one month after exiting the program. Over 85% of mothers reunited with at least one of their children while they were in treatment. Furthermore, the women saw improvements in their lives including increased employment, increased safe and stable housing, and increased connections to recovery supports.

A Mother's Journey through Treatment and Recovery

Pa Houa Thao, interviewed by Natalie Prater and Myra Shevchenko

Pa Houa Thao represents the importance of a family treatment model for moms with substance use disorders. Through her personal dedication and strengths, along with the services received at Wayside Family Treatment Center, she is proud to say that she has maintained sobriety for nine months. While at Wayside, she was able to reunify with two of her children. Pa was able to overcome obstacles of having little familial support and financial resources, and now hopes to be a role model for moms who are in the same situation she found herself in.

saw the CPS case worker assigned to her family as someone who was there to take her kids away, not a person who could help. She says that when her seven children were removed from her custody, she was not necessarily pushed in the direction of treatment. Pa shared that her case worker would suggest that she seek out services to obtain a substance use disorder assessment, but further information was not provided on what that could or would lead to. Pa did not know what getting the assessment would entail, the costs associated with it, and what it would mean for her children's open

Pa says that her experience with CPS could have been more positive if she had been steered toward a treatment program by her worker. She also believes it would have been beneficial to be provided with more education on resources and services available to her as a mother who was battling addiction. Pa says that at times it was difficult for her to know how to ask for help during her involvement with CPS – something compounded by the shame and guilt associated with addiction. Pa hopes that CPS case workers can continue to grow and learn about the stigma parents living with addiction experience, and how to best assist them in reunifying with their children in the time frame they are given.

Based on her experience and recovery journey, Pa is highly motivated to advocate for other mothers in similar situations. She also hopes that by sharing her story with people who are working to recover from addiction, or professionals working within the field, she can have an impact on their lives. Pa is currently living with two of her children in stable housing. She remains actively involved and connected with recovery supports through both Wayside and within her community.

Having her children with her as she completed her program, including the ability for one of her children to join her in groups, made all the difference in Pa's course of treatment.

Prior to her successful completion of the programming at Wayside, Pa battled addiction for 15 years. She had attempted treatment in the past, but the programs she attended were not able to meet her needs. The event that caused her to have a change in perspective and pushed her to seek treatment was the death of her mother in April, 2018. The world she experienced after not having her mother in her life was "completely empty." Pushed by her grief and loss, she was determined to attend treatment in order to reunify with her children. Currently, she emphasizes the importance of surrounding herself with recovery supports and sees her faith as a particularly important aspect of her personal recovery journey.

"Wayside changed my life," she says. The program was helpful in substance use treatment and recovery support and staff there worked with Pa to prepare her for life after the program. Some ways that Wayside assisted in this was connecting her with employment, housing, and parenting classes. Wayside also worked with her child protection worker and helped Pa have a voice, advocating for her throughout the process. Being reunited with her two youngest children while at Wayside was a surreal moment for Pa because she did not think reunification would ever happen. Having her children with her as she completed her program, including the ability for one of her children to join her in groups, made all the difference in Pa's course of treatment. The connections and resources Wayside provided, as well as the connection to her children, made Pa feel more prepared for success compared to previous experiences with treatment.

Because of her substance use and addiction, Pa had a four child protection cases. Her experience and feelings about child protections services (CPS) were not initially positive. Pa

CPS case. Although treatment was not directly recommended to Pa by her case worker, she knew that in order to get her children back in her care safely, she needed to seek help and support. Pa took the initiative to find a treatment program that would work for not just her but also her children.



A Court of Empathy and Support: Minnesota Treatment Court

The Honorable Mark C. Vandelist

Before being appointed to the bench by Governor Dayton in January 2014, I was a personal injury attorney for more than 30 years. I had no idea what terms like CHIPS, GAL, ACEs, or Rule 25 meant. Seeing defendants in criminal court and parents facing termination of their parental rights in child protection cases quickly made me realize that my own life was very privileged.

I was raised by two loving parents, never wanting for a meal or a warm house to sleep in. I grew up in a small town in the 1960s and '70s, and the only illegal drug available was marijuana. Eventually, I met and married my wife, we had three children, bought a house in the suburbs, and lived a very comfortable and sheltered life.

I read reports about the opioid crisis but was still shocked at the number of people who came before me addicted to methamphetamine. It was not only the inter-generational addiction in families that shocked me but also the fact that this drug transcended cultural and economic barriers. In one week, I was in Le Sueur County with a criminal calendar and over half of the defendants were addicted to meth. Then in Dakota County I saw suburban housewives with meth drug charges. Then, with an arraignment calendar in Scott County, at least two-thirds of the defendants I saw were on drug charges and most involved meth use.

Over time, I have become personally vested in each of the participants as if they are my own family. I travel the road to recovery with them, I learn about their families, I hear about their kid's sporting activities, and I even perform some of their wedding ceremonies.

The most heart-breaking cases were the child protection cases where the parent had a meth addiction so strong that they could not stop even when faced with the termination of their parental rights.

And there I was, appointed to make life-altering decisions regarding people I knew little, if anything, about. It was a daunting task. I committed to educating myself on addiction, child protection, drug courts, family dependency courts, and problem-solving courts. I learned that graduates of heavily researched treatment courts had a success rate of over 65% compared to defendants who were sentenced to prison (Finigan, Carey & Cox, 2007). So with the help of the Le Sueur County Board of Commissioners, I started Le Sueur County's first treatment court in spring of 2015.

