



Volume XIII, Summer 2017

A Matter of Substance

Challenges and Responses to Parental Substance Use in Child Welfare

According to national data, parental substance use disorder (SUD) is one of the leading underlying factors contributing to the finding of neglect as the basis for child removal.¹ While the number of children in foster care nationally has dropped significantly over the last decade, recent data is showing an upward trend associated with the opioid epidemic, which includes both prescription drugs as well as illegal drugs, such as heroin. Child welfare removals have increased in some California counties, though case file reviews suggest that opioids may not be the primary contributing factor.

In this issue of *insights*, we present California's methods for capturing and reporting SUD-related child welfare entries, as well as other sources that measure the impact of parental substance use in California and nationally. After discussing the potential number of families affected by substance use disorder, **we look at how much the state's efforts to integrate child welfare services with behavioral health, the courts, and Alcohol and Other Drugs (AOD) programs have supported family reunification even in the face of an upward trend of SUD in some California counties.** And finally, we discuss ways to keep moving forward with focused state efforts during a time of possible rollbacks on health care coverage and other social services.

¹ "Substance abuse and child maltreatment," Wells, 2009. <https://www.ncbi.nlm.nih.gov/pubmed/19358920>



California Child Welfare
Co-Investment Partnership

IN THIS ISSUE:

- Data on children affected by parental substance use disorders
- Promising strategies for prevention and treatment
- Moving forward



When the crack epidemic hit our state, agencies and the courts were not as focused on keeping families together, which had ripple effects for a generation. The good news is we are more integrated and prepared now for what may be coming."

State Sen. Holly J. Mitchell, Chair of the Senate Budget Committee



For years California did not have a very robust system to respond to substance use disorders. The Affordable Care Act allowed us to expand. Right now we are implementing a whole new service delivery program, a new dynamic of care, which will have an impact on the child welfare system."

Karen Baylor, Deputy Director of Mental Health and Substance Use Disorder Services, California Department of Health Care Services

Substance Use Disorder (SUD) Definition

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and/or failure to meet major responsibilities at work, school, or home. A diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

“When reviewing these data, consider that only a handful of states have a standardized screening tool used to detect parental substance use disorders during investigations of child abuse and neglect. Additionally, very few states have statewide policies and protocols on how the results of investigations regarding parents’ substance use are to be recorded in states’ information systems.”³

Nancy Young, Director, Children and Family Futures

National Data

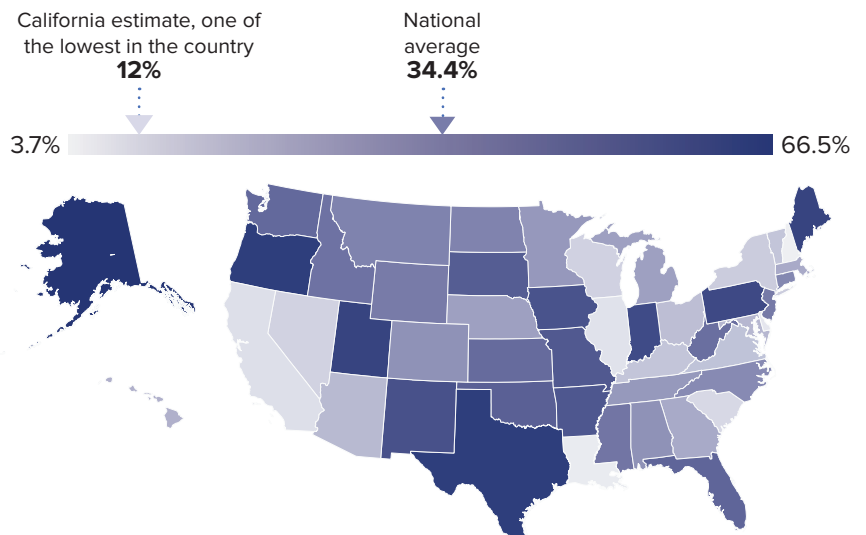
The primary source for national data on the correlation of substance use and child welfare is from the [Adoption and Foster Care Analysis and Reporting System \(AFCARS\)](#), which collects case-level information on all children in foster care and those who have been adopted with Title IV-E waiver involvement. However, there are still flaws in the use and consistency in measurement and reporting of substance abuse in AFCARS across states.

In 2015, the percent of children entering care with substance use as the documented circumstance of removal was 34.4 percent. Parental substance use is often reported as a removal reason in conjunction with neglect, which is the most common category of maltreatment for young children nationally and in California (more than 85 percent in 2015).²

The map below indicates significant state level variation, with California showing only 12 percent of children entering care in 2015 with substance use as a reason. It should be noted that state data is not necessarily comparable for a number of reasons. For example, states have different category options available in their data systems to capture this information, and local investigation and data entry practices vary. In addition, California law is clear that parental substance abuse, in the absence of neglect or other abuse, is not a basis to detain a child in the child welfare system.

Another national source of data is the Substance Abuse and Mental Health Services Administration’s (SAMHSA) [National Center on Substance Abuse and Child Welfare](#) where the most recent reports show that each year, an estimated 400,000-440,000 infants (1 in 10 births in the U.S.) are affected by prenatal alcohol or illicit drug exposure.

Percentage of Children Entering Care Due to Parental Substance Use, 2015



Source: AFCARS Report for fiscal year 2015.⁴ Estimates based on all children in out-of-home care at some point during the fiscal year.

