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From Policy to Practice: Comprehensive and Coordinated Family-Centered Treatment for Families Affected by Substance Use Disorders

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University of North Carolina

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Children's Bureau
An Office of the Administration for Children & Families

Quality Improvement Center
Collaborative Community Court Teams

Center for Children and Family Futures
Strengthening Partnerships, Improving Family Outcomes

National Quality Improvement Center for Collaborative Community Court Teams

A Program of

Administration on Children, Youth and Families

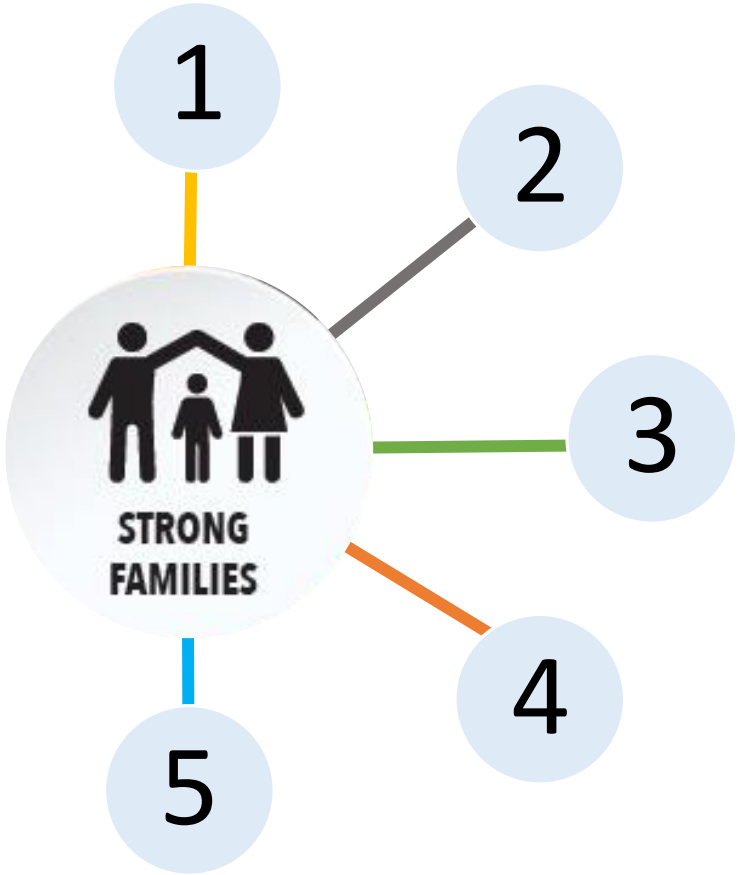
Children's Bureau

OVERVIEW OF THE NATIONAL QUALITY IMPROVEMENT CENTER FOR COLLABORATIVE COMMUNITY COURT TEAMS (QIC-CCCT)

CB's Goals and Priorities

Change our work's focus

- Preventing maltreatment
- Preventing unnecessary placement



Develop and support a healthy and stable child welfare workforce

- Competent, skilled and informed
- Capable and visionary leadership

Prioritize the importance of families

- Children must be kept in their communities and schools
- Foster parents must become resources to help support birth parents

Focus our interventions on the well-being of children and their parents

- Address both parent and child trauma
- Don't cause additional trauma through unnecessary removal

Build the capacity of communities to support children and families

- Locally based resources and services
- Supports families need must be located where families live

QIC-CCCT Goals

IMPLEMENTATION

Enhance the capacity of CCCTs to appropriately implement the provisions of the Comprehensive Addiction and Recovery Act (CARA) amendments to the Child Abuse and Prevention Treatment Act (CAPTA)

CAPACITY

Enhance and expand CCCTs' capacity to effectively collaborate to address the needs of infants, young children, and their families/caregivers affected by substance use disorders (SUDs) and prenatal substance exposure

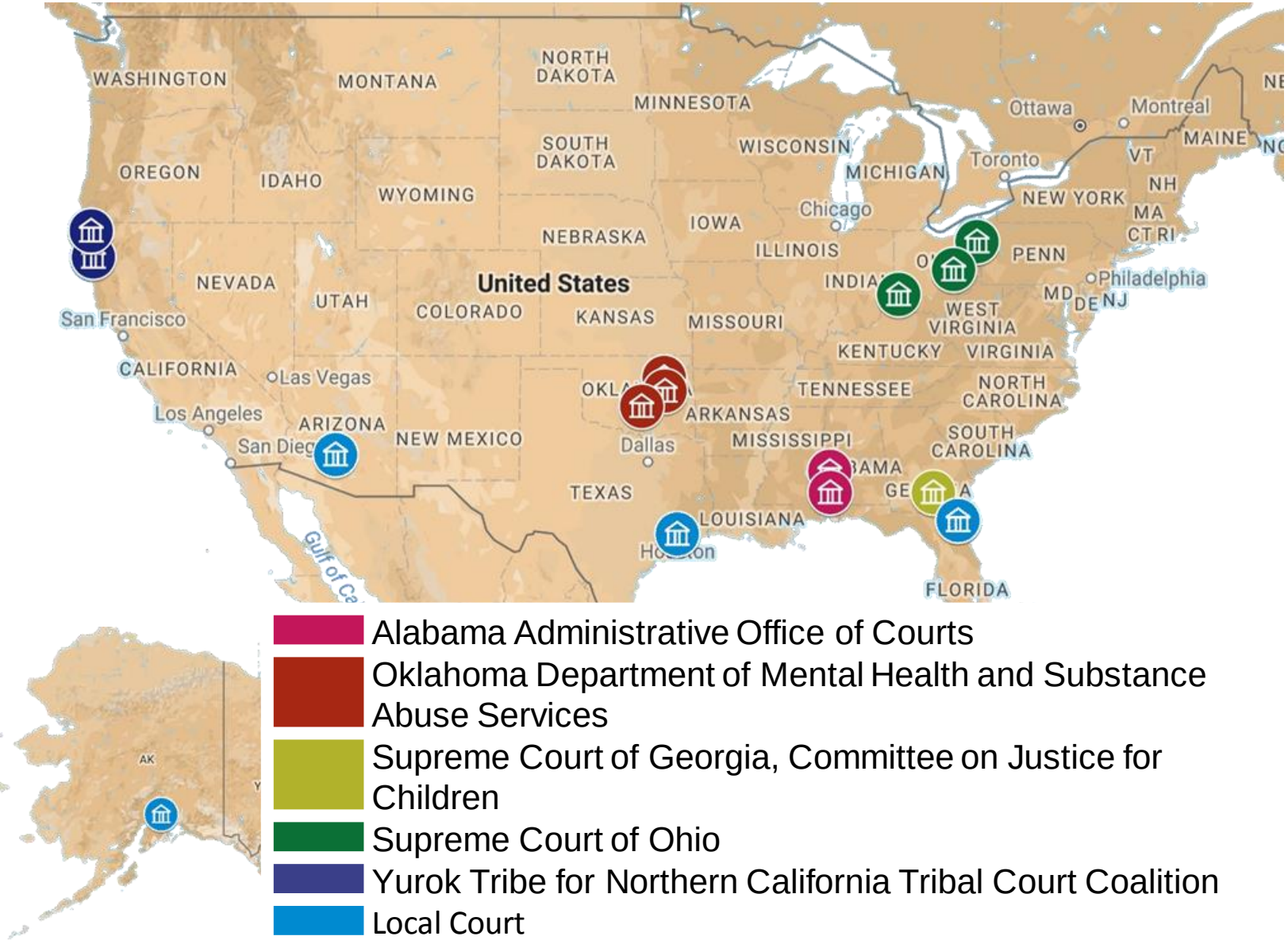
SUSTAINABILITY

Sustain the effective collaborative partnerships, processes, programs, and procedures implemented to achieve the goals of each demonstration site

DISSEMINATION

Provide the field with lessons they can apply about effective practices for implementing the requirements of CARA and meeting the needs of children and families affected by substance use disorders

Demonstration Sites



- Alabama Administrative Office of Courts
- Oklahoma Department of Mental Health and Substance Abuse Services
- Supreme Court of Georgia, Committee on Justice for Children
- Supreme Court of Ohio
- Yurok Tribe for Northern California Tribal Court Coalition
- Local Court

QIC-CCCT Sites: Court Models

Nine Family Treatment Courts

Three Early Childhood/Infant Toddler Courts

One Family Treatment Court & Early Childhood Court

Two Joint Jurisdiction Family Wellness Courts (Tribal/County)

Collaboration

Demonstration sites must include intensive collaboration among the following agencies:

State/Tribal Government Oversight Level

- Court Improvement Program
- Child Welfare
- Substance Use Disorder Treatment
- Public Health: Maternal and Child Health
- Tribal Government, Consortia

Local Court Team Level

- Child Welfare
- Substance use disorder treatment and mental health providers
- Maternal and infant health care providers
- Hospitals
- Attorneys

