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Family-Centered Behavioral Health Support
for Pregnant & Postpartum Women

ATTC | Center of Excellence



EASIER TOGETHER

Partnering with Families
to Make Recovery Possible

Participant Manual

ATTC Center of Excellence on Behavioral
Health for Pregnant and Postpartum
Women and Their Families

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About Us

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To learn more about the Center's resources and technical assistance activities, visit www.attcppwtools.org.

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Module 1

Introduction

Training Goals and Objectives

Help programs understand family-centered care and the implications of stigmatizing language and myths.

By the end of this module, participants will be able to:

1. Explain why family-centered care matters.
2. Define family-centered care in the context of pregnant/postpartum women's (PPW) addiction treatment.
3. Evaluate the impact of language, myths, and stigma on care for PPW with substance use disorders and their families.




Easier Together:
Partnering with Families to
Make Recovery Possible



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Module 1: Introduction to “Easier Together” Curriculum

- Explanation of curriculum and audience
- Why does this matter?
- Defining family-centered care
- Language, stigma, and obstacles



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Acknowledgements



Kathryn Icenhower, PhD
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Introductions

- ▶ Name
- ▶ Field
- ▶ Top area of expertise

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Introduction to “Easier Together” Curriculum

► Comprised of 6 Modules:

Module 1 — Introduction (45 min)

Module 2 — Family-Centered Care (45 min)

Module 3 — Building Programs for Fathers (45 min)

Module 4 — Implementing Family-Centered Programming (45 min)

Module 5 — Family-Centered Clinical Interventions (45 min)

Module 6 — Case-Based Application (45 min)

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Target Audience

► **The primary audience of the “Easier Together” curriculum is addiction treatment providers** who are working with pregnant and postpartum women with substance use disorders. The secondary audience is their community partners, including professionals from the fields of:

- Mental health
- Healthcare
- Child welfare
- Child development
- Housing/vocational services
- Other community partners

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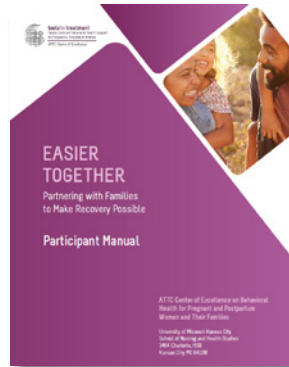


Hands-On Review of Participant Manual

► Participant manual

Each module contains:

- Training goals and objectives
- Copy of slides
- Resources – worksheets, activities, assessments, recommended reading, reference list



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Visit www.attcppwtools.org for More Resources

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Goal and Objectives

Goal: Help programs understand family-centered care and the implications of stigmatizing language and myths.

Objectives: Participants will be able to:

- ▶ Explain why family-centered care matters.
- ▶ Define family-centered care in the context of pregnant/postpartum women's (PPW) addiction treatment.
- ▶ Evaluate the impact of language, myths, and stigma on care for pregnant/postpartum women (PPW) with substance use disorders and their families.

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Key Question

Why does this topic matter?

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Why Does This Matter?

► ____ % of U.S. treatment facilities offer at least one special program or group for pregnant/postpartum women.

- a) 10% b) 21% c) 45% d) 60%

(SAMHSA N-SSATS, 2016)

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Why Does This Matter?

► ____ % of U.S. treatment facilities offer childcare services.

- a) 6% b) 18% c) 35% d) 50%

(SAMHSA N-SSATS, 2016)

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Why Does This Matter?

- ____ % of U.S. treatment facilities offer residential beds for clients' children.

a) 3% b) 18% c) 35% d) 50%

(SAMHSA N-SSATS, 2016)

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Why Does This Matter?

Family-centered care results in:

- Improved treatment and retention outcomes for individual women
- Improved outcomes for children and other family members

(Werner, Young, Dennis & Amatetti, 2007)

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What is **Family-Centered Care** for Pregnant/Postpartum Women with Substance Use Disorders?