² "First Entries into Foster Care, by Reason for Removal" kidsdata.org, 2016. <http://www.kidsdata.org/topic/16/fostercare-entries-reason/table>
³ "Examining the Opioid Epidemic: Challenges and Opportunities," Feb. 2016. <https://www.finance.senate.gov/imo/media/doc/23feb2016Young.pdf>
⁴ "AFCARS Foster Care File 2015: Dataset 200" NDACAN, 2016. <http://www.ndacan.cornell.edu/datasets/dataset-details.cfm?ID=200>

California Data

The Child Welfare Services/Case Management System (CWS/CMS) is a statewide case management tool that supports the child welfare system of services in California. When a parent or caregiver is reported for possible child abuse or neglect, the referral is entered into CWS/CMS and goes to an intake social worker. About a quarter of these children have no further inquiry in a given year. For those that do result in a case filed, an emergency response worker will indicate suspected abuse or neglect (300 codes) and initiate an investigation within 24 hours for urgent responses and with an allowance of up to 10 days for less severe allegations. There are some legally mandated fields that must be entered as the investigation progresses, e.g., severe neglect, sexual abuse, and physical abuse. However, substance use is not a mandated field, as it is not a legal reason for removing a child from a home.

Caseworkers can indicate substance use as an underlying factor in CWS/CMS, but this is an optional data field. This may partially explain why a sample of CDSS case file review data shows that only between 15-20 percent of removals include reference to substance use, a percentage much lower than other states (50-70 percent).

In addition to CMS/CWS, [Structured Decision Making \(SDM\)](#) is a tool for assessing safety and risk during CPS investigations, and includes a screening for parental substance use. SDM is currently used in all 58 California county child welfare agencies. SDM and case plan reviews are two ways to ascertain how often substance use disorders are an underlying factor for removal in California counties. Corroborating case reviews and estimates from child welfare workers on SUD involvement in neglect cases, a 2015 [report](#) based on SDM completions by social workers, found that 58 percent of the families screened in California had substance use intervention identified as a family need.

Beyond Child Welfare: California Data Collection on SUD

Although the CWS/CMS system does not currently provide data that can confirm or refute a clear link between SUD and child welfare entries, other datasets can be used to further analyze the possible linkage.

Office of Statewide Health Planning (OSHPD): OSHPD collects data from individual, licensed health care facilities to produce reports on newborns affected by drugs transmitted via placenta or breast milk. Reports show a 95 percent increase between 2008 (1,862) and 2015 (3,633).⁵

“For more accurate data, you would want to get substance use identifiers into CWS/CMS. As a former social worker, I am sure that the levels of substance use in child welfare cases are 70 percent or higher, similar to what we see in the service plans.”

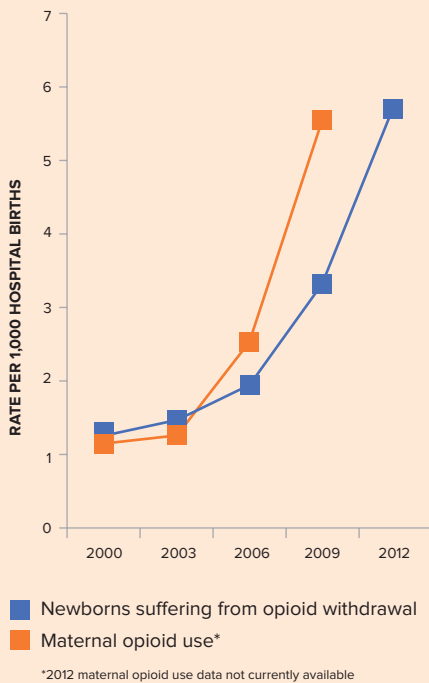
Nancy Taylor, Principal Manager, Center for Families, Children & the Courts

“The good news is that these concerns about data collection are being addressed with our new case management system, [CWS/CMS-NS](#), which will both bring us into compliance with federal law as well as give counties and the state the data we need to accurately respond and plan to meet the needs of our families and children affected by substance use disorders.”

Greg Rose, Deputy Director, California Department of Social Services

5 "Newborns Affected by Drugs Transmitted Via Placenta of Breast Milk," OSHPD 2006 - 2015. <https://www.documentcloud.org/documents/3552873-3633.html>

Neonatal Abstinence Syndrome and Maternal Opioid Use in the U.S.



There was a five-fold increase in the proportion of babies born with NAS from 2000 to 2012, when an estimated 21,732 infants were born with NAS. Source: The Kids Inpatient Database 2000-2012.

California Department of Public Health (CDPH)'s Prescription Drug Overdose Prevention Initiative:

While not specific to child welfare, this initiative offers another source of substance use data with its [California Opioid Overdose Surveillance Dashboard](#), which provides county-level non-fatal and fatal opioid-involved overdose and opioid prescription data. The dashboard is the result of ongoing collaboration between CDPH, OSHPD, Department of Justice (DOJ), and the California Health Care Foundation (CHCF). Although a preliminary inquiry into dashboard data and CMS/CWS suggested a likely relationship, examining the contribution of opioid use requires a more complex examination that accounts for other factors and social determinants known to be associated with CPS outcomes.

Also resulting from the collaboration, CDPH's statewide workgroup on opioid safety recently added a task force to address maternal and neonatal opioid exposure. The multidisciplinary group will look to address the need for medication-assisted treatment for women of childbearing age, early screening, and responding to the CARA act requiring DSS to address infant exposure to opioids.