Treatment court is held every week. When a participant comes before me, I listen, try to understand their situation, and encourage



changed behavior. Every participant must be in outpatient treatment and must attend at least two Alcoholics Anonymous or Narcotics Anonymous meetings per week. This is to ensure that each individual follows a schedule, has a routine, and develops consistency. We also agree upon tasks that they need to complete, such as getting their driver's license back, obtaining and keeping a job, finding a place to live, or completing application forms for health insurance. When I see them in court the next

to disappoint if they screw up. I serve as a disinterested, yet compassionate, authority figure. I have frequently been referred to as the "daddy judge" because I believe in them but also assign consequences if they violate the rules. The personal relationship that develops between a participant and a judge cannot be replicated in any other forum. A level of trust inevitably forms between us, which in turn allows the participant to be honest with not only me, but more importantly, with themselves.

Most of the people I see in court have never had anyone listen to them, understand them, or for that matter believe in them. Most often their experience with the criminal justice system, or any type of authority, has been negative or degrading. When someone in an authority position acknowledges them, listens, and believes in them over time, it can change their world.

Ultimately, I think it is important to realize that someone doesn't need to be a highly trained professional to make a difference in people's lives. Simply listen, be empathetic, supportive, and kind. But always keep in mind, it is their addiction to overcome, and they need to own it and deal with it. We can only provide the tools to help: It is up to them to pick up those tools and use them.

Judge Mark C. Vandelist was appointed in 2014 to Minnesota's First Judicial District and presides in Le Sueur County, Minnesota. Contact: mark.vandelist@courts.state.mn.us

week I follow up to find out if they were able to do what we talked about.

Treatment court is primarily centered on incentives and sanctions, which provides both positive and negative reinforcement. If a participant is doing well they get to choose a small, medium, or large reward each week such as a gas card or a tube of toothpaste, items donated by the local community. If a participant is not doing well they get a sanction. A minor sanction could include writing a paper on how they are going to stay sober and then reading it in front of the whole court. A major sanction could include jail time.

Over time, I have become personally vested in each of the participants as if they are my own family. I travel the road to recovery with them, I learn about their families, I hear about their kid's sporting activities, and I even perform some of their wedding ceremonies.

I am someone who is there to listen, consistently following up, and am someone for them

Barriers in Rural Communities for Families Who Struggle with Substance Abuse

Stephane Buchwitz

As a child protection and chemical dependency social worker in Roseau County, Minnesota, for 15 years, I have worked with many families who struggle with substance abuse issues. Though a common misconception, substance abuse is as frequent in rural areas as urban, sometimes more so. Prescription drug abuse and heroin use have grown universally while adults living in rural areas have higher rates of alcohol abuse, tobacco use, and methamphetamine use (Substance Abuse in Rural Areas, 2018). Like urban families, substance abuse, child protection, and

risk behaviors, and isolation. When people in rural communities experience problems with substance abuse, getting help can be challenging. Probably the largest challenge is limited detox, treatment, and post-treatment services. This frequently requires long travel without access to public transportation, which may be especially difficult for those who do not have a valid driver's license, and it is especially dangerous for individuals who are not driving sober. In my experience, some health plans allot for the use of volunteer drivers but there are many restrictions on their use. There is some evidence

As social workers or other professionals working with clients, lack of services and transportation create barriers that are difficult to overcome. If substance abuse is significant, parents may be required to comply with alcohol and/or other drug testing, substance use assessments, support meetings, etc. This can be overwhelming for any family when they are already required to comply with an extensive family safety plan. As their social worker, I have to recognize and process this with the family. Testing also can be done very differently depending on where a family lives. Here, the law enforcement center conducts most of the alcohol and other drug testing. Parents are required to pay a \$5 fee per test which adds up quickly. This becomes a true hardship for the families that we work with. Outpatient substance abuse treatment or individual therapy, if required, creates additional expenses.

Many parents do not have reliable transportation, stable and gainful employment, or appropriate child care. The implications of this look different for rural families who need to access services that are very spread out geographically when – or if – they are available. The average distance between towns in this county is approximately 20 miles and we do not have a taxi service or other transportation services, such as Uber or Lyft. Families utilize the public bus system for treatment and other services, which is limited in operation to 7:00 a.m.-3:00

Many parents do not have reliable transportation, stable and gainful employment, or appropriate child care. The implications of this look different for rural families who need to access services that are very spread out geographically when – or if – they are available.

mental health are often intertwined among the rural families we work with. However, in rural communities, professionals wear many different hats – within our own agency and in the community. In Roseau County, I have dual caseloads consisting of families involved with child protection as well as adults experiencing substance use disorder who are court ordered to receive services.

Certain characteristics that can lead to substance abuse in rural communities include limited education, poverty, unemployment, high-

that individuals are less likely to complete a substance abuse program when they have to travel a greater distance to access it (Beardsley, Wish, Fitzelle, O'Grady, & Arria, 2003). Limited education and experience of first responders and medical personnel, including the use of the lifesaving Naloxone in situations of opioid overdose, is also a problem. And finally, lack of privacy and confidentiality can also be a barrier to seeking help for individuals living in less populated rural communities (Substance Abuse in Rural Areas, 2018).

Continued on page 34



Culturally Specific Treatment: Prevention and Healing at White Earth Nation

Laurie York, interviewed by Korina Barry and Kate Walthour

Laurie York, director of Indian Child Welfare at White Earth Nation, describes the Maternal Outreach and Mitigation Services (MOMS) program as a holistic, intensive, and culturally specific method to address opioid and other substance abuse among pregnant mothers.