Collaboration and Partnership

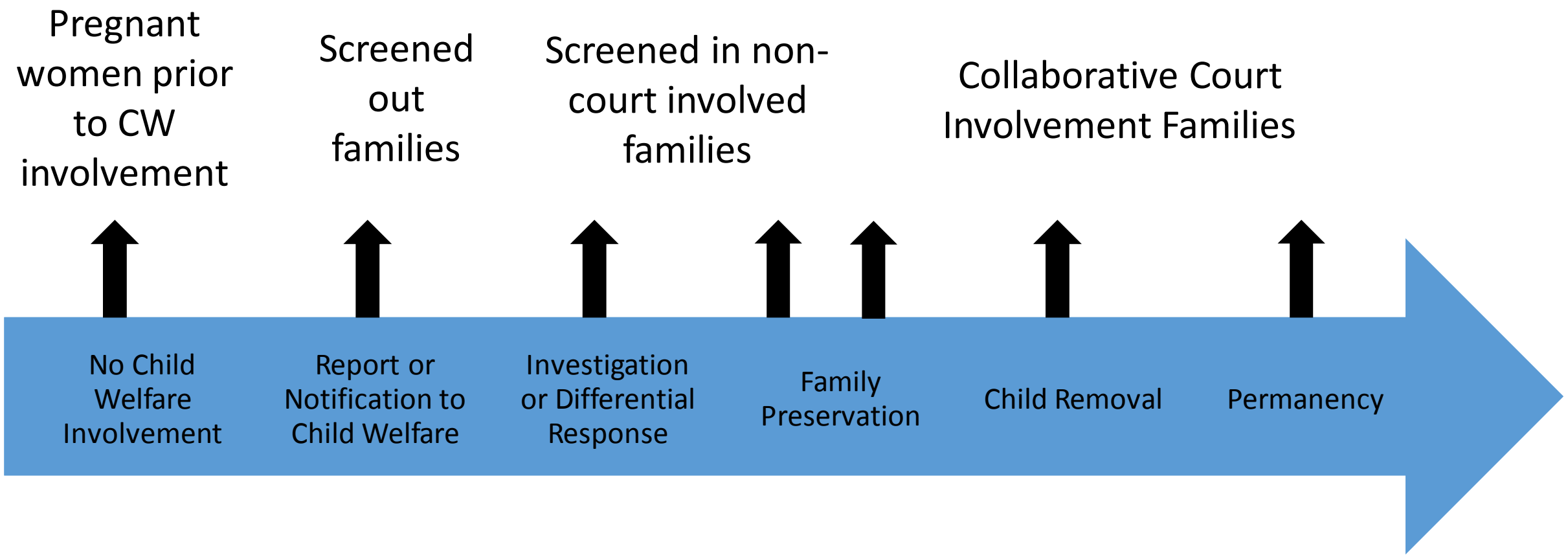
Core Partners	
Child Welfare	15
Substance Use Disorder Treatment	15
Medical/Health Care	12
Children's Services (including Home Visiting and Early Intervention)	12
Public Health	11
Attorneys	9
Medication Assisted Treatment Providers	9

Demonstration sites strengthened partnerships and expanded Core Team membership with representation from new systems.

- Challenges to building and strengthening cross-system collaboration:
  - ✓ Concerns about confidentiality
  - ✓ Lack of knowledge about Plans of Safe Care
  - ✓ Limited staff and system capacity
  - ✓ Stigma and bias

Expanding Target Populations

11 sites expanded their target populations to serve families outside of the collaborative court



Implementing CARA Amendments to CAPTA

Start of QIC	Current	
7 sites	*13 sites*	have begun to **implement Plans of Safe Care** in some capacity
2 sites	*11 sites*	reported that the **court is involved** in implementing or reviewing/asking about Plans of Safe Care
4 sites	*12 sites*	have **developed a template/document** for the Plan of Safe Care in at least some cases
0 sites	*12 sites*	are either implementing or planning to implement **prenatal Plans of Safe Care**

Family-Centered Services

Demonstration sites are addressing the needs of infants, young children, and their caregivers by:

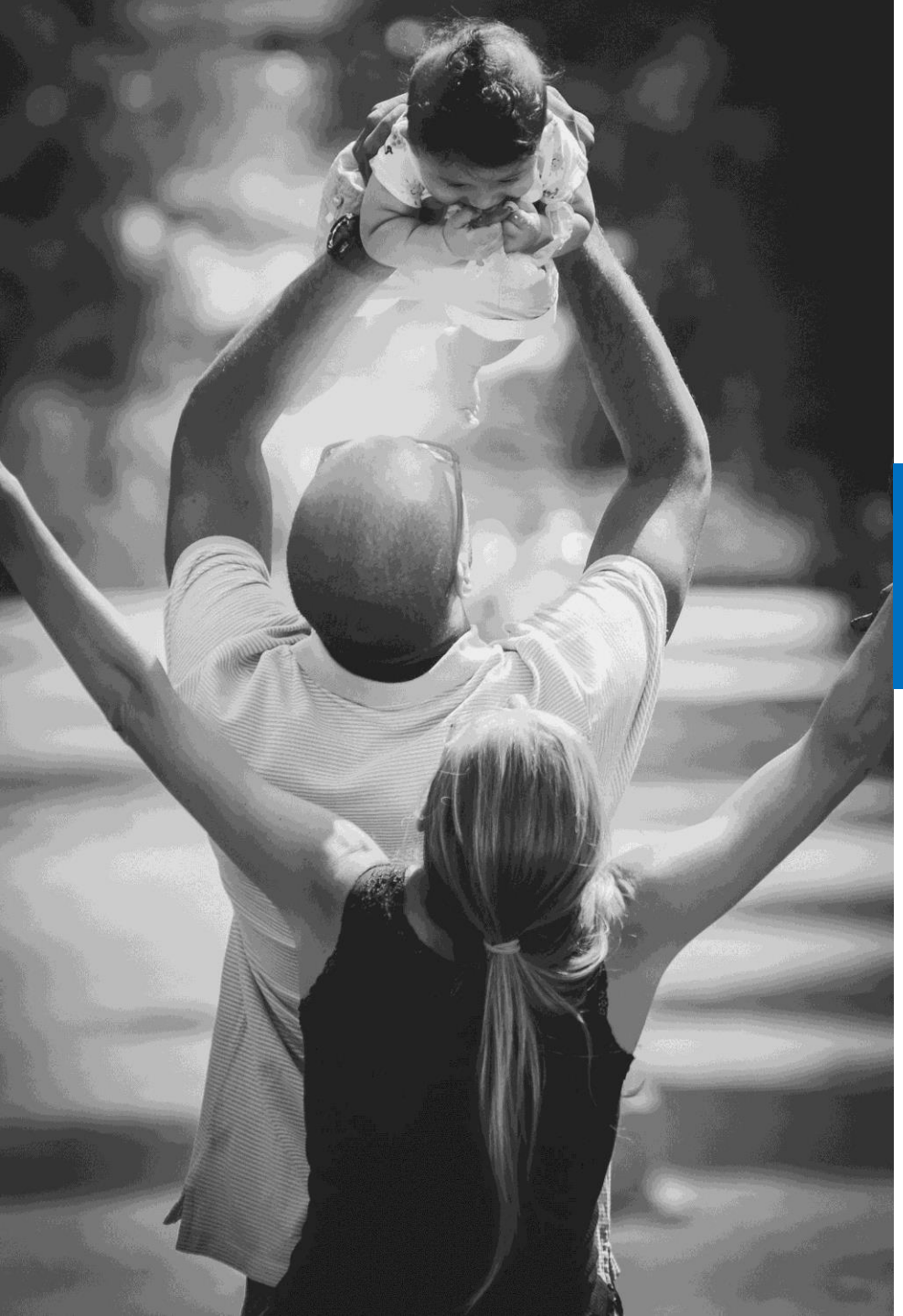
Implementing new services, enhancing existing services, and engaging new partners	**12 Sites** have developed or expanded partnerships and services for parents with substance use disorders.
Enhancing referral processes	**5 Sites** have improved referral processes for development assessments and early childhood services.
Improving information sharing and communication protocols	**9 Sites** have created/improved linkages with Early Intervention, Home Visiting, or Head Start.

Strengthening Parental Capacity

Demonstration sites have enhanced their capacity to be family-centered and address parent-child relationships.

- 12 sites provide access to evidence-based services that address parent-child interaction

Primary Parent-Child Evidence-Based Interventions	
Child-Parent Psychotherapy	8 sites
Celebrating Families/Strengthening Families	4 sites
Parent Child Interaction Therapy	4 sites
Nurturing Parenting	3 sites



The Family First Prevention Services Act (FFPSA)

Family First Prevention Services Act of 2018[1]

- Sec. 50712.(j)(1) CHILDREN PLACED WITH A PARENT RESIDING IN A LICENSED RESIDENTIAL FAMILY-BASED TREATMENT FACILITY FOR SUBSTANCE ABUSE.—
  - "(A) the recommendation for the placement is specified in the child's case plan before the placement;
  - (B) the treatment facility provides, as part of the treatment for substance abuse, parenting skills training, parent education, and individual and family counseling; and
  - (j)(1)(C) the substance abuse treatment, parenting skills training, parent education, and individual and family counseling is provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing."

- For Children's Bureau overview of the legislation, see **https://www.acf.hhs.gov/sites/default/files/cb/im1802.pdf.**

- Please direct questions on how these provisions apply to your state to the Children's Bureau Regional office. **https://www.acf.hhs.gov/cb/resource/regional-program-managers**