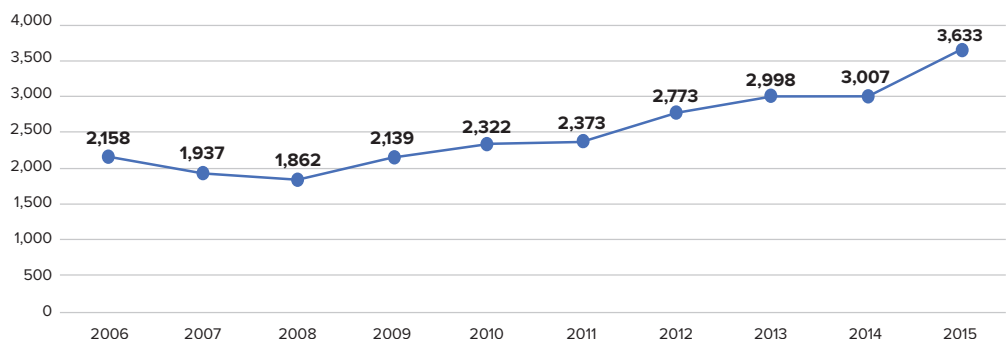
Indicators of Prenatal Substance Use Disorders

Infants exposed to alcohol and drugs during pregnancy run the risk of suffering from birth defects, low birth weight, premature birth, small head circumference, sudden infant death syndrome (SIDS), and subsequent developmental and behavioral delays and/or challenges.

Fetal Alcohol Spectrum Disorders (FASD) include a range of changes to the brain resulting from alcohol exposure in utero that impacts the child's ability to function.

Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn who was exposed to addictive drugs, specifically opiates in utero. Drugs such as heroin, codeine, oxycodone, methadone, and buprenorphine pass through the placenta and cause the baby to become dependent on the drug along with the mother. After birth, the baby experiences withdrawal symptoms that may include excessive crying, fever, poor feeding, rapid breathing, trembling, and vomiting. NAS has been on the rise nationwide.

California Newborns Affected by Substance Use* Transmitted Via Placenta or Breast Milk



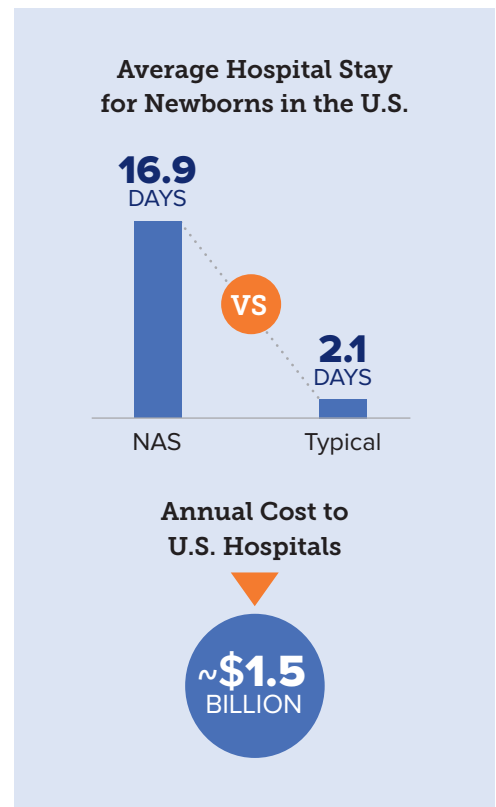
*Includes cocaine, hallucinogenic agents, other narcotics, other drugs of addiction, or noxious substances, or those that displayed withdrawal symptoms of the same. Source: Inpatient Discharge Data, 2006-2015; Office of Statewide Health Planning and Development

California has seen a 68% increase in newborns affected by NAS since 2006.

Nationally, in 2012, newborns with NAS stayed in the hospital an average of 16.9 days (compared with 2.1 days for other newborns), costing U.S. hospitals an estimated \$1.5 billion; the majority of these charges (81 percent) were paid by state Medicaid programs.⁶ These rates may be related to not only prevalence of SUD among lower income parents, but also variations in screening practices in public hospitals in comparison to private institutions which may screen less frequently. The rising frequency (and costs) of drug withdrawal in newborns points to the need for more measures to prevent exposure to opiates, specifically early detection and treatment for pregnant mothers and, more generally, women of childbearing age. Additionally, researchers have called for more study into the effects of punitive and intervention approaches to deter maternal substance use and potential increases this may cause to the likelihood that a mother will avoid detection by avoiding medical care.⁷

In California, data from the California State Inpatient Databases, show the rate of infants born with NAS per 1,000 delivery hospitalizations more than tripled between 2008 and 2013, from a rate of 2.9 to 6.4.⁸ Similarly, a [recent study](#) underwritten by the California Health Care Foundation found a significant increase in California babies born with NAS from 2008 to 2012, with much higher instances of NAS being reported in African American births and Medi-Cal births.

While federal law under the Child Abuse Prevention and Treatment Act ([CAPTA](#)) requires that states have policies in place for reporting NAS and other prenatal substance exposure, the law is clear that this does not necessarily constitute child abuse or neglect.⁹ California State Statute indicates that a report of a substance-exposed infant only occurs when “other factors are present that indicate risk to a child.” This policy leaves it up to the discretion of the medical practitioner as to what constitutes sufficient reason to report the prenatal substance exposure to CPS, and it remains unclear the extent to which race or ethnicity biases may affect medical decisions to report (see “Equity Lens,” next page). Experts stress the importance of providing support and treatment options, and not further stigmatizing or penalizing women struggling with substance use.



“Incorporating CARA requirements into CAPTA is a work in progress with states so that plans for safe care are consistent and supportive of child well-being. We’d like to see the system evolve to where safe care is woven into maternal and child health, and social and family support statutes, instead of a child abuse and neglect statute.”