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Definition

Family-Centered Care:

Providing services for the whole family to make recovery possible; although the mother is the entry point, the family becomes the client

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The Culture Conversation



Language and culture may influence . . .

- ▶ Health, healing, and wellness belief systems
- ▶ How illness, disease, and their causes are perceived
- ▶ How treatment is sought
- ▶ Delivery of healthcare services by providers

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p. 27 of participant manual



Historical Influences: Family-Centered Care





Historical Influences

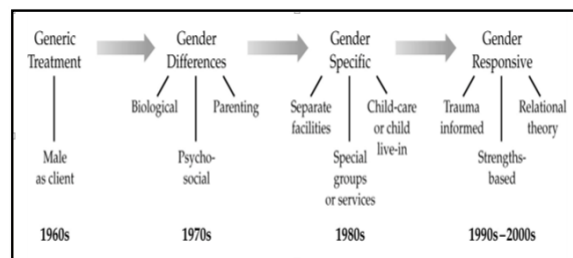
- ▶ Family Preservation and Support Services Program (1993)
- ▶ Comprehensive Community Mental Health Services for Children and Their Families Program (1994)
- ▶ Family-Centered Practice (child welfare field, 2001)
- ▶ Family-Centered Care (pediatrics field, 2003)

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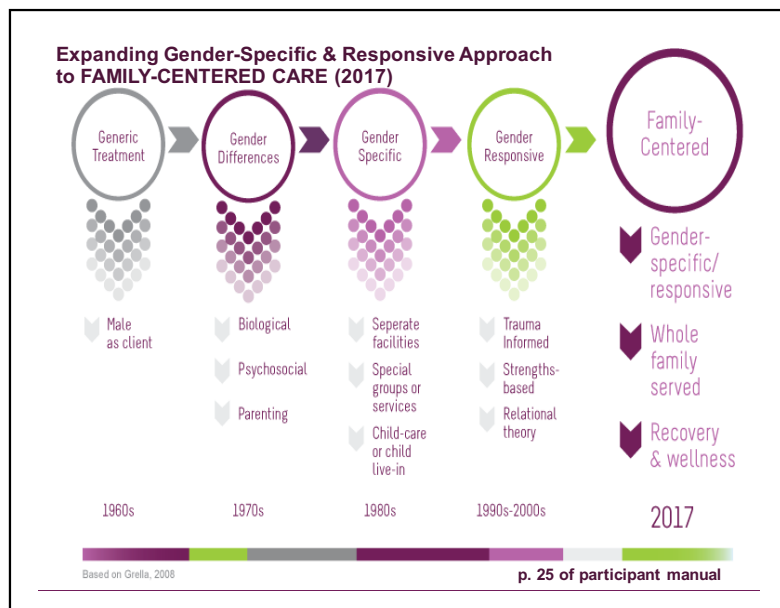