Important Audience Note

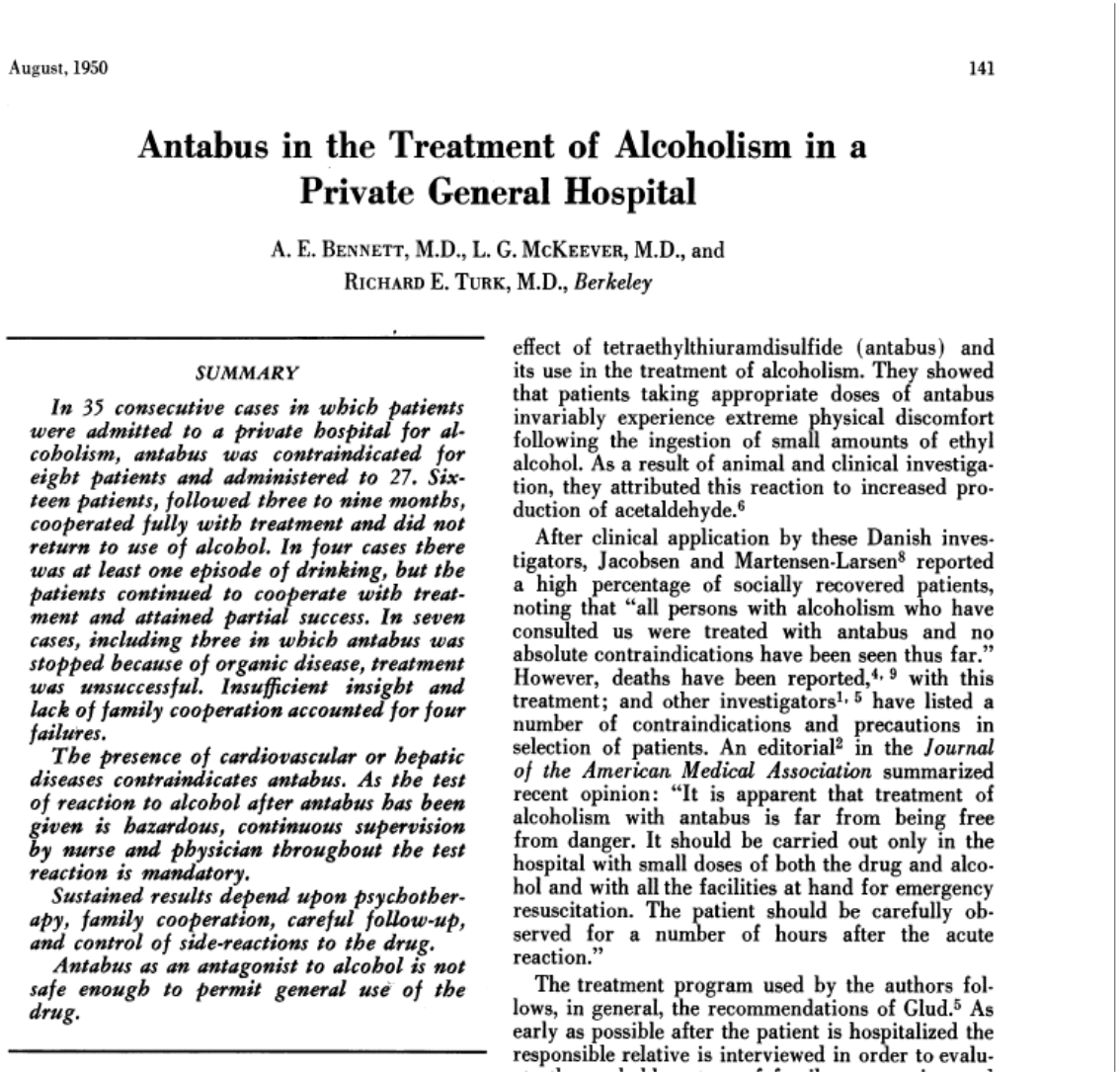
- Some of the following slides provide examples of evidence-based practices that address components of the statute.
- The examples are for illustration purposes only and are not an exhaustive list of all evidence-based practices.
- The examples provided do not imply that these practices are required by the statute or approved by the Children's Bureau as meeting their requirement.

From Policy to Practice: Comprehensive and Coordinated Family-Centered Treatment for Families Affected by Substance Use Disorders

Hendree E. Jones, UNC Horizons
Professor, Department of Obstetrics and Gynecology
University of North Carolina

History of Family-Centered Services

- Marriage and family therapy had its origins in the 1950s
- NIDA Perinatal 20 grants included aspects of family in treatment projects



Antabus in the Treatment of Alcoholism in a Private General Hospital

A. E. Bennett, M.D., L. G. McKeever, M.D., and
Richard E. Turk, M.D., *Berkeley*

SUMMARY

In 35 consecutive cases in which patients were admitted to a private hospital for alcoholism, antabus was contraindicated for eight patients and administered to 27. Sixteen patients, followed three to nine months, cooperated fully with treatment and did not return to use of alcohol. In four cases there was at least one episode of drinking, but the patients continued to cooperate with treatment and attained partial success. In seven cases, including three in which antabus was stopped because of organic disease, treatment was unsuccessful. Insufficient insight and lack of family cooperation accounted for four failures.

The presence of cardiovascular or hepatic diseases contraindicates antabus. As the test of reaction to alcohol after antabus has been given is hazardous, continuous supervision by nurse and physician throughout the test reaction is mandatory.

Sustained results depend upon psychotherapy, family cooperation, careful follow-up, and control of side-reactions to the drug.

Antabus as an antagonist to alcohol is not safe enough to permit general use of the drug.

effect of tetraethylthiuramdisulfide (antabus) and its use in the treatment of alcoholism. They showed that patients taking appropriate doses of antabus invariably experience extreme physical discomfort following the ingestion of small amounts of ethyl alcohol. As a result of animal and clinical investigation, they attributed this reaction to increased production of acetaldehyde.[6]

After clinical application by these Danish investigators, Jacobsen and Martensen-Larsen[8] reported a high percentage of socially recovered patients, noting that "all persons with alcoholism who have consulted us were treated with antabus and no absolute contraindications have been seen thus far." However, deaths have been reported,[4, 9] with this treatment; and other investigators[1, 5] have listed a number of contraindications and precautions in selection of patients. An editorial[2] in the *Journal of the American Medical Association* summarized recent opinion: "It is apparent that treatment of alcoholism with antabus is far from being free from danger. It should be carried out only in the hospital with small doses of both the drug and alcohol and with all the facilities at hand for emergency resuscitation. The patient should be carefully observed for a number of hours after the acute reaction."

The treatment program used by the authors follows, in general, the recommendations of Glud.[5] As early as possible after the patient is hospitalized the responsible relative is interviewed in order to evalu-

How is Family Defined?

- Traditional families
- Single parents
- Blood relatives
- Adoptive families
- Foster relationships
- Grandparents raising grandchildren
- Stepfamilies
- Extended families
- Elected families

For practical purposes, family can be defined according to the individual's closest emotional connections.

Substance Abuse Treatment and Family Therapy. Treatment Improvement Protocol (TIP) Series, No. 39. Center for Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2004

Treatment that **Supports Families**

- Treatment that supports the family as a unit has been proved to be effective for maintaining maternal drug abstinence and child well-being.
- A woman must not be unnecessarily separated from her family in order to receive appropriate treatment.

Sharon Amatetti, Family-Centered Treatment for Parents with Substance Use Disorders 2007

http://www.slideshare.net/jschwartz/transformation-of-the-culture-of-recovery-in-america-by-william-l-white-october-2011

Key Concepts
Family Centered Treatment

- Substance use disorders are treatable
- Women define their families
- Families are dynamic with complex needs; treatment must be dynamic
- Conflict happens and can be resolved
- Safety first!

Young, N.K., Feinberg, F. Wisconsin Bureau of Prevention, Treatment and Recovery (BPTR) Teeleconference Series Thursday, August 26, 2010

Key Concepts
Family Centered Treatment

- Comprehensive and culturally competent
- Coordinating across multiple systems
- Based on the unique needs and resources of individual families
- Gender and age responsive and specific
- Multidisciplinary staff working with mutual respect and shared understanding
- Supporting the creation of healthy family system

Young, N.K., Feinberg, F. Wisconsin Bureau of Prevention, Treatment and Recovery (BPTR) Teeleconference Series Thursday, August 26, 2010

Family Treatment

Needs

PARENTS

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

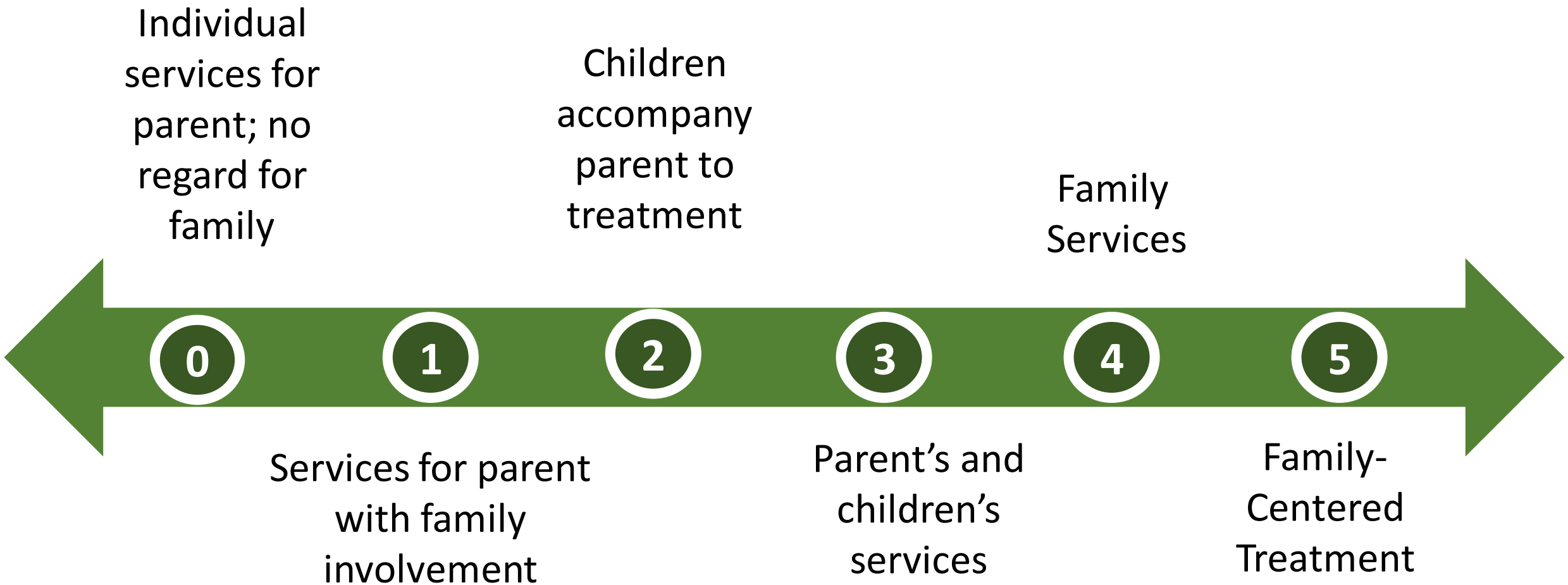
FAMILY

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

CHILD

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

Family-Centered Treatment **Continuum**



https://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf

Key Concepts
Family Centered Treatment

- Treatment plans include family issues and parenting
- Needs for each member of the core family are gathered and a plan developed with the parent in treatment to address the needs
- Parenting knowledge, strengths and areas for skill building are assessed and an intervention plan is put in place – *training and HOW do things is more important they telling parents what to do*
- Having childcare or child-friendly environments
- Outcomes measured are for parent and child

* Women want programs to allow children to accompany their mothers and women-only programs.

* Elms, N., Link, K., Newman, A. *et al.* Need for women-centered treatment for substance use disorders: results from focus group discussions. *Harm Reduct J* 15, 40 (2018).