Bruce Lesley, President, First Focus

6 "Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009 to 2012," Patrick et. al., Aug. 2015, <http://www.nature.com/journal/v35/n8/full/jp201536a.html>
 7 "Pregnant women and substance use: fear, stigma, and barriers to care," Stone, Feb. 2015, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5151516/>
 8 Federally Available Data (FAD) Resource Document of State Inpatient Databases, Health Resources and Services Administration, Aug. 2016, <https://www.hrsa.gov/about/organization/bureaus/mchb/fad-resource-document.pdf>
 9 Article 2.5. Child Abuse and Neglect Reporting Act [11164 - 11174.3] https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=PEN&division=&title=1&part=4.&chapter=2.&article=2.5.

“ We get very few referrals from affluent hospitals.

All of our tox-positive tests come from the county hospital.”

Judy Webber, Deputy Director, Ventura County DCFS

“ To address the bias, we need universal testing and I believe this is the right climate to advocate for this, especially as the opioid epidemic is hitting states which may have considered this not their problem.”

Debi Moss, Director, Marin County Child Welfare

Equity Lens: Does the Data Show Disproportionality?

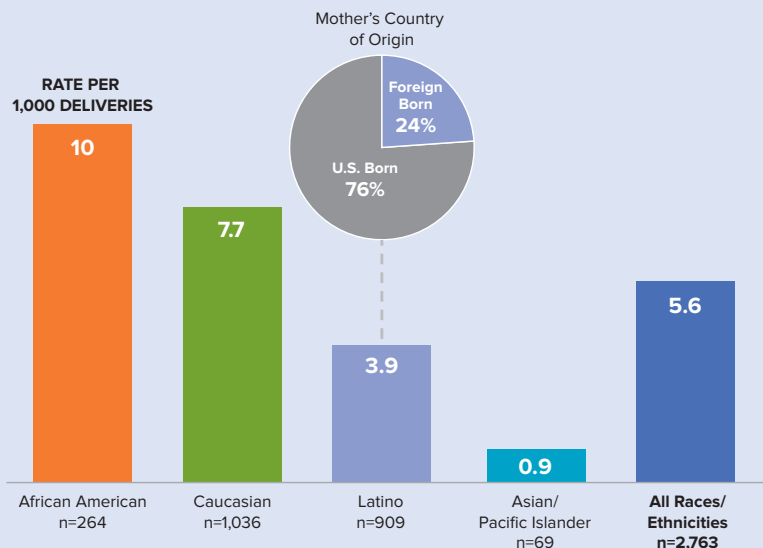
There is some evidence that the Medi-Cal population (lower income Californians) is more likely to get screened and referred to CPS.

- A 2011 study on California births found that due to a variety of socioeconomic factors, substance use was detected at rates up to nearly four times higher among mothers on Medi-Cal.¹⁰
- National research from *JAMA Pediatrics* found large differences in rates of NAS diagnosis between rural and urban births, rates for rural children being nearly 70 percent higher. Furthermore, rural patients in lower income quartiles had much higher rates of NAS than the higher incomes, while in urban areas income quartiles showed less disproportionality.

A recent study published in *Pediatrics*, found that among all infants neonatally reported to Child Protective Services (CPS) in California, 40.6 percent had been diagnosed with substance exposure at birth. After adjusting for sociodemographic differences, black and Hispanic newborns with identified prenatal substance exposure were no more likely than white infants to be reported for maltreatment.

Infants Born with Neonatal Abstinence Syndrome

By Race/Ethnicity, California, 2014



Source: California Health Care Almanac, "Maternity Care in California: Delivering the Data", Jun. 2016.¹¹ Not included: Other (rate 18.1 n=485).

¹⁰ "Racial and Ethnic Disparities: A Population-Based Examination of Risk Factors for Involvement with Child Protective Services," Putnam-Hornstein, et. al., Jan. 2011. <https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=263879>

¹¹ "Maternity Care in California: Delivering the Data," California Health Care Foundation, Jun. 2016. <http://www.chcf.org//media/MEDIA%20LIBRARY%20FILES/PDF/PDF%20M/PDF%20MaterntyCareCalifornia2016.pdf>

Addressing Bias in Screening and Reporting

Hospital screening practices may be introducing bias for those in lower socio-economic income brackets, which is often correlated with race and ethnicity. That noted, there are differing points of view on policy options, such as universal screening.

Universal screening would address some of the bias that is seen in the disproportionate number of referrals from public hospitals. Some physicians in San Diego County have taken this step prompted by a dramatic national increase in the number of newborns affected by drugs transmitted by the placenta or breast milk between 2014 and 2015 (page 4). These physicians have now begun automatically conducting urine toxicology screens on all mothers.

Focus on Family Preservation

Children who have experienced neglect or abuse in families affected by substance use disorders have been found to remain in substitute care placements for significantly longer periods of time, and experience significantly lower rates of family reunification relative to almost every other subgroup of families in the child welfare system.¹² That noted, removing a child from his or her home can be one of the most traumatic events a child can experience and placement in out-of-home care has been linked to poor behavioral, physical, and mental health outcomes.

There are promising strategies that can ensure safety as well as reunify families. And many experts and studies suggest that children will potentially fare better by remaining in their parents' care as part of a family-focused drug treatment program rather than by being removed from the family. Avoiding removal can reduce trauma, produce cost savings, and result in better short- and long-term outcomes for children and families.¹³

“There are some strong arguments to be made on both sides. But I do worry about false positives, the expense, and that without the proper treatment options, universal testing might do nothing more than create a punitive health surveillance system in which some women avoid needed health care and services because of fear of criminalization or losing their child.”