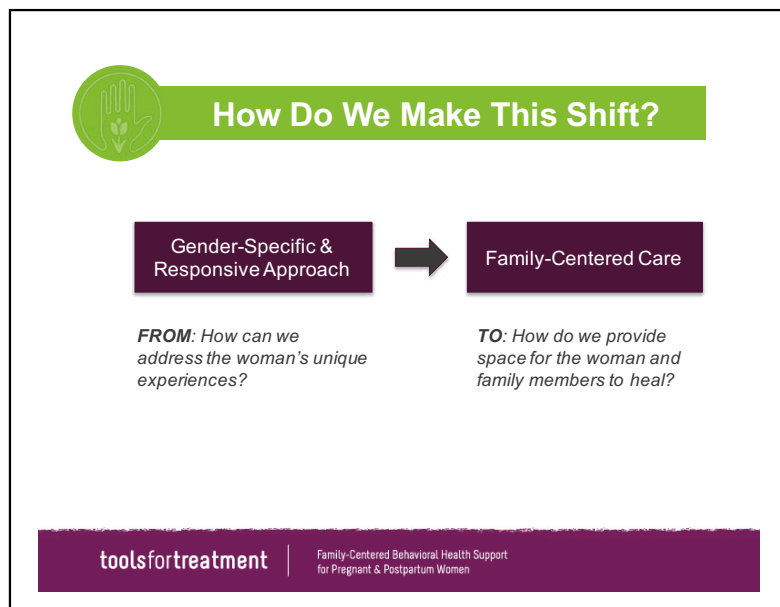
Gender-Specific & Responsive Approaches



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What Do You Think?

► **Family-centered care decreases focus on the woman.**

Agree?

Disagree?

Not sure?

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Language, Myths, Stigma, and Obstacles





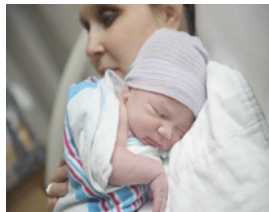
Fact or Myth 1

- Babies are born addicted to the substances they were exposed to in utero.

Example in the media:

"Born addicts, opioid babies in withdrawal from first breath"

Source: *The Washington Times*,
2/18/17



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Myth

- No baby is born "addicted." Meeting criteria for a substance use disorder involves a number of behaviors related to substance use despite experiencing negative consequences.
- Evidence of physiologic dependence on opioids is called neonatal abstinence syndrome (NAS), a condition that can be diagnosed and effectively treated with protocols that have been available for decades.
- Appropriate care such as breastfeeding and "comfort care" (swaddling, skin-to-skin contact, etc.) is often sufficient to prevent or minimize signs of distress.



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Fact or Myth 2

- Methadone and buprenorphine are safe medications for addiction treatment during pregnancy.

Example in the media:

"Medication-assisted treatment is the path recommended [for pregnant women with opioid use disorders] based on current scientific evidence."

- Source: 89.3 WFPL, 6/23/17



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Fact

- The evidence for the efficacy of methadone maintenance treatment – most particularly its use in the care of pregnant women – has been overwhelmingly consistent for almost half a century.
- Buprenorphine is another safe and effective medication for use during pregnancy and has been shown to have additional benefits for the infants, including milder NAS.



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Fact or Myth 3

- ▶ Labeling a child as a “crack baby,” “addicted baby,” “meth baby,” “victim” etc. puts the child at risk for health and social consequences later in life.

Example in the media:

“‘Crack baby’ brings to mind hopeless, damaged children with birth defects and intellectual disabilities who would inevitably grow into criminals.”

- Source: *The Atlantic*, 7/16/17



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Fact

- ▶ Labeling a child as a “crack baby,” “addicted baby,” “meth baby,” “victim” etc. puts the child at risk for:

☐ Stigma and discrimination in school starting at pre-school.

☐ Medical misdiagnosis.

☐ Separation from supportive families as a result of inappropriate child welfare interventions.



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Words Have Power. People First.

Using affirmative language to inspire hope and advance family recovery.

Stigmatizing Language	Current Language
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
Crack Babies	Substance-exposed infant or Substance-affected infant
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 opioid use disorder
Reformed addict or alcoholic	Person in recovery
Substance Abuse	Substance use disorder
Substance abuse/abuser	Person with a substance use disorder
Substance Misuse	Substance use / non-medical use
Victims / "tiny victims"	Prenatally exposed to [drug name]



Wrap-Up

"Demonizing pregnant women creates an environment where punishment rather than support is the predominant response, and will inevitably serve to discourage women from seeking care."

- "Open letter..." (p. 28-35 of participant manual)

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Next Modules

- ▶ **Module 2:** Family-Centered Care
- ▶ **Module 3:** Building Programs for Fathers
- ▶ **Module 4:** Implementing Family-Centered Programming
- ▶ **Module 5:** Family-Centered Clinical Interventions
- ▶ **Module 6:** Case-Based Application

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