Best Practices for Trauma-Informed (or Responsive) Organization Structure & Treatment Frameworks:

Trauma Definition

"Resulting from an event, series of events, or set of circumstances

That is experienced by an individual as physically or emotionally harmful or threatening and

That has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being"

Event + Experience of the event + Effects = Trauma

Source: https://www.samhsa.gov/trauma-violence

Best Practices for Trauma-Informed (or Responsive) Organization Structure & Treatment Frameworks:
Trauma Types

There are three types of trauma:

- Acute trauma: A single traumatic event that is time-limited
- Chronic trauma: Multiple traumatic events, which can be diverse and repeated, and/or frequent (e.g., interpersonal violence)
- Complex trauma: Chronic Trauma with two key attributes:

    1) Starts early, from age 0-5 year

    2) Usually inflicted by adults who are expected to care for the child

- When trauma during childhood is caused by those who should be protecting and nurturing the child, the trauma has direct implications on adult functioning
- Trauma is commonly reported among those with substance use disorders and/or who grow up in homes with active substance use occurring

Best Practices for Trauma-Informed (or Responsive) Organization Structure & Treatment Frameworks: **Trauma-Informed Care Definition**

A definition of trauma-informed approach incorporates three key elements:

(1) *Realizing* the prevalence and impact of trauma

(2) *Recognizing* how trauma affects all individuals involved with the program, organization, or system, including its own workforce

(3) *Responding* by putting this knowledge into practice

> *Trauma-Informed Care (TIC) – adoption of principles and practices that promote a culture of safety, empowerment, and healing. Based on what we know about the prevalence and impact of trauma, it is necessary to ensure widespread adoption of trauma-informed care*

https://www.integration.samhsa.gov/clinical-practice/trauma

Best Practices for Trauma-Informed (or Responsive) Organization Structure & Treatment Frameworks: **Principles of A Trauma-Informed Approach**

https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm

TIPS: Responding to Women or Other Family Members in Family-Centered Care

- Understand the treatment experience from the person's viewpoint
- Provide integrated services
- Know that you must think about how trauma experiences are present in every interaction
- A major focus of treatment is helping the family members believe that something they do can actually make a difference in their own lives

Best Practices for Trauma-Informed (or Responsive) Organization Structure & Treatment Frameworks: **Trauma-Specific Interventions**

Trauma-informed care addresses organizational culture and practice while **trauma-specific** services are clinical interventions

Many different treatment programs exist to treat trauma and PTSD as well as integrated trauma and SUD

Several websites provide information about treatment programs, including target populations, languages, training and costs:

1. **California Evidence-Based Clearinghouse (CEBC) for Child Welfare** (http://www.cebc4cw.org/topic/trauma-treatment-adult/)
2. **National Center for PTSD** (https://www.ptsd.va.gov/)
3. **National Child Traumatic Stress Network (NCTSN)** (http://www.nctsn.org/resources/topics/treatments-that-work)
4. **Trauma-Informed Care in Behavioral Health Services.** Treatment Improvement Protocol (TIP) Series, No. 57. Center for Substance Abuse Treatment (US). Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (https://www.integration.samhsa.gov/clinical-practice/SAMSA_TIP_Trauma.pdf)

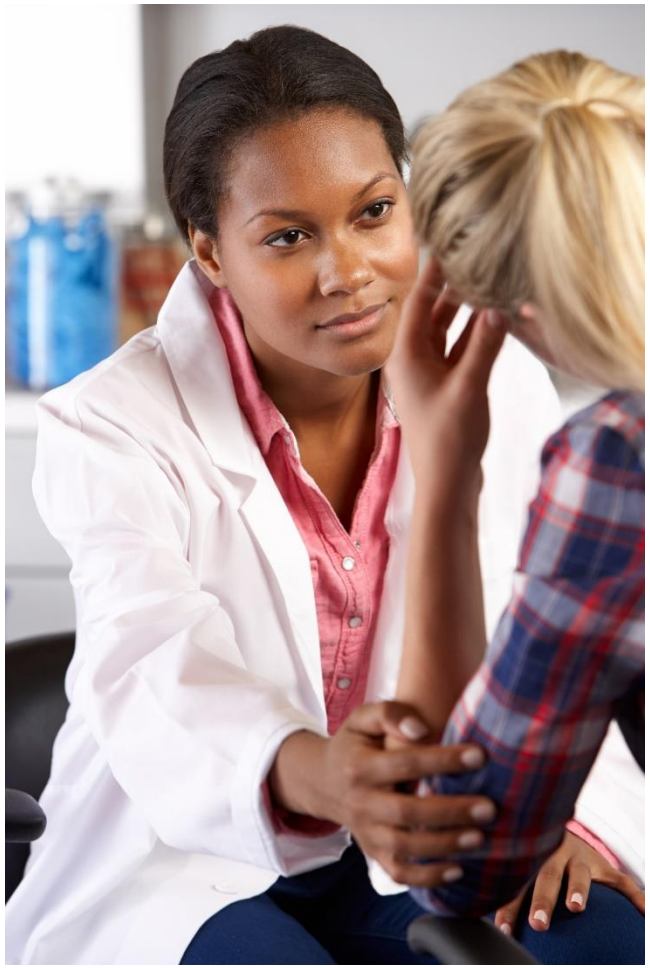
Best Practices for Trauma-Informed (or Responsive) Organization Structure & Treatment Frameworks:
Trauma-Specific Interventions for Those with Substance Use Disorders

Some interventions have been explicitly designed to treat trauma symptoms simultaneously with substance use disorders and/or other mental health disorders. A few of these are (not an exhaustive list):

1. Dialectical Behavioral Therapy
2. Helping Women Recover and Beyond Trauma
3. Seeking Safety
4. Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
5. Trauma Recovery and Empowerment Model (TREM)
6. The Sanctuary Model

Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series, No. 57. Center for Substance Abuse Treatment (US). Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014.; http://www.cebc4cw.org/search/by-program-name; https://www.samhsa.gov/ebp-resource-center

Vicarious Trauma



Also called:

Compassion fatigue

Secondary traumatic stress

Secondary victimization

People working with trauma survivors may experience vicarious trauma because of the work they do.

Vicarious trauma is the emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured.

Tools to Address Vicarious Trauma

- Self-care toolbox
- Formal and informal opportunities to talk to a supervisor to de-brief
- Grounding Skills
- Ways to Find Work/Life Balance
- Mindfulness & self–compassion

Acknowledging the Positive

- Post Traumatic Growth
- Vicarious Resilience
- Compassion Satisfaction
- Vicarious Transformation

Best Practices for Parenting Skills and Education Foundation in Substance Use Disorder Treatment

- Parent education:
  - Social learning theory
- Skills-based interventions:
  - Teach parents how to improve safety at home or recognize and respond to symptoms of trauma
  - Help families better understand children's emotions and needs
  - Improve attachment between caregiver and child
  - Reduce problem behaviors in children
  - Enhance placement stability

https://www.childwelfare.gov/pubPDFs/parented.pdf

Best Practices for Parenting Skills and Education Foundation in Substance Use Disorder Treatment-Attachment Theory Review

- Healthy ("Secure") relationships with caregivers have a positive impact on child development
- Unhealthy ("Insecure or Disorganized") relationships are associated with poor developmental outcomes including substance abuse and other mental health issues
- The relationship patterns learned in childhood are often carried into our adult relationships
- We now have **interventions** designed to improve child and caregiver relationships

Best Practices for Parenting Skills and Education Foundation in Substance Use Disorder Treatment: Examples

Common Elements

Aim to improve attachment relationship between children and their caregivers

Help to improve sensitivity to children's needs in the child's caregiver

Have research supporting their efficacy

Three Interventions Grounded in Attachment Theory Used with Families in Treatment for Substance Use Disorder

Circle of Security

https://www.circleofsecurityinternational.com/

Child Parent Psychotherapy

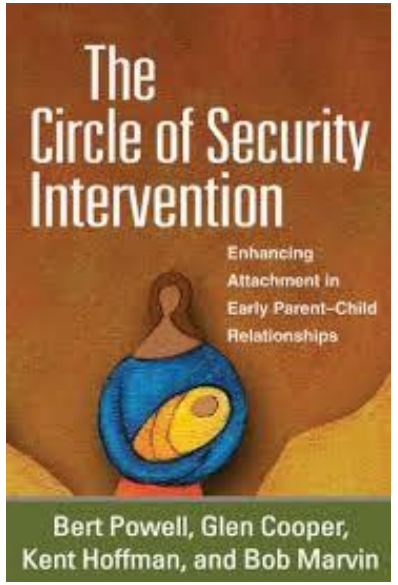
http://childparentpsychotherapy.com/

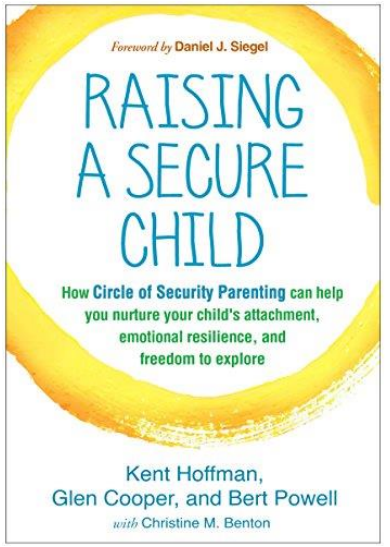
Attachment and Biobehavioral Catch-Up

http://www.abcintervention.org/

Circle of Security Parenting

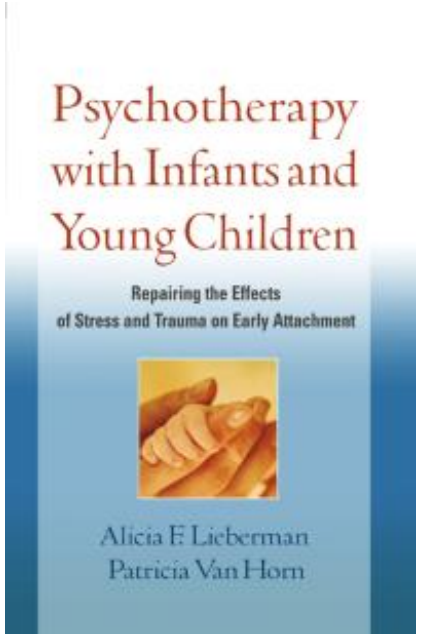
- Parent education model
- Children under the age of 6 in high-risk populations
- 8-10 sessions caregiver group
- Uses a DVD, facilitator manual, and handouts
- Requires a 4 day training
- Available in multiple languages!