Emily Putnam-Hornstein, Associate Professor and Director, Children's Data Network, USC

¹² "Families in Child Welfare Affected by Substance Use: issue 1," Vol. 94, No. 4, 2015. http://www.acbhcs.org/providers/SUD/docs/perinatal/CWJ_2015Vol94_4.pdf

¹³ "Epidemiological perspectives on maltreatment prevention," Wulczyn, 2009. <https://www.ncbi.nlm.nih.gov/pubmed/19719022>

Medication Assisted Treatment (MAT)

MAT—prescription of a recovery drug such as buprenorphine, methadone, or suboxone, administered along with counseling and other addiction treatment supports—is expanding across the state, with the number of providers waived to prescribe these drugs (prescription requires a training and a license/waiver from the DEA) steadily increasing.¹⁵ Studies have shown that buprenorphine treatment yields a 50-60 percent recovery rate compared to less than 10 percent with drug-free (abstinence and counseling) treatment.¹⁶ New efforts by California DHCS to increase availability of buprenorphine statewide and increase MAT utilization for tribal communities begin this year with the help of new federal funding under the State Targeted Response to the Opioid Crisis Grant program.

“I have a client now on buprenorphine with a very violent past, she got herself on it and has been a completely different person. She’s calm and has been able to manage her recovery.”

Lynette Lefort, Recovery Specialist, Alameda County

Treatment on Demand

The sooner a parent or caregiver enters substance use treatment the more likely it is that their children who have been removed can be reunified with the caregiver.¹⁴ Expansion of evidence-based treatments, such as medication-assisted treatment, may also be offered under the [Drug Medi-Cal Organized Delivery System](#), which is being piloted and implemented by the California Department of Health Care Services (see page 13).

Create and Implement a Recovery Plan

Implementation of the American Society of Addiction Medicine (ASAM) placement criteria in many treatment programs in California has helped create manageable case plans for parents in recovery, and has helped to increase the likelihood that a parent and his or her removed child will be reunified. Recovery plans can include a variety of supports including 12-step programs, residential treatment, establishing connection to faith-based organizations, or use of a recovery coach to assist in accessing these services.

“ [ASAM] is very focused on a person-centered approach. It doesn’t deal with simply the person’s drug of choice, but it brings in personal, lifestyle factors. If someone is homeless for instance, they will look at that criteria, and try to get that person social supports. Very comprehensive. It’s a good wrap-around approach.”

Tom Renfree, Deputy Director, Substance Use Disorder Services, County Behavioral Health Directors Association of California

Recovery Coaches

In tandem with the parent struggling with substance use, a coach works with the caseworker, treatment provider and other parties to facilitate a successful recovery. In trials, recovery coaches were seen to increase reunification rates by 14 percent and increase foster care case closure rates (reunification and other) by 15 percent, saving the child welfare agencies an average of \$2,500 per child in families they assist.¹⁷

Community-based Treatment

Community-based treatment includes outpatient programs, which may or may not have clinical services, or sober-living and detox facilities. These treatment programs can draw on a variety of funding sources and can be more flexible in their approach, and they are often in communities that may not have the funds or ability to sustain a residential treatment facility.

¹⁴ “Does substance abuse treatment make a difference for child welfare case outcomes?” Green et. al., 2007. <http://www.sciencedirect.com/science/article/pii/S0190740906001782>

¹⁵ “DATA-Certified Physicians,” Accessed May, 2017. https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians?field_bup_us_state_code_value=CA

¹⁶ “SAMHSA Opioid STR.” Accessed May, 2017. <http://www.dhcs.ca.gov/Individuals/Pages/State-Targeted-Response-to-Opioid-Crisis-Grant.aspx>

¹⁷ “Recovery Coaches for Substance-Abusing Parents,” Coalition for Evidence-Based Policy, Jan. 2012. <http://evidencebasedprograms.org/wp-content/uploads/2012/12/Recovery-Coaches.pdf>

Prevention

“ We can have better health outcomes for parents and children when substance using parents are referred to counseling and preventative treatment, rather than punitive approaches that promote the removal of a child and prosecution.”

Amy Price, Program Executive, Zellerbach Family Foundation

Wraparound and Safety Organized Practice

Team-driven service and support models such as [Wraparound](#), [Safety Organized Practice](#), and Team Decision Making have been adopted in counties across California.¹⁸ These promising practices, used in the Title [IV-E Waiver project](#), use youth and family engagement to support recovery and reunification and include system partners (such as substance use treatment providers) in the planning, delivery, and management of necessary services.

Treatment and Recovery

Family Treatment Drug Courts (FTDCs) are specialized courts with integrated substance use disorder treatment and child welfare services. Their goal is to facilitate early child reunification and many believe that they represent a less adversarial intervention which supports participants' likelihood to seek treatment. This is a voluntary program, led by the presiding judge in each county. That noted, family drug treatment courts have grown exponentially in California in the past two decades from only 2 programs in 1995 to 33 in 2017.¹⁹

“ The best interventions I've seen are the family drug courts. These courts bring the providers into the courtroom, with the goal of helping the parent become a safe parent by stopping the drug abuse.”

Honorable Leonard Edwards, Mentor Judge, Judicial Council of California

Priority Access to Services and Supports

The Priority Access to Services and Supports (PASS) task force has developed a protocol to guide counties to facilitate priority access, coordination and quality to appropriate behavioral health services and supports for parents in reunification, which include mental health and substance use disorder services. Ventura County has been piloting the [PASS](#) protocols since 2016.