The MOMS program began in 2015 in response to growing identification of newborns' prenatal exposure to substances among the White Earth tribal community of Minnesota. Holistic components of the program include case management, mental health services, parenting groups, medication-assisted treatment referrals, prenatal care, parenting and early childhood education, cooking and nutrition classes, and support services for infants and children. Along with those services includes the culturally specific elements, which are core to the program. The MOMS program has over 30 parent graduates and has seen great success in either reunifying families or preventing children from entering foster care.

Upon seeing the success of the MOMS programming, a need was identified to support fathers and other non-pregnant mothers and



culture as prevention and intervention while supporting families. Gizhawaaso has prevented 147 children from entering foster care in its first fiscal year.

The addition of these programs have dramatically changed the lives of families and is impacting the larger community. Families are experiencing sobriety and are learning new ways of addressing anger, grief, or loss together and in community with each other. The approach used in all White Earth treatment

The addition of these programs have dramatically changed the lives of families and is impacting the larger community. Families are experiencing sobriety and are learning new ways of addressing anger, grief, or loss together and in community with each other.

women. White Earth added a medication-assisted treatment (MAT) program to their behavioral health services. However, Laurie is quick to clarify that it is not simply a “dosing program”, as participants are able to access culturally specific treatment. The MAT program has successfully graduated 65 individuals since it began in 2016.

The Gizhawaaso program also began in 2016 and was funded through a grant from the Minnesota Department of Human Services to address disparities in child welfare. Gizhawaaso, an Ojibwe meaning “protectors of the young” when translated to English, is a culturally specific program designed to prevent out-of-home placement of children. This funding supported White Earth Indian Child Welfare (ICW) in hiring additional staff, including a cultural coordinator, to oversee their foster care re-entry prevention and family skills work. The Cultural Coordinator supports ICW workers in utilizing

programming emphasizes the incorporation of sacred Ojibwe practices including, cedar ceremonies, fasting camp, naming ceremonies, moss bag making, sweats and the sewing of traditional ceremonial wear and other regalia. These practices are taught in community along with important traditional stories. These activities also include discussions around anger management, healthy communication, and other important topics. Many community participants choose to gift or even sell the items they make. This economic benefit to the participant is another contributor to healing, increased self-worth, and economic stability for families.

For example, the challenge of learning how to bead provides participants with the opportunity to manage frustration, work in community with others, as well as spend time alone while being productive. This results in self-gratification for completing something. The money earned from selling the beadwork can be put

toward household bills. The investments the program makes in supplies is another way they provide culturally specific support. Spending \$50 on knockers and push poles for a family to harvest and sell wild rice can provide them with \$300-400 that the family can bring back to their community.

Another aspect of culturally specific programming is the staff time and intention dedicated to getting to know families and creating strong relationships with them. By providing services to the whole family and attending ceremonies side by side, staff believe they are keeping families together and healing collectively as a community.

Laurie asserts that the most important outcome of the culturally specific programming is that children are learning traditional ways of coping as the alternative to using drugs. They are immersed in the teachings, culture, learning how to live off of the land, and understanding how to make money from their natural environment. The ability for a Native child to know their name, clan, and where they are from gives them an immeasurable sense of belonging. This will serve them later in life and help them become healthy adults. Since today's children will someday be parents of the community, the program believes they are serving future generations.

Laurie emphasizes one of the primary differences between their programming and traditional treatment approaches is that White Earth addresses the emotional harm caused by historical and present-day traumas of Native people. Historical trauma is arguably the primary reason people in tribal communities turn to substance use. Traditional culture, language, and parenting practices that had evolved over thousands of years were abruptly forbidden. Interrupting that existing way of life caused a great amount of hurt and pain and requires a healing process that implements these pieces back into the lives of families. Laurie explains, “it was what worked, it is what works now and it will help future generations.” These healthy parenting styles will break cycles and be passed down to future generations.

Laurie York is director of White Earth Indian Child Welfare at White Earth Nation. Contact: laurie.york@whiteearth-nsn.gov

The Power of Youth Voice: Being Heard in Child Welfare

Viviana Castillo, interviewed by Kate Walthour

“If I was being heard, I probably wouldn’t have wanted to die.” Twenty-year old Vivianna “Viv” Castillo feels so passionately about communicating this reality to professionals that she hands out personalized business cards printed with the words “Meet the kid, not the file.”

Viv’s reflections and insights on her experience with the child welfare system, as well as her life-long connection with substance abuse, provide important lessons for professionals working with youth and families. Like many youth in foster care, Viv tells her life story matter-of-factly and it’s clear she’s told it many times before. Pregnant at 19 or 20 and abusing heroin, Viv’s biological mother was unable to put the needs of her daughter first. Due to his own drug use and violent behavior, her biological father was incarcerated and Viv has never met him.

At 13, Viv was placed in foster care in response to her brother’s school disclosure that there was drug use in the home. Growing up on the Red Lake Nation Reservation, she acknowledges the normalcy of many children demonstrating signs of poverty and neglect. However, Viv believes that having bruises and missing teeth alerted their teachers that something much more abusive was happening. Yet, it was reported drug use that was ultimately the catalyst for intervention. After being placed separately and then together, Viv and her brothers lived in several non-relative and relative foster homes over subsequent years.

She continued using marijuana and alcohol, believing it was the only thing that helped ease her depressed feelings. This included mixing use with prescribed psychiatric medications. The numbing effects of the medications encouraged self-harm behavior “in order to feel

Though they are experienced foster parents, Viv is the first child they’ve cared for who has extended her stay beyond age 18.