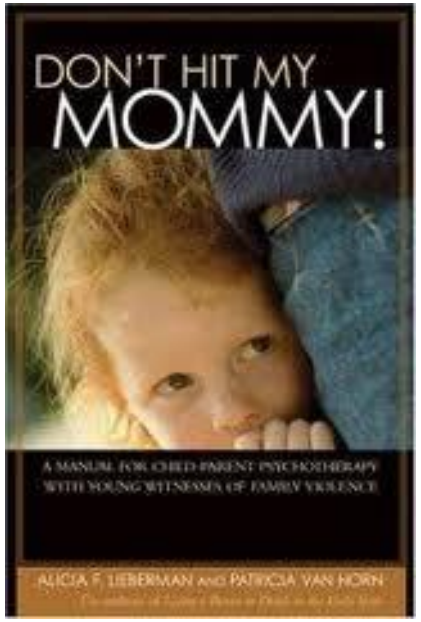




Child Parent Psychotherapy

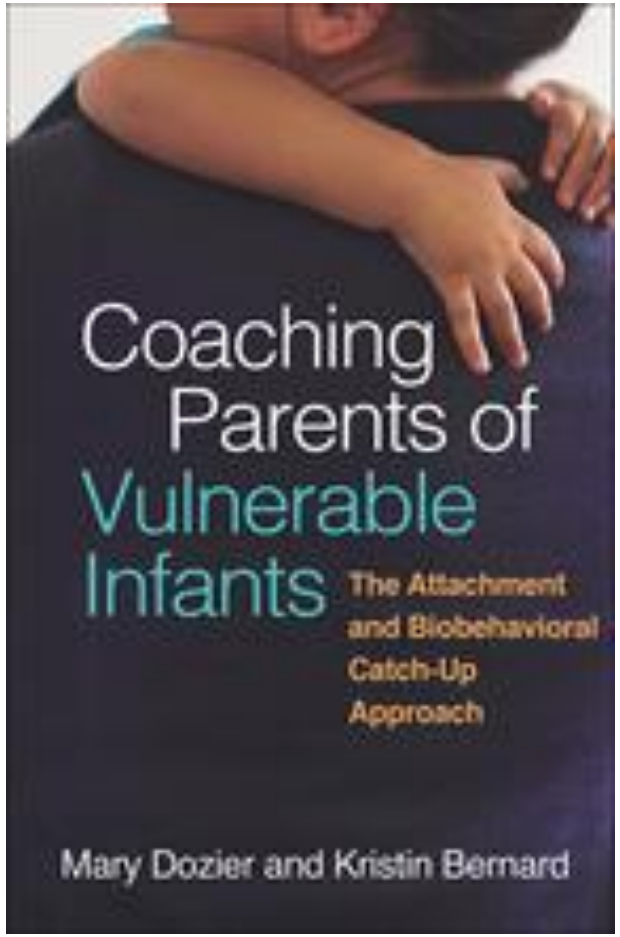
- Therapeutic intervention model for caregiver and child
- For caregiver with children ages birth to 6 years old
- Focuses on helping both the caregiver and the child understand traumatic events and repair attachment relationship





Attachment and Biobehavioral Catch-up

- Coaching model
- For caregivers and children ages 6 months to 2 years
- 10 video-taped sessions
- Focuses on helping caregiver practice specific behaviors linked to secure attachment including:
  - Expressing delight
  - Following the child's lead
  - Nurturing behaviors
  - Decreasing scary behaviors during child caregiver interactions



Substance Use Disorder Treatment Contents: Parenting Skills and Education Training- More Examples

Intervention	Population of Focus	Objective	Duration	Delivery setting	Website
Incredible Years (separate programs for parents, teachers, and children)	Parents or caregivers of children 0-12 years old teachers of young children, and children ages 4–8	To promote social and emotional competence and prevent, reduce, or treat behavioral and emotional problems in young children	18 to 30 weeks	Community agency, outpatient clinic, school, birth-family home, foster or kinship home, hospital, or workplace	http://www.incredibleyears.com/
Nurturing Fathers Program	At-risk fathers and families experiencing moderate levels of dysfunction (any age children)	To teach parenting and nurturing skills to men through the promotion of healthy family relationships and knowledge of child development	13 weeks	State or local community agency, school, church, prison, etc.	http://nurturingfathers.com/
Parent-Child Interaction Therapy	Children ages 2–7 with behavioral and parent-child relationship problems and their parents/primary caregivers	To decrease negative externalizing behaviors, increase social skills and cooperation, and improve the parent-child attachment relationship	10 to 20 weeks	Community agency or outpatient clinic	www.pcit.org
SafeCare	Parents with a history or risk of child abuse and neglect (any age children)	To teach parents how to interact positively with their children and respond appropriately to challenging behaviors, recognize safety hazards in the home, and how to respond appropriately to symptoms of illness or injury	18 to 20 weeks	Adoptive home, birth-family home, or foster or kinship home	www.safecare.org
Triple P Positive Parenting Program	For parents and caregivers of children ages 0–16	To inform parents and caregivers about strategies for promoting social competence and self-regulation in children	Varies	Community agency, outpatient clinic, school, adoptive home, birth-family home, foster or kinship home, hospital, or residential care	www.triplep.net

https://www.childwelfare.gov/pubPDFs/parented.pdf

Elements of Effective Parenting Skills Building and Education and Programs

- There is no “one-size-fits-all” approach
- Programs need to:
  - Fit community and cultural needs
  - Have available staff and adequate resources
  - Offer individualized interventions for the parents and children at risk of potential or repeated maltreatment
  - Provide parents with an opportunity to network with, and receive support from, parents who are in or who have been in similar circumstances
  - Make efforts to engage fathers
  - Treat parents as equal partners when determining which services would be most beneficial for them and their children
  - Tailor programs to the specific needs of families
  - Address trauma to ensure that it does not interfere with parenting and healthy development
  - Ensure families with multiple needs receive coordinated services
  - Offer programs that are culturally relevant to meet the needs of diverse populations

https://www.childwelfare.gov/pubPDFs/parented.pdf

Individual Counseling: Examples

Behavioral Therapies:

- Cognitive-Behavioral Therapy (Alcohol, Marijuana, Cocaine, Methamphetamine, Nicotine)
- Contingency Management Interventions/Motivational Incentives (Alcohol, Stimulants, Opioids, Marijuana, Nicotine)
- Community Reinforcement Approach Plus Vouchers (Alcohol, Cocaine, Opioids)
- Motivational Enhancement Therapy (Alcohol, Marijuana, Nicotine)
- The Matrix Model (Stimulants)
- 12-Step Facilitation Therapy (Alcohol, Stimulants, Opiates)
- Family Behavior Therapy
- Behavioral Therapies Primarily for Adolescents

https://www.drugabuse.gov/publications/principles-drug-addiction-treatment/evidence-based-approaches-to-drug-addiction-treatment/behavioral-therapies

Family Counseling: Examples

- Many typical programs focus first on parental substance use and do not adequately address the additional risk factors for neglect.
- Although commonly recommended in child welfare system treatment plans, current practice typically refers parents to services to address these needs in a piecemeal manner.
- One notable exception is the recent advance from the Family Drug Court literature.
- Engaging Moms Project has demonstrated high substance use disorder treatment completion rates and positive CWS outcomes compared to usual case management services
- The Families Actively Improving Relationships (FAIR) program indicated that mothers who received FAIR were likely to engage in and complete their comprehensive treatment program compared to those in the treatment as usual group

Saldana L. Child Welfare. 2015; 94(5): 167–18; Marlowe DB, Carey SM. Research Update on Family Drug Courts. National Association of Drug Court Professionals. 2012 May; 2012; Dakof GA, et al., Journal of Substance Abuse Treatment. 2010;38:263–274.

The Power of Words to Hurt or Heal

Stigmatizing Language	Preferred Language
abuser	a person with or suffering from, a substance use disorder
addict	person with a substance use disorder
addicted infant	infant with neonatal abstinence syndrome (NAS)
addicted to [alcohol/drug]	has a [alcohol/drug] use disorder
alcoholic	person with an alcohol use disorder
clean	abstinent
clean screen	substance-free
co-dependency	term has not shown scientific merit
crack babies	substance-exposed infant
dirty	actively using
dirty screen	testing positive for substance use
drug abuser	person who uses drugs
drug habit	regular substance use
experimental user	person who is new to drug use
lapse / relapse / slip	resumed/experienced a recurrence
medication-assisted treatment (MAT)	medications for addiction treatment (MAT)
opioid replacement	medications for addiction treatment (MAT)
opioid replacement therapy (ORT)	medications for addiction treatment (MAT)
pregnant opiate addict	pregnant woman with an opioid use disorder
prescription drug abuse	non-medical use of a psychoactive substance
recreational or casual user	person who uses drugs for nonmedical reasons
reformed addict or alcoholic	person in recovery
relapse	reoccurrence of substance use or symptoms
slip	resumed or experienced a reoccurrence
substance abuse	substance use disorder

Adapted from: The Rhetoric of Recovery Advocacy: An Essay On the Power of Language W.L. White; E.A Salsitz, MD., Addiction Medicine vocabulary; Substance Use Disorders: A Guide to the Use of Language Prepared by TASC, Inc. Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services (DHHS), rev. 4.12.04

What About Confidentiality?