“ Of the 118 parents screened for the PASS pilot, 60 percent had two referrals, for either specialty mental health, the Beacon program (ACA funded), or an alcohol and drug treatment program. However, not enough time has passed to see outcomes, and we have considerable difficulty with follow through, which is not surprising with addiction.”

Judy Webber, Deputy Director, Ventura County DCFS

¹⁸ All County Letter No. 16-84, CA DHCS, Oct. 2016. [http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/ACL16-84_MHSUDSIN16-049_CFTGuidelines\(4\).pdf](http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/ACL16-84_MHSUDSIN16-049_CFTGuidelines(4).pdf)

¹⁹ Fact Sheet: Collaborative Justice Courts” Judicial Council of California, Mar. 2017. http://www.courts.ca.gov/documents/CollaborativeCourts_factsheet.pdf

Highlighted Programs

“Family Treatment Drug Court funding in California is very decentralized and challenging to keep up with. In Alameda, the majority of funding is through SAMHSA grants, Sacramento on the other hand has braided funding structures together from a variety of sources to meet the needs of its families. Riverside county has traditionally used title IV-B funding, Medi-Cal and support from local organizations.”

Phil Breitenbucher, Program Director, Children and Family Futures

“Coming into regular dependency court, the parent may be intoxicated, skeptical of government and our intention, and oppositional to social services. But if this is what it will take ‘to get my baby back’ and we have the recovery specialists, they will engage.”

Honorable Charles Smiley, Superior Court Judge, Alameda County

FTDCs use different eligibility criteria in identifying and assessing clients. Some FTDCs focus on early intervention, while others focus on intensive services for adults, and team-based services. There are counties, like Sacramento and Los Angeles, that have multiple family drug courts that address the needs of various populations, or child-age groups.

Sacramento has shown particularly strong results. According to a 2011 study, 45 percent of families who participated in the program were reunited with their children, nearly twice as high as the countywide average of 27 percent for all children in out-of-home placement during that same time period.²⁰

Alameda County Family Drug Court

Over the past three years, parents participating in the Alameda family drug court have been 45.4 percent African American. Communities of color tend to experience a greater burden of mental health and substance use disorders often due to poorer access to care; inappropriate care; and higher social, environmental, and economic risk factors. A critical role of The Alameda Family Drug Court is to address these disparities by providing parents access to quality treatment.

The Alameda County Family Drug Court has a \$325K annual budget, with the primary funding source from a time limited grant. With this budget, which includes evaluation, they serve 75 family groups annually, with graduation rates at 40 percent, and of those who graduate, 95 percent reunify.

Sobriety Treatment and Recovery Teams (START)

[START](#) is a teaming approach used in several states and is included on the California Evidence Based Clearinghouse. Originating in Kentucky in 2006, this community-based treatment model encourages shared decision-making among caseworkers, parent mentors, and parents, to create a holistic assessment of the parents’ needs and get them into timely treatment. Participating parent mentors are themselves in recovery with at least three years of sobriety and experience with the child welfare system. Under the START program, studies have shown that mothers achieved sobriety at nearly twice the rate of mothers in typical services, and their children were placed in out-of-home care at half the typical rate for mothers in treatment.

²⁰ “Research Update on Family Drug Courts,” National Association of Drug Court Professionals, May 2012. <http://www.nadcp.org/sites/default/files/nadcp/Research%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf>

Parent-Child Assistance Program (PCAP)

[PCAP](#) is an evidence-based home visitation case-management model for mothers who abuse alcohol or drugs during pregnancy. The program goals are to help mothers build healthy families and prevent future births of children exposed prenatally to alcohol and drugs.

In 2012, the Lake County Tribal Health Consortium began implementation of PCAP, focused on preventing substance-exposed pregnancies and births, as well as reducing the prevalence of Fetal Alcohol Spectrum Disorder, two of the primary health concerns within the tribal population. The program is funded by a [Tribal Maternal Infant Early Childhood Home Visiting grant](#) created by the Affordable Care Act. A combination of home visitation services, medical services, and community supports were created through the program with the goal of strengthening families while incorporating cultural activities and tribal learning. Since services began, there have been decreased entries of Native American youth into care and overall increased rates of contact with health services and safety planning.

Residential Treatment

Residential treatment is available in 39 of California's 58 counties (see page 12), but services and availability of beds differ greatly by county.

- 24 counties have residential treatment available to women with accompanied children, though only 3 treatment facilities in the state list women and youth as their target populations, meaning that many times older children cannot accompany their parents to treatment.
- Only seven counties, including Los Angeles and San Francisco, have residential treatment programs where children can accompany fathers. Often these programs have a very limited number of beds, and openings can be competitive.
- Even large counties such as Alameda, Orange, and Sacramento lack a full continuum of services. Additionally, both large and small counties may lack an appropriate number of beds per the size of their population, for example San Joaquin county only has 236 residential treatment beds for a population of 685,306.
- Some counties do not have long-term residential treatment available, but do have facilities that provide short term residential detoxification for patients.²¹

“Addiction is a chronic disease that requires a whole-person approach, and a lot of the problems with relapse stem from sending people out into the world without ongoing recovery supports. This is why we need to support families through the recovery and reunification process.”

Tom Renfree, Deputy Director, Substance Use Disorder Services, CBHDA

“We are not able to meet the demand for treatment in San Francisco and a particular challenge is trying to find places that can take parents with their children.”