When asked about her experience with the various tribal caseworkers she was assigned to, Viv admits that she rarely got to see them because of their high caseloads. She remembers meeting only three of the 12 caseworkers she’s had. Viv expressed frustration with professionals who frequently said she wasn’t old enough to make decisions for herself, despite taking on the role of primary caregiver for her younger brothers by the age of 9.

She believes that when professionals can meet the child instead of simply going by their age or what is written in their file, they can make more tailored decisions for what the child needs and what they are expressing they want. Her best experiences with professionals are with those who authentically get to know her and listen to her as a human being, not just a “client.”

She hadn’t formed much of a relationship with any professional until she moved to her current foster home and was assigned a case manager who works for the group home she exited. Viv has enjoyed the long-standing relationship they have had as well as with the therapist she sees weekly at the same organization. “When I got older and I was able to advocate for myself more, I was able to say ‘Hey, this is messed up and I need someone to talk to me.’ When I was finally able to say that, it got way easier.”

Viv has developed a sense of confidence and hope for the future. After graduating from high school, her parents emphasized that college would be a smart choice. Bribing her with ice cream, her dad brought her to an open house at the local tribal college. She left with an acceptance letter and a class list.

Viv believes she’s transitioning to a healthier lifestyle since she moved into her foster home. Though she smokes regularly, she doesn’t go out of her way to use marijuana and does not feel it is a “crutch” or that she needs it. It has also taken some negative experiences of feeling out of control while intoxicated to no longer enjoy drinking alcohol. She has better strategies and more support when she is struggling with her mental health. “I’m safe now.”

Now in her fourth semester of college, Viv will transfer to a four-year university this fall to pursue a bachelor of science degree. Along with a busy schedule of school and work, Viv is one of the original members of Minnesota’s Youth Leadership Council, a group of current and former foster youth who advocate for children in the child welfare system.

“Meet the kid, not the file.”

At 7 months old, Viv went to stay with her great-grandmother for 1 week, which ultimately turned into 13 years. She and two younger brothers, who eventually joined her, continued to be exposed to substance abuse and physical abuse by some members of their family. Because she grew up in an environment where substance use was normal, she was smoking cigarettes by age 8 and marijuana by age 9. She reports she was an alcohol dependent by age 10.

something,” she says. At 15, Viv became suicidal and experienced frequent psychiatric hospitalizations. After a very serious suicide attempt at age 16, she was discharged from the hospital to a group home.

From the group home, Viv was placed in her current non-relative foster home where she has lived for 3 years. Viv calls her current foster parents mom and dad and has grown to feel safe and loved in their home. She says having parents who care about her and want her to succeed helped her turn her life around.



A Parent's Journey through an FASD Diagnosis

Barb Clark

Nineteen years ago, our beautiful daughter was placed into our arms after spending the first 5 weeks of her life in foster care. Although difficult to calm and struggling to sleep, she was a fairly easy baby, and she lived life big – smiling a lot, laughing a lot, and screaming a lot. As she began to take her first steps, I had some concerns: She loved being the center of attention and her activity level was off the charts. Our first pediatrician quickly dismissed our observations.

As parents, we meet all the needs of our infants and toddlers almost immediately, and instant gratification was the only speed at which our daughter responded. However, as she continued to grow, it became more difficult to make her happy. We tried, like most parents, to teach her patience and social skills, such as turn taking and playing well with other children. Yet, my daughter could not grasp these concepts and a traditional parenting approach did not work. She started stealing things at the age of two, and giving her consequences along with a discussion about why stealing is wrong did not phase her. She wanted it now and no typical intervention could stop that impulse. Despite all of this, our pediatrician was confident that she was on target. After all, she always passed her developmental screenings, including the all-important pre-school screening.

Since none of the professionals we had been working with could find answers that made sense, when our daughter turned 6 years old we turned to the internet and found the answers we were searching for. As we read about the characteristics of Fetal Alcohol Spectrum Disorder (FASD), we felt as if someone was describing our child. We did not know much about FASD before this point, and most of the information we did have was inaccurate. For example, we thought that children with FASD had low IQs and distinctive facial features, but these symptoms are actually fairly rare.

Our daughter was diagnosed with Alcohol Related Neurodevelopmental Disorder (ARND) which is the invisible diagnosis that falls under the FASD umbrella. As we learned that a brain injury due to prenatal alcohol exposure was causing our daughter's difficulties, we were flooded with emotions. We felt relief that we finally had answers, but we felt grief over the struggles she would endure. We also felt empowered to learn how to help our daughter create the best life she could possibly have and set off on a journey to learn as much as possible about FASD.

It took us many more years to meaningfully incorporate different strategies for handling her challenging behaviors, basing them on our understanding of the way her unique brain worked. For many, including my husband and



myself, it was hard to understand the need to approach her differently. Like most children with FASD, she had an average IQ. At times, she appeared so typical that it was easy to believe she was willfully disobeying us and was much more in control of her behaviors than she actually was. What looked like manipulation,

honest, reflective discussion. The approach worked. She learned to stop stealing and our relationship grew stronger because we met her where she was at, instead of setting expectations so high that she could never succeed.

New research shows that 1 in 20 children have FASD (May et al., 2018). Presumably,

As we read about the characteristics of Fetal Alcohol Spectrum Disorder (FASD), we felt as if someone was describing our child. We did not know much about FASD before this point, and most of the information we did have was inaccurate.

however, was really a battle with short-term memory issues and impulse control and processing difficulties. Once we could understand this fully, our strategies and our relationship with our daughter changed for the better.