- **The 42 CFR part 2 regulations**
  - Protect patient records created by federally funded programs for the treatment of substance use disorder (SUD)
  - SAMHSA is currently proposing to revise part 2, to facilitate better coordination of care for substance use disorders which will also enhance care for opioid use disorder (OUD)
- **What's Not Changing Under the New Part 2 Rule:** The proposed rule will not alter the basic framework for confidentiality protection of SUD patient records created by federally funded treatment programs
- Part 2 will continue to prohibit law enforcement use of SUD patient records in criminal prosecution against the patient
- Part 2 will also continue to restrict the disclosure of SUD treatment records without patient consent, other than as statutorily authorized in the context of a bona fide medical emergency; or for the purpose of scientific research, audit, or program evaluation; or based on an appropriate court order for good cause

Practical Considerations for Family-Centered Care

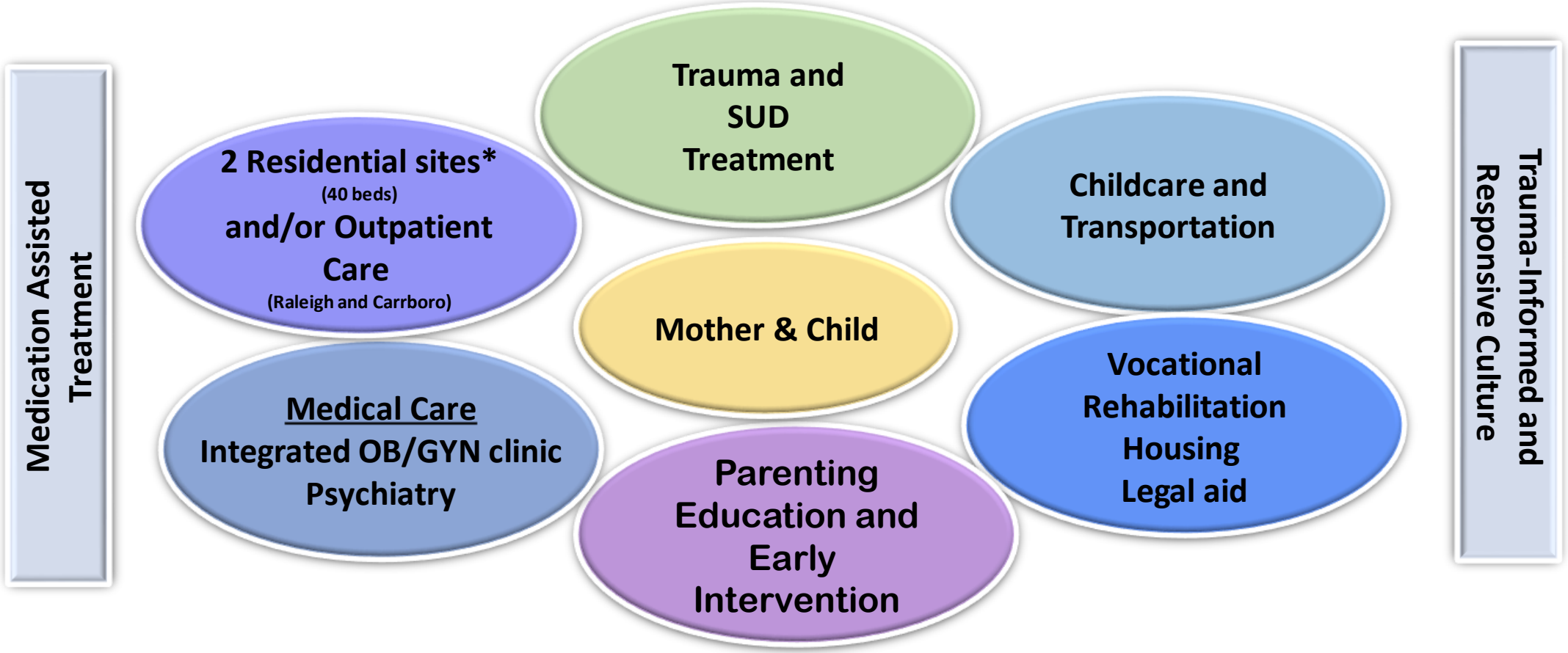
- Location and level of integration of services for the family
- Transportation issues
- Level of concrete expectations and explanations
- Collaboration with Child Protective Services
- Partnerships (HUD, Public Health)- releases of information
- How to get the whole family into treatment
- Financial debt, criminal records prevent safe housing
- Never underestimate the power of stigma and discrimination

Practical Considerations for Family-Centered Care

- Shared decision making
- Concrete language and specific actions
- Issues of distance, transportation, cost and relationships
- Confidentiality
- Cultural responsivity
- Ensuring people get all the information they need, in a way that is accessible for them
- Care Coordination among infant and maternal health care providers, hospitals, substance use treatment provider and child welfare (when needed)

UNC Horizons: Examples of Residential and Outpatient Family-Centered Care

Unified Philosophy Informed by Social Learning, Relationship and Empowerment Theories

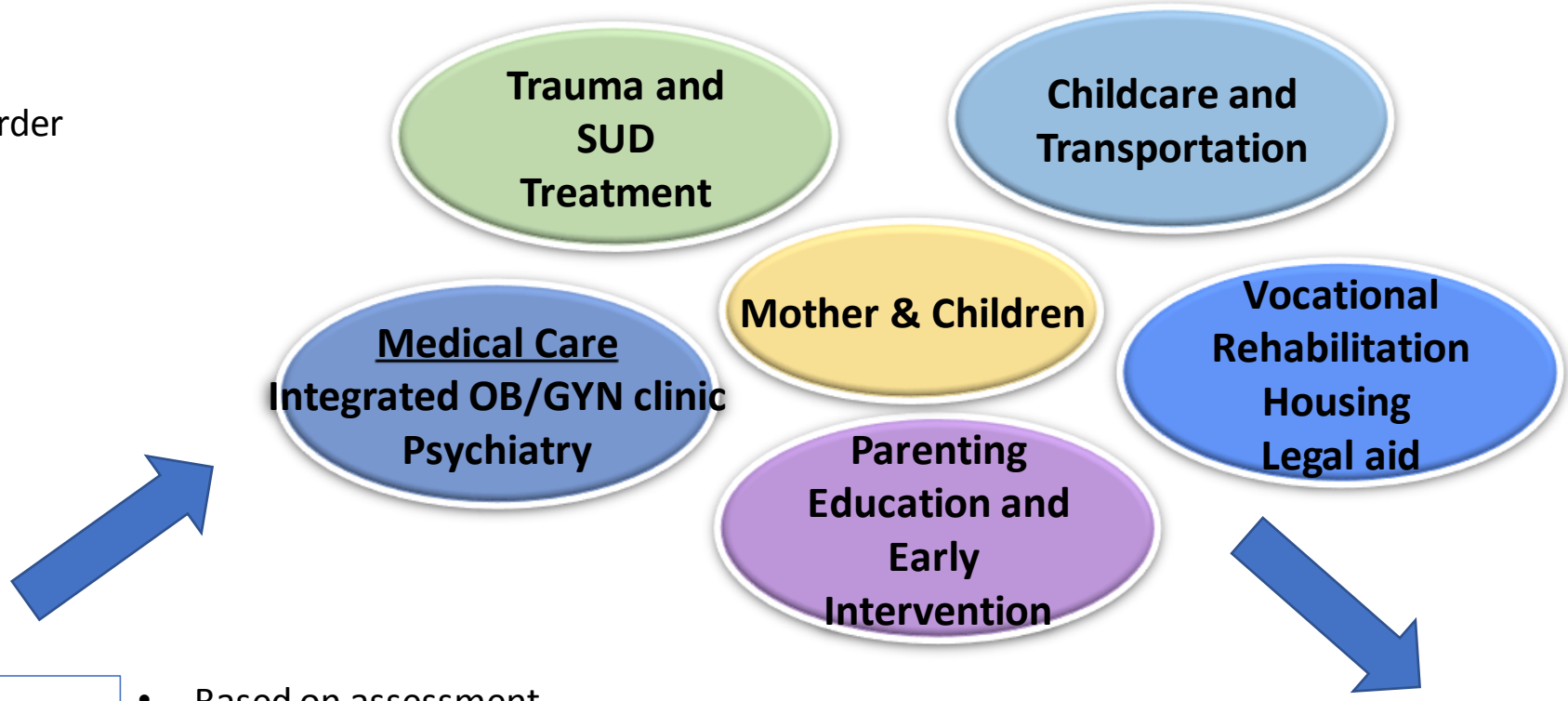


Who We Serve

UNC Horizons: Example of Residential Family-Centered Care

Patient Example: Mother is 32 years old

- IV heroin and oral benzodiazepine use disorder
- 2 children (newborn and 3 year old)
- Father of the children is in recovery
- Unemployed
- Came to Horizons from prison



- Screened and assessed over the phone
- Prison brings mother and newborn to residence
- Peer support specialists move her in
- Sees nurse and medication assisted treatment initiated
- Mother and child attend groups
- Father brings 3 year old 1 month later

- Based on assessment
  - Parenting - Circle of Security (in group) and Child Parent Psychotherapy (in home)
  - Individual Counseling- Motivational Interviewing and Cognitive Behavioral Therapy
  - Family Counseling- Couples therapy