Sylvia Deporto, Child Welfare Director, San Francisco County

21 "Fact Sheet: Collaborative Justice Courts" Judicial Council of California, Mar. 2017. http://www.courts.ca.gov/documents/CollaborativeCourts_factsheet.pdf

Access to Treatment Varies Across Counties



Nineteen counties in California have no access to residential drug treatment. And while there are 33 FTDCs in California, they are in less than half of California counties and are often affected by budget shortfalls.

Source: California Department of Health Care Services ²² and the Judicial Branch of California, 2017. ²³

²² Department of Health Care Services Licensing and Certification Section Status Report, Dec. 2016. http://www.dhcs.ca.gov/provgovpart/Documents/Status_Report_December_2016.pdf
²³ "Fact Sheet: Collaborative Justice Courts" Judicial Council of California, Mar. 2017. http://www.courts.ca.gov/documents/CollaborativeCourts_factsheet.pdf

SHIELDS for Families

One of the leading model programs nationally, [SHIELDS for Families](#) has helped vulnerable children and families in Los Angeles County for the past 25 years. Their programs encompass the full spectrum of human needs—from housing and transportation, to substance use treatment to child protective services.

SHIELDS addresses substance use disorders from early intervention to drug courts to long-term residential treatment programs. Their programs bring a strong emphasis on family strengthening and preservation. SHIELDS' prenatal programs allow adult pregnant and parenting women with children to live together while they are completing their treatment programs.

SHIELDS funding is maintained by a combination of federal block prenatal funding, state mental health funding, and child welfare grants from both the state and federal government.²⁴ On average, the cost is approximately \$25,000 per family, with a 12-18 month duration. The first step is intensive, with gradual step down.

“Whether you are a mother or father. Addiction is a family disease; it affects the children as much as the parents. If we want to stop this intergenerational abuse we have to make sure the programs and funding follows.”

Dr. Kathryn Icenhower, CEO and Co-Founder, SHIELDS for Families

Funding for Residential Treatment

As part of the Affordable Care Act (ACA) roll-out, states could apply for a waiver to eliminate federal restrictions on funding residential treatment through Medicaid.²⁵ California was granted the waiver in 2014, as well as several other states, however, the restriction still applies for facilities with fewer than 16 beds. ACA also requires covering drug treatment services as essential coverage through any form of insurance, thereby enabling almost all insured patients with either public or private coverage, to have access to and coverage for residential treatment services. Statewide efforts are underway in California to reorganize systems of care to deliver a larger array of services across California through the new Drug Medi-Cal Organized Delivery System. However, some providers are concerned that counties that opt in to the waiver will now be obligated to use a “medical necessity” criteria which could limit the length of treatment to six months, when studies indicate that longer term support is a key factor in recovery.

²⁴ “Funding Family-Centered Treatment for Women With Substance Use Disorders,” Children and Family Futures, Inc., May, 2008. https://www.samhsa.gov/sites/default/files/final_funding_paper_508v.pdf

²⁵ “States Seek Medicaid Dollars for Addiction Treatment Beds,” The Pew Charitable Trusts, Apr. 2017. <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/04/05/states-seek-medicaid-dollars-for-addiction-treatment-beds>

“Medi-Cal is the primary source of funding for treatment, and with the ongoing threat to repeal and replace the ACA, SUD treatment is in serious jeopardy. This would have far-reaching and serious implications for our child welfare system and its ability to support reunification.”

Frank Mecca, Executive Director, CWDA of California

“There aren't a lot of resources for after-care, to support a person dealing with the challenges of everyday life that happen one day at a time, for the rest of your life. This is particularly true about housing here in Alameda County. Because of the cost of living, some families have to move out of county, without their community of support, or find shared housing where they sometimes may be drawn back into their addiction by their roommates.”

Brittany Walker Pettigrew, Program Manager, Alameda County Social Services

Access to Services

Many counties report challenges to accessing services, including treatment on demand and residential treatment, particularly facilities that include fathers and/or non-infant children.

Funding Uncertainty

Chief among the challenges of expanding promising strategies is funding for treatment services. Many federal supports to SUD treatment on demand, Family Treatment Drug Courts, and residentially based services have seen reduced funding in recent years, with some grants sun-setting.

Support for Parents to Complete Treatment

Parents involved with the child welfare system who use substances typically demonstrate low rates (10-22 percent) of substance use treatment completion. Lack of child care and the need to balance competing demands of parenting and working toward recovery are major barriers to seeking and completing treatment.²⁶ There is also a ripple effect for these parents as they may lose their Medi-Cal coverage when they lose their child, and fall deeper into their disorder.

“With all the challenges (child care, jobs, etc.) facing parents working through addiction, I actually don't know how any of them are able to complete treatment programs.”

Shelby Boston, Child Welfare Director, Butte County

Aftercare for Parents Who Recover and Reunify

Recovery from addiction can be a lifelong challenge. Notably in California, lack of affordable housing may necessitate relocation within the state, disconnecting the parent with his or her local support network. National studies frequently cite inadequate housing, food instability, utility disconnection, unemployment, and general financial stress as common difficulties making recovery more difficult for parents even after completing treatment.²⁷

²⁶ “Completing Substance Abuse Treatment in Child Welfare: The Role of Co-Occurring Problems and Primary Drug of Choice,” Choi et. al., 2006. <http://journals.sagepub.com/doi/abs/10.1177/1077559506292607>

²⁷ “Families in Child Welfare Affected by Substance Use: issue 1,” Vol. 94, No. 4, 2015. http://www.acbhcs.org/providers/SUD/docs/perinatal/CWJ_2015Vol94_4.pdf

Collaboration Challenges

Coordinated, effective family interventions are often hampered as parents are served in one system while their children are served through another, and insufficient mechanisms exist to ensure communication, collaboration, and compliance across the systems.