After years of wanting to knock our heads against the wall in frustration, we started to understand that her impulsivity was part of her brain injury, and that giving consequences was not an effective strategy. Thus, instead of giving a consequence for stealing, we had a conversation about how she felt when she first saw the item, how she felt when she took the item, how she feels now, and how the owner of the item feels. This approach never worked in the past due to our anger and the threat of having an item taken away increasing her already high levels of anxiety (common for most children who have an FASD). When we changed to a calm and understanding demeanor, she knew we were not mad and was open to having a more

these rates are significantly higher in adoptive and foster families. Our story proves that training on parenting children who live with an FASD is crucial for foster and adoptive parents. We wasted many years, causing our daughter more frustration and trauma before we truly understood and changed our approach to how we parented her. The road we have traveled has been filled with difficulties and successes, but through it all one thing is clear: our relationship and connection with her is the key to helping her thrive.

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Poverty, Parental Addiction, and Family Reunification

Continued from page 11

SES services also need to be combined with treatment services. We know from earlier research that treatment outcomes are better when SES needs are addressed (Osterling & Austin, 2008). This finding was corroborated by the SES risk factor study outlined above.

Finally, these findings indicate that families with parental SUD can and do reunify. Front line child welfare workers may be troubled to observe the maltreatment that can befall a child at the hands of a parent struggling with addiction. However, once that parent is appropriately supported and warmly guided into recovery, they are capable of becoming a conscientious, caring, and consistent parent. It is unfortunate to think that some children may fail to reunite with their parents simply because the parent's substance use disorder was misunderstood and needed socioeconomic supports were not provided.

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Understanding the Impact of Prenatal Substance Use on Mother and Child

Continued from page 13

substance exposure if prenatal or postnatal documentation of maternal substance use and/or obvious signs are not present at birth. Accessing the mother or child's medical records can be particularly difficult for families involved in the child welfare system.

Treatment for the substance-exposed infant should include the parents and consideration of the environment, with particular attention to the relationship between mother and infant. Treatment for all substance-exposed infants is non-pharmacologic care that begins at birth (or ideally in the prenatal period) and continues throughout hospitalization and beyond. This includes identification and understanding of the symptoms in the infant, assessment of maternal psychological functioning, and modification of the environment and handling of the infant to minimize symptoms. Medication treatment for NAS is reserved for infants who continue to exhibit significant symptoms after maximum, individualized non-pharmacologic care.

Generally, infants at risk for NAS are assessed every 3-4 hours immediately after birth. They are hospitalized for 4-5 days and observed for the development of NAS symptoms to avoid the development of NAS after discharge. Recently, new methods of assessment/intervention for NAS, such as the Eat, Sleep, Console approach, based on the ability of the infant to eat, sleep, and be

consoled from crying are being implemented in the U.S. These new approaches should be assessed to ensure that short- and long-term health outcomes are positive for mother and child before implementation.

Long-term care for substance-exposed children should include frequent and knowledgeable pediatric care and developmental assessments, with concurrent attention to the bio-psycho-social well-being of the mother. Referral to early intervention services should be made as soon as delays, deficits, or behavioral issues are identified. Assessment for exposure to violence should be frequent. Care for the mother and child should be nonjudgmental and non-punitive, avoiding any overt or covert biases.

Evidence suggests identifying the substance-exposed mother and child and implementing comprehensive services for both, and/or other caregivers, are key in minimizing the serious and long-term effects of prenatal substance exposure and optimizing family outcomes.

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Advancing Lessons Learned in Child Welfare and Recreational Use Marijuana Legalization

Continued from page 15

State partners can provide training, group case consultation, screening and path assignment guidance, and reexamination of safety and risk protocols. In addition, community partnerships across the continuum of prevention, early intervention, and child protection intervention should be identified. Stronger partnerships can promote prevention efforts such as education and other supports for parents on prenatal drug exposure, safe storage practices, safe caregiving, safe cultivation considerations, and advancement of safe sleep practices.

For states with legalization on the horizon, prioritizing data system and performance measure enhancements will guide the demonstration of outcomes. These systemic improvements will support preparedness in responding to the evolving implications of legalized recreational

marijuana use on the constantly changing child welfare landscape.

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Child Welfare Practices of the Sobriety Treatment and Recovery Teams (START) Model

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As child welfare leadership in states, counties, and tribes strive to create better systems of care and stronger outcomes for families affected by parental SUD and child maltreatment, it is important to understand that this is an adaptive challenge that requires fundamental systems change. Skills training is not enough. The strategies of START discussed here, such as ensuring quick access to SUD treatment and changing the system of care through collaboration, are challenging to implement. These strategies will require ongoing support, technical assistance, and consistent messaging and expectations over time.

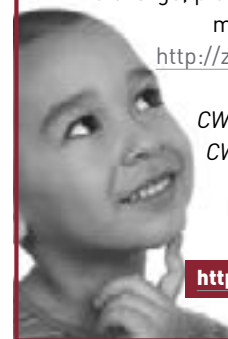
Tina Willauer, MPA, is program director of Sobriety Treatment and Recovery Teams at Children and Family Futures, Inc. Contact: twillauer@cffutures.org

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Multisystemic Therapy-Building Stronger Families (MST-BSF): Comprehensive Treatment for Co-Occurring Child Maltreatment and Parental Substance Abuse

Continued from page 23

family, peer, school, and community systems, and engages extended family members and other natural ecology members in interventions to address systemic problems and to support the sustainability of treatment gains. A rigorous analytic process is used to design and prioritize interventions, based on the individualized drivers in each case.