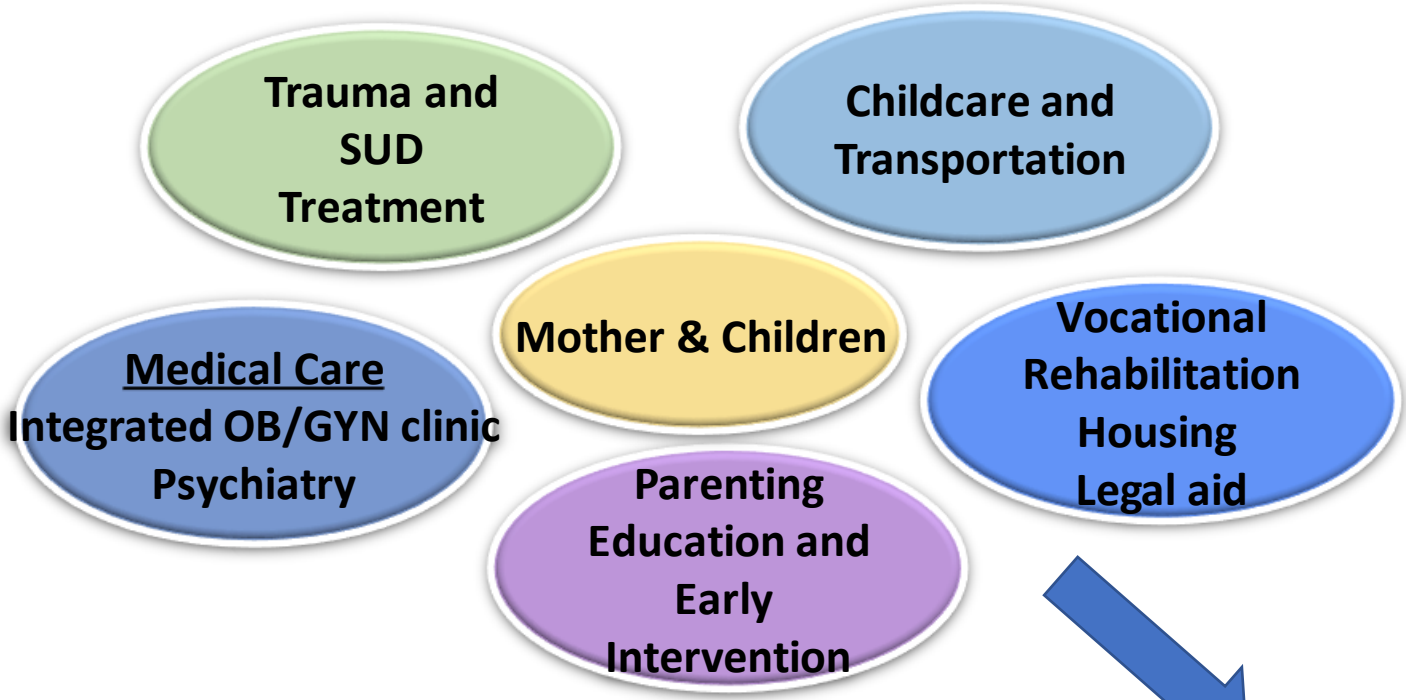
Frequency and duration depends on severity of issues and goals being met

- Residential completion based on goals being met
- *Continuing care includes parenting, case management, individual and couples counseling*
- *Children may continue in child care*

UNC Horizons: Example of Outpatient Family-Centered Care

Patient Example: Mother is 25 years old

- Prescription opioid use disorder and smokes cannabis
- Pregnant, first child
- Unemployed
- Living with mother and step-father



- Screened over the phone
- Assessed and intake completed the next day
- Outpatient induction onto medication assisted treatment

- Based on assessment
  - Parenting - Circle of Security (in weekly group)
  - General parenting/prenatal groups
  - Tour L&D and Newborn areas
  - Plan of Safe Care developed
  - Individual Counseling- Motivational Interviewing and Cognitive Behavioral Therapy
  - Postnatal Horizons protocol

- Outpatient completion based on goals being met
- *Continuing care includes peer support specialist and parenting support as needed*

UNC Horizons Program: Early Intervention and Therapeutic Services for Children

Parenting Education and Early Intervention

- All children receive age-appropriate mental health and social/emotional assessments; and individual, group, and/or family therapy as needed
- All children screened for speech and language, occupational therapy, physical therapy, dental, hearing and vision and referred for developmental evaluations
- About 90% of the residential children ages 0-5 qualify for and receive early intervention services

UNC Horizons Postnatal Protocol

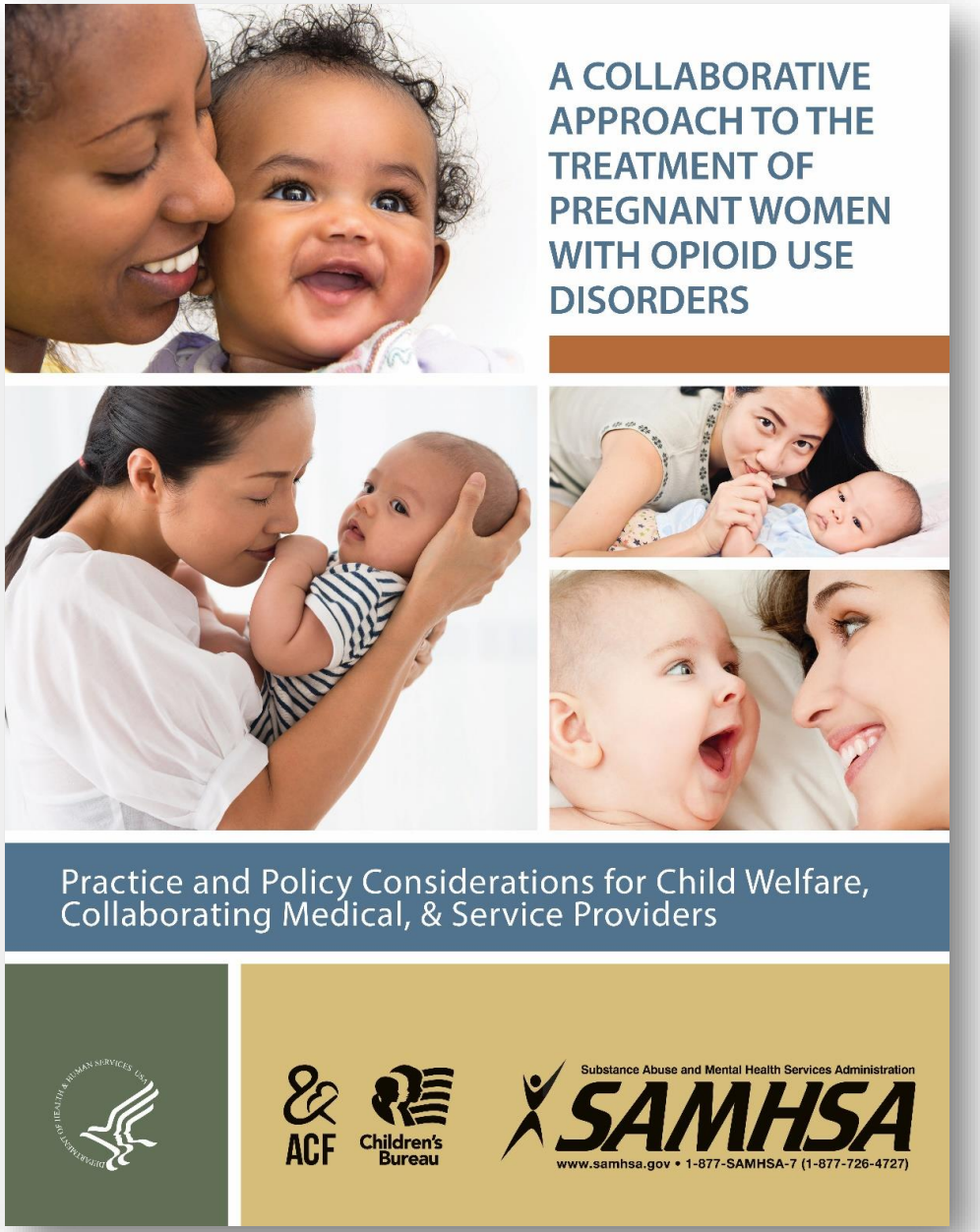
- Visit from child therapist within first week of delivery, even if in NICU
- Focus on infant strengths, learning infant cues (Hug Your Baby)
- Continue on going parent education (twice per week)
- Continue on going parent education (twice per week)
- At 6 weeks: Referrals for developmental assessments (Early Intervention) including Speech/Language, Occupational Therapy, Physical Therapy, and Social-Emotional Assessment
- Support Dyad: Weekly Child Parent Psychotherapy (CPP)

Summary

- Family is defined by those being served.
- Trauma-informed care at its essence is about respect, empathy and empowerment.
- There are many ways to meet the treatment provisions for Children Placed with a Parent Residing in a Licensed Residential Family-Based Treatment Facility for Substance Abuse in the Family First Prevention Services Act, within the requirements outlined in the legislation

Questions?