Child Welfare Mandates and Recovery “Clocks” are Misaligned

Research on policy and practice across systems reveals wide misunderstandings about addiction. Studies show that courts often require parents struggling with addiction to complete more tasks than parents without substance use disorder and in a timeframe, that does not reflect an understanding that relapse is a normal part of the recovery process.

“The law allows for up to 18 months of family reunification services, and then the process of terminating parental rights begins.”

Greg Rose, Deputy Director, California Department of Social Services

Addressing Stigma

Research from a federally-funded demonstration project included clinicians reporting that “most state courts and case managers hold negative opinions of parents with substance abuse.” Project clinicians described these perceptions of parents with substance use disorders as “judgmental, shaming, lacking empathy, and casting parents as criminals.” One clinician said that parental substance use was viewed as a sign that the parent did not love their child(ren), particularly if the parent relapsed later in the life of the case.

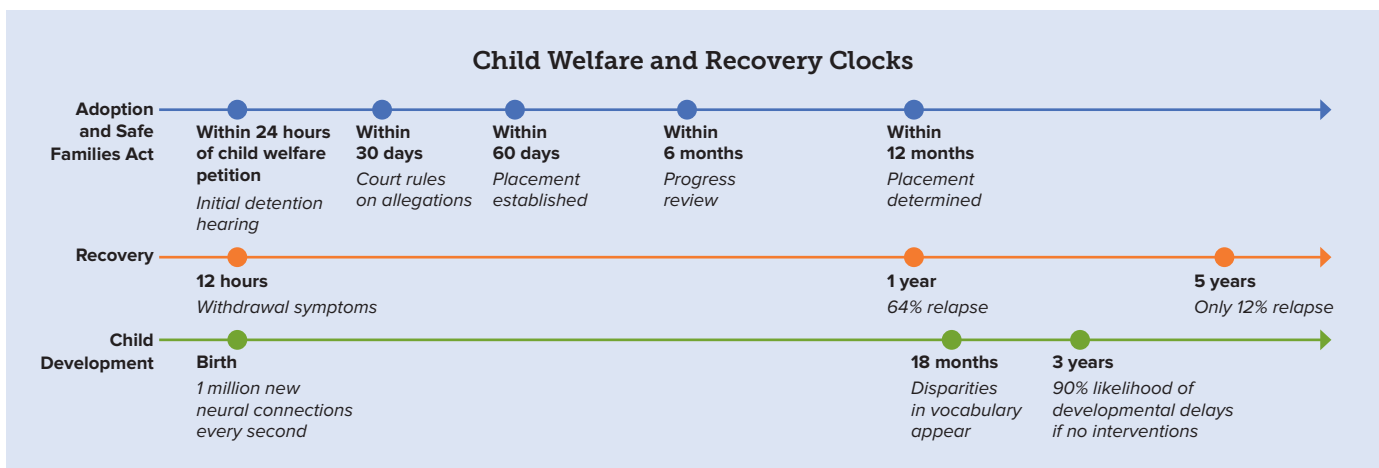
Stigma can also inhibit parents with addiction from seeking treatment and support, particularly when they have had previous child welfare involvement.²⁸

“I gave up everything to go into residential rehab and drug dependency court to get my son back. And yet, four weeks after I got him back, I relapsed. The pressure of raising a 2-year-old and working on my own stuff was just too much. Luckily, I was still in the residential rehab program and they got me back on track right away. Today, four years out of rehab, I still struggle every day, and admittedly, sometimes I fail.”

Anthony, in recovery from SUD, father of an 8-year-old son

“We need to shift from seeing parents as the ‘bad people’ doing drugs to ‘bad drugs’ taking over people. Our approach should be about strengthening families and not trying save children from their parents.”

Haydée Cuza, Executive Director, California Youth Connection



28 “Predictors of foster care exits to permanency: A competing risks analysis of reunification, guardianship, and adoption,” Akin, 2011. <http://www.sciencedirect.com/science/article/pii/S0190740911000193>



California Child Welfare Co-Investment Partnership

The California Child Welfare Co-Investment Partnership is a collaboration of private and public organizations working to improve outcomes in the child welfare system. The Partnership comprises four philanthropic organizations (Casey Family Programs, Conrad N. Hilton Foundation, Walter S. Johnson Foundation, and Zellerbach Family Foundation) and the California Department of Social Services, the Judicial Council of California's Center for Families, Children & the Courts, and County Welfare Directors Association. *insights* is an ongoing publication of the Partnership that examines the links between data, policy, and outcomes for our state's most vulnerable children and families. Download previous editions of *insights* and find out more about the Partnership at co-invest.org.

For this issue of *insights*, in addition to those quoted, we would like to thank the following individuals for sharing data and their perspectives:

Ken Berrick, Seneca Center; Shelby Boston, Butte County Department of Employment and Social Services; Molly Brassil, Harbarger Consulting; Wendy Christian, Office of Systems Integration; Kathryn Dresslar, Walter S. Johnson Foundation; Katherine Elliott, CDSS; Lauren Hill, Alameda County Superior Court; Don Kingdon, Harbarger Consulting; Lynette Lefort, Alameda County Superior Court; Erin Maher, Casey Family Programs; Kathy Maes, Lake County Department of Social Services; Gavin O'Neil, Alameda County Superior Court; Marlies Perez, California Department of Health Care Services; John Pugliese, California Department of Public Health; Daniel Webster, California Child Welfare Indicators Project; Matt Willis, Marin Health and Human Services; Eileen Yamada, California Department of Public Health