Various research-supported treatments are provided to all members of the family who need it, based on family need and the drivers of prioritized problems. Because all cases are referred due to a child safety concern and caregiver substance abuse, core interventions are delivered to all families (see Table 2). Other interventions are delivered as warranted. Table 3 lists as-needed interventions provided (see also, Swenson and Schaeffer, 2018).

A feasibility study found that 87% of families offered the MST-BSF model agreed to treatment (Swenson et al., 2009). Currently MST-BSF is serving child welfare-involved families in seven sites throughout Connecticut where the model was developed. Over the past two years, the program has served over 150 families. Of these, 92.5% completed treatment, which lasted on average 7.5 months. During the course of treatment, 91.7% of caregivers had no new cases of child maltreatment and 95% of children remained with their caregiver in the home (internal performance tracking; MST Services, Inc.). A randomized clinical trial

examining outcomes longitudinally for MST-BSF relative to other community-based services is nearing completion.

The MST-BSF approach is a high-quality integrated care model that serves as a one-stop shop for families with multiple interrelated needs. By directly providing a full range of evidence-based treatments and services to all members of the family who need it (including multiple children and caregiver partners), MST-BSF goes beyond what many other intensive programs are typically able to provide (Marlowe & Carey, 2012). Given the nation's opioid crisis and the typically poor outcomes achieved when parental substance abuse is a factor in child maltreatment cases, wider dissemination of models like MST-BSF is desperately needed.

Cindy M. Schaeffer, PhD, is an associate professor at the Division of Child and Adolescent Psychiatry, University of Maryland Baltimore. She also provides consultation and training services for MST Services, LLC, which has the exclusive licensing agreement through the Medical University of South Carolina for the dissemination of MST technology. Contact: Cschaeff@som.umaryland.edu

Cynthia Cupit Swenson, PhD, is a professor in the Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina. She is also a consultant in the development of MST-CAN programs through MST Services. Contact: swensoc@muscc.edu

Barriers in Rural Communities for Families Who Struggle with Substance Abuse

Continued from page 29

p.m. daily. As families are required to complete more services, they spend more time on the public transport bus, more time in town waiting for the bus, or fail to get to vital services in the evening due to lack of transportation (e.g. outpatient treatment). Unfortunately, many of our clients do not have safe or sober individuals who can assist them in their transportation needs or care for their children when they are away, which puts their children at more risk.

Living in rural communities offers many positive attributes but also presents many barriers for services and transportation needs. The lack of these services in rural communities not only affects our clients but also their families and the community in which they reside. For many of our rural clients, their substance abuse and treatment needs create a negative domino effect as financial, transportation, and child protection burdens cannot be easily resolved. It is also taxing on the social workers and other professionals working with the family, whose intent is to help them become successful and substance free. Additional state and federal allocations should be considered to address these issues and ensure that clients who reside in rural areas are afforded the same treatment services and options as those who reside in urban areas.

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The Well-being Indicator Tool for Youth (WIT-Y)

The Center for Advanced Studies in Child Welfare (CASCW) at the University of Minnesota has partnered with Anu Family Services to develop the Well-being Indicator Tool for Youth (WIT-Y), a self-assessment tool for youth aged 15-21 years. The WIT-Y allows youth to explore their well-being across eight domains: Safety and Security, Relationships, Mental Health, Cognitive Health, Physical Health, Community, Purpose, and Environment.

The WIT-Y consists of three components:

The WIT-Y Assessment, The WIT-Y Snapshot, and The WIT-Y Blueprint.