Resources



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

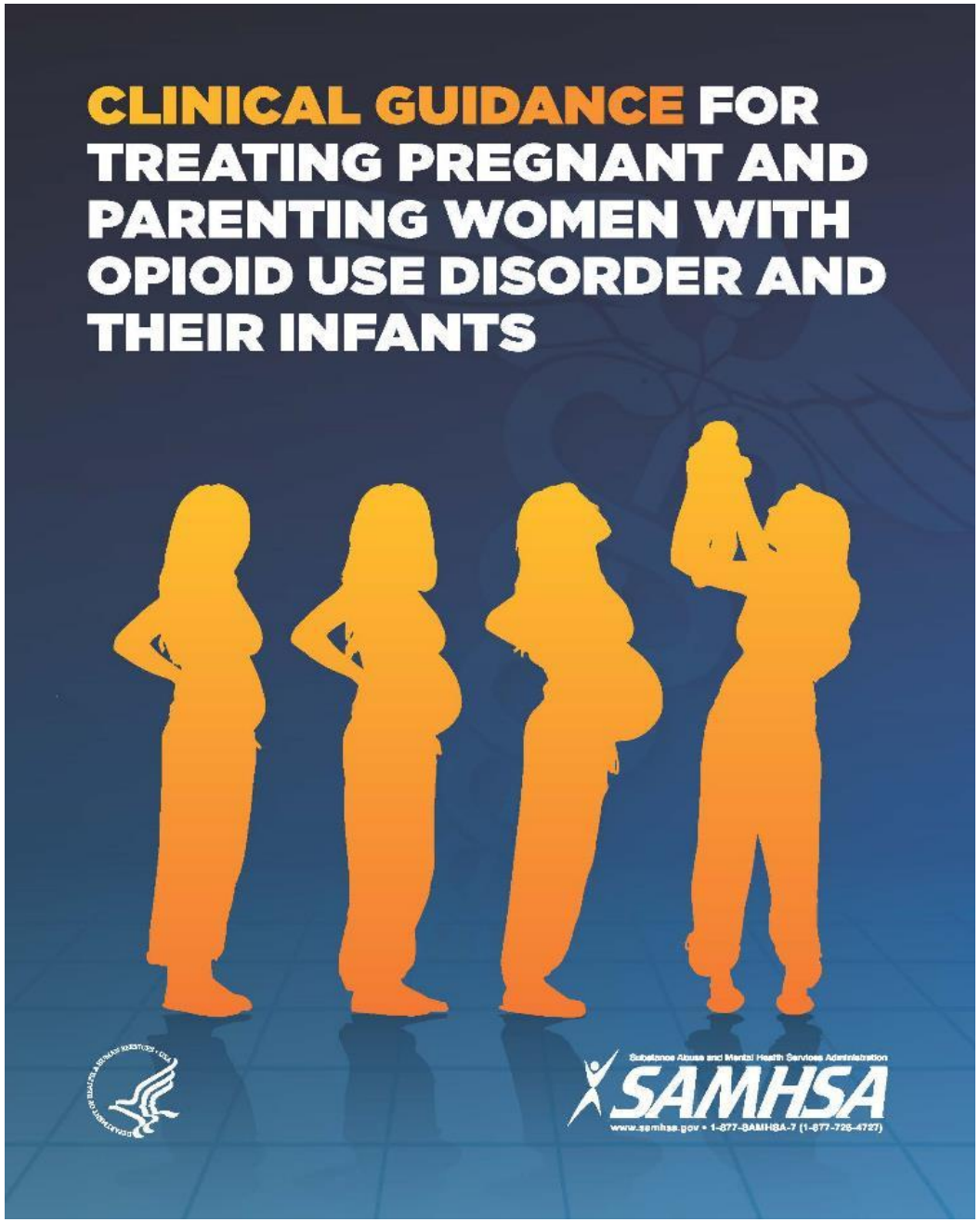
Audience

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

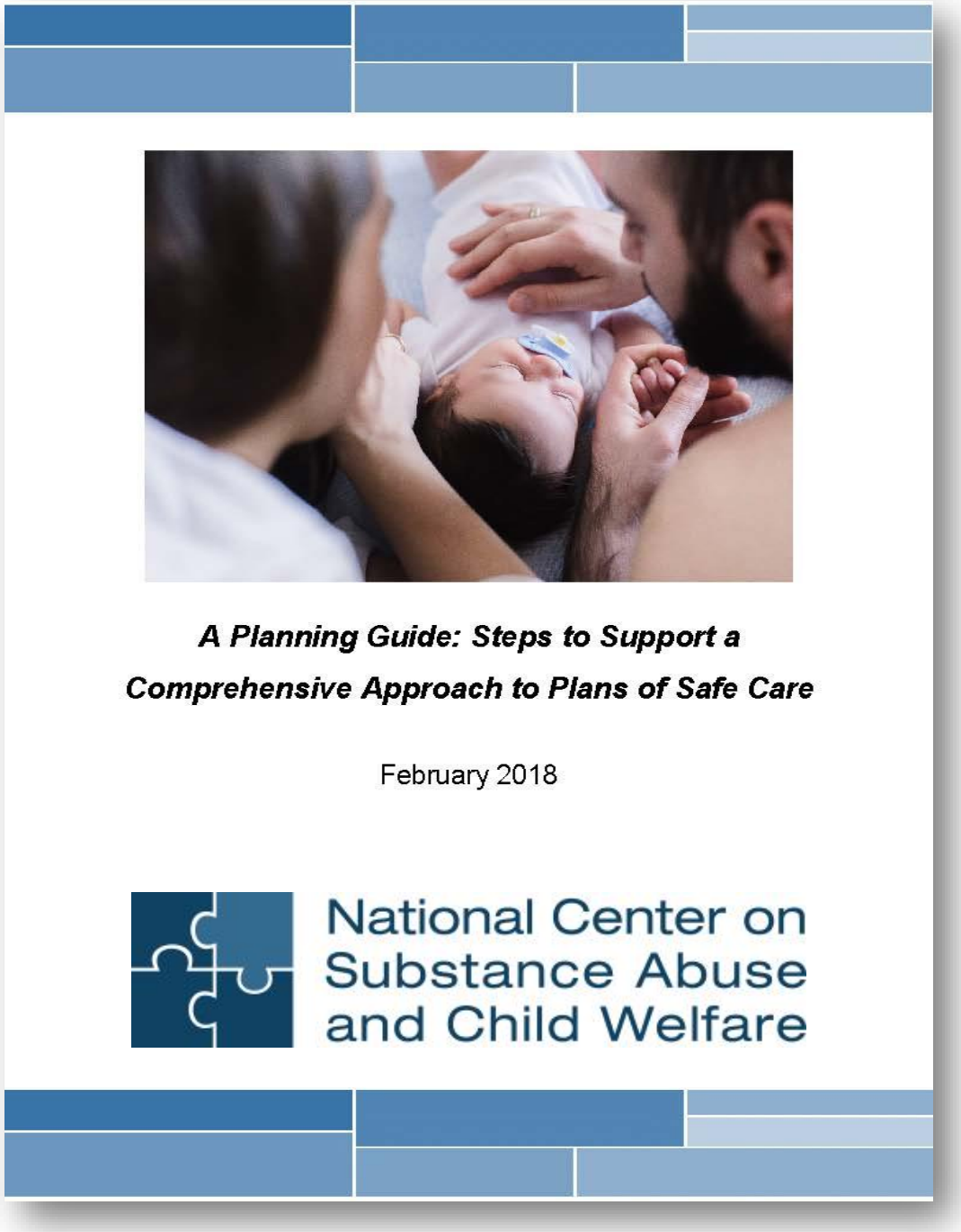
National Workgroup

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

Available for download here: https://www.ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf



Available for download here: https://store.samhsa.gov/shin/content//SMA18-5054/SMA18-5054.pdf



Plan of Safe Care Planning Guide TA Tool (2018)

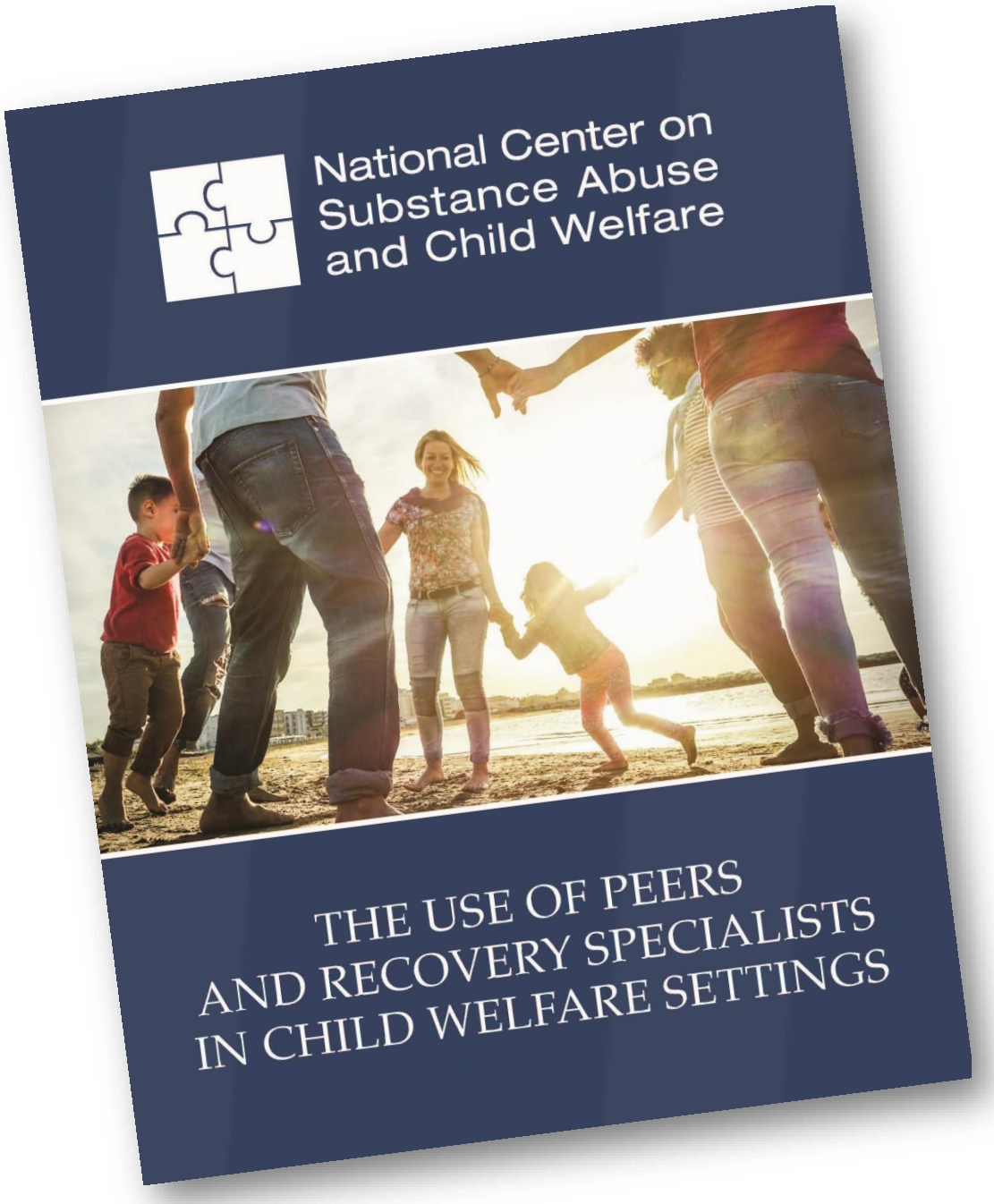
Designed as a planning guide that NCSACW can use with you to further your communities' efforts in developing a comprehensive approach to implementing Plans of Safe Care

ncsacw@cffutures.org

National Center on Substance Abuse and Child Welfare

This technical assistance tool provides on-the-ground examples from 12 states and 5 Tribes (Minnesota) across the country that have implemented comprehensive approaches to Plans of Safe Care (POSC) for infants with prenatal substance exposure (IPSE) and their families and caregivers.

These concrete examples can help states and agencies consider practice and policy system changes to best serve these families in their own communities.



National Center on Substance Abuse and Child Welfare

Just Published!

Download your copy @

www.ncsacw.samhsa.gov

NCSACW Online Tutorials Cross-Systems Learning

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National Center on Substance Abuse and Child Welfare

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- Webinars
- Online Tutorials
- Toolkits
- Video

Please visit:
http://www.ncsacw.samhsa.gov/

Raising the Bar!

Family Treatment Court Best Practice Standards

8 Standards & Provisions

Just Released!

https://www.cffutures.org/fdc-tta/ftc-best-practice-standards-2019/

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