For additional information visit: z.umn.edu/wity



Center for Advanced Studies
in Child Welfare



Agency Discussion Guide

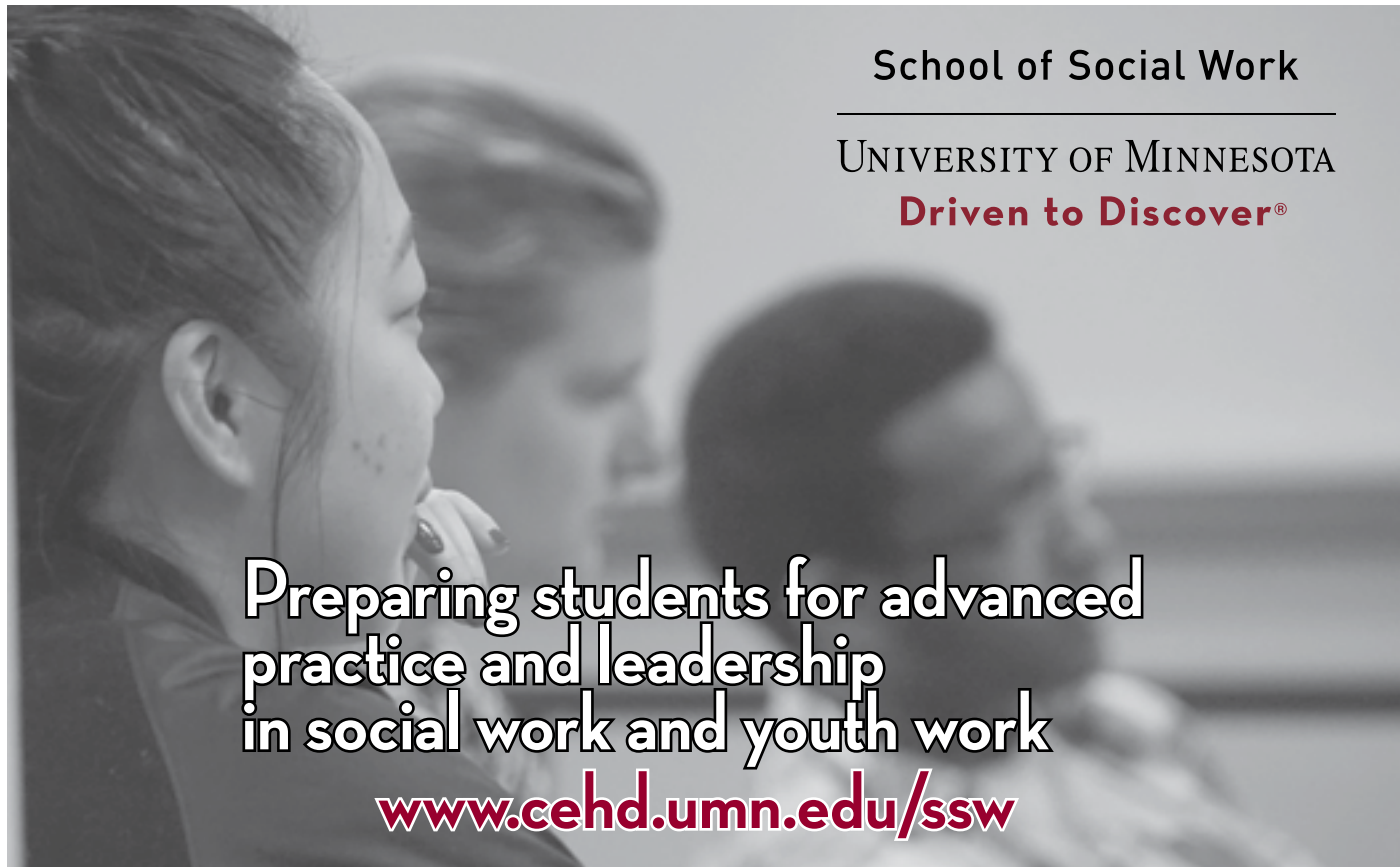
The agency discussion guide is designed to help facilitate thoughtful discussions during supervision and team meetings about the information presented in this issue.

Discussion on Practice Implementation

1. He (p.12) discussed barriers in collaboration that exist between the substance use treatment system and the child welfare system. How can professionals improve our client(s) dual involvement? Keeping in mind that there are numerous aspects that contribute to an individual's participation in either system, how can we prioritize the needs of caregivers and children to promote recovery and reunification from a person-centered perspective?
2. Gonzalez (p.10) discusses three spheres of stigma surrounding a parent with a substance use disorder. How can we change and improve our practice in order to address the stigma and potential shame parents may feel?
3. This publication includes numerous topics that affect child welfare practice. For example, substance use prevention of foster care youth, support of fathers with substance use disorder, specific treatment modalities, and perspectives of professionals or individuals who are directly impacted. How has this information enhanced your understanding of substance abuse? How do you anticipate integrating what you have learned into your work supporting children and families?

Discussion on Agency- & System-Level Changes

1. As discussed in multiple articles within the publication, it is common that the child welfare, substance use, and mental health fields work separately from one another and struggle to collaborate effectively. How has this lack of communication and partnership affected your agency's support and engagement with individuals and families impacted by substance use? What do you think your agency could do differently to increase collaboration and partnerships between these systems?
2. The information presented in this publication addresses the countless systemic barriers within the child welfare system and substance use field that can interfere with an individual's or family's ability to succeed and recover (e.g. access to appropriate treatment, lack of integrated care and coordination, conflicting philosophies, etc). What barriers have you observed within your own agency? How can you support both policy and practice change within your agency and beyond to reduce the obstacles families face in accessing appropriate services and care?
3. This publication features various perspectives, including those of mothers, youth, child welfare workers, judges, and others (p. 25-32). Some of these individuals have provided constructive feedback and suggestions for how to improve various aspects of substance use and child welfare practice. How can you utilize this feedback to make changes within your agency? In what ways could you apply the information provided to advocate for modifications to be made at a local, state, or federal level?



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Administration on Children, Youth and Families
Children's Bureau



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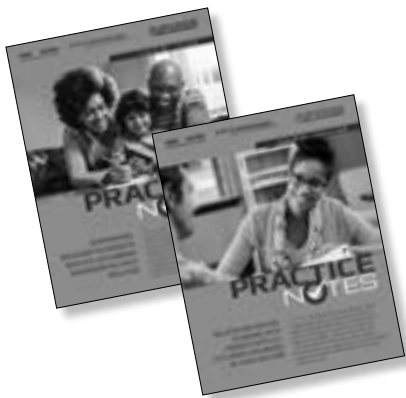
Supporting Parents with Co-occurring Disorders (CODs) in Child Welfare

Developed for professionals working in the field of child welfare.



Video Series: A three-part short video series that will help you and your team identify signs of CODs, understand barriers to recovery for clients, improve case and safety planning, and recognize the importance of integrated treatment options for families managing CODs in child welfare. z.umn.edu/parentswithcod

- **Video #1:** Supporting Parents with Co-occurring Disorders in Child Welfare
- **Video #2:** Case Planning that Supports the Path to Recovery
- **Video #3:** Integrated Approaches, Bias, and Meeting Parents Where They Are



Practice Notes: Two practice briefs on:

“Supporting Recovery in Parents with Co-occurring Disorders in Child Welfare” z.umn.edu/pn26

“Relapse Prevention Planning for Parents with Co-occurring Disorders in Child Welfare” z.umn.edu/pn31cods



COD Resource Booklet: A quick reference booklet which provides information on many aspects of CODs and recovery for individuals simultaneously navigating the child welfare system. z.umn.edu/COD-reference

To request hard copies of any of these materials, email cascw@umn.edu.

Resources

This list of resources is compiled with input from CW360 authors and editors as well as CASCW and MNCAMH staff.

Governmental Organizations & Resources

- *Administration for Children and Families* <https://www.acf.hhs.gov>
- *Center on Addiction* <https://www.centeronaddiction.org/>
- *Centers for Disease Control and Prevention, Early Intervention Information by State* <https://www.cdc.gov/ncbddd/actearly/parents/states.html>
- *National Center on Substance Abuse and Child Welfare* <https://ncsacw.samhsa.gov/>
- *National Institute on Alcohol Abuse and Alcoholism* <https://www.niaaa.nih.gov/>
- *National Institute on Drug Abuse* <https://www.drugabuse.gov/>
- *National Institute of Mental Health* <https://www.nimh.nih.gov/index.shtml>
- *National Registry of Evidenced-Based Programs and Practices* <https://www.samhsa.gov/nrepp>
- *Substance Abuse and Mental Health Services Administration* <https://www.samhsa.gov/>
- *U.S. Department of Health & Human Services, Children's Bureau* <https://www.acf.hhs.gov/cb>

National Organizations & Resources

- *American Academy of Child & Adolescent Psychiatry* <https://www.aacap.org/>
- *Celebrating Families!*™ www.celebratingfamilies.net
- *Children and Family Futures* <https://www.cffutures.org/>
- *Children's Defense Fund* <https://www.childrensdefense.org/>
- *KEEP- Keeping Foster and Kin Parents Supported and Trained* <https://www.keepfostering.org/>
- *Multisystemic Therapy including the Multisystemic Therapy-Building Stronger Families (MST-BSF)* www.mstservices.com
- *National Child Welfare Workforce Institute* <https://ncwwi.org/>
- *National Abandoned Infants Assistance Resource Center* <https://socialwelfare.berkeley.edu/tags/national-abandoned-infants-assistance-resource-center>
- *National Drug Court Institute* <https://www.ndci.org/>
- *Sobriety Treatment and Recovery Teams (START)* <https://www.cebc4cw.org/program/sobriety-treatment-and-recovery-teams/detailed>

Minnesota Organizations & Resources

- *Minneapolis American Indian Center* <http://maicnet.org/>
- *Minnesota Indian Women's Resource Center* <https://www.miwrc.org/>
- *Minnesota Center for Chemical and Mental Health* <https://mncamh.umn.edu/>
- *Minnesota Prevention Resource Center* <https://mnprc.org/>
- *Minnesota Recovery Connection* <https://minnesotarecovery.org/>
- *Proof Alliance (Formerly MOFAS)* <https://www.proofalliance.org/>
- *Wayside Recovery Center* <https://waysiderecovery.org/>
- *White Earth Nation MOMs program* <http://www.whiteearthculturaldivision.com/programs/moms-program>
- *Youth Leadership Councils* <https://mn.gov/dhs/people-we-serve/children-and-families/services/adolescent-services/programs-services/youth-leadership-councils.jsp>

Policy Specific Organizations & Resources

- *Center for the Study of Social Policy* <https://cssp.org/>
- *GrandFamilies* <http://www.grandfamilies.org/>
- *Legal Action Center* <https://lac.org/>
- *Movement Advancement Project* <http://www.lgbtmap.org/>
- *State laws regarding substance use during pregnancy* <https://www.gutmacher.org/state-policy/explore/substance-use-during-pregnancy>
- *State statutes on parental drug use as child abuse* <https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/drugexposed/>

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Minnesota Realistic Job Preview for Child Protection



CASCW produced a new RJP that can be used to assist in hiring processes, and can be particularly helpful with the recruitment, selection, and retention of child protection workers. We also encourage universities to share this video with students considering a career in the field of child welfare. In an effort to capture the complexity and diversity of the child welfare system in Minnesota, CASCW partnered with key stakeholders, including six different counties that represented rural, urban, and suburban populations. This project included the perspectives of managers, frontline workers, and families previously involved with the child protection system. You can view the Minnesota Child Protection RJP along with 12 extended interview video clips at: <http://z.umn.edu/mnrjp>



About CW360°

Child Welfare 360° [CW360°] is an annual publication that provides communities, child welfare professionals, and other human service professionals comprehensive information on the latest research, policies and practices in a key area affecting child well-being today. The publication uses a multidisciplinary approach for its robust examination of an important issue in child welfare practice and invites articles from key stakeholders, including families, caregivers, service providers, a broad array of child welfare professionals (including educators, legal professionals, medical professionals and others), and researchers. Social issues are not one dimensional and cannot be addressed from a single vantage point. We hope that reading CW360° enhances the delivery of child welfare services across the country while working towards safety, permanency and well-being for all children and families being served.

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In This Issue of CW360^o

Explores the impact and implications of families' co-occurring involvement in the child welfare and substance use disorder treatment systems in the United States

- The latest evidence on addiction and recovery and the prevalence of substance use in families involved in child welfare in the U.S.
- Key contributing factors for involvement and the systemic barriers that impact families
- Critical information on how professionals within these two areas of practice can integrate services and work collaboratively to best serve children and their families
- The emergence of evidence-informed, innovative, and promising practices and policies

CW360^o

a comprehensive look at a
prevalent child welfare issue

Feature Issue: Understanding Substance Use
and Interventions in Child Welfare, Spring 2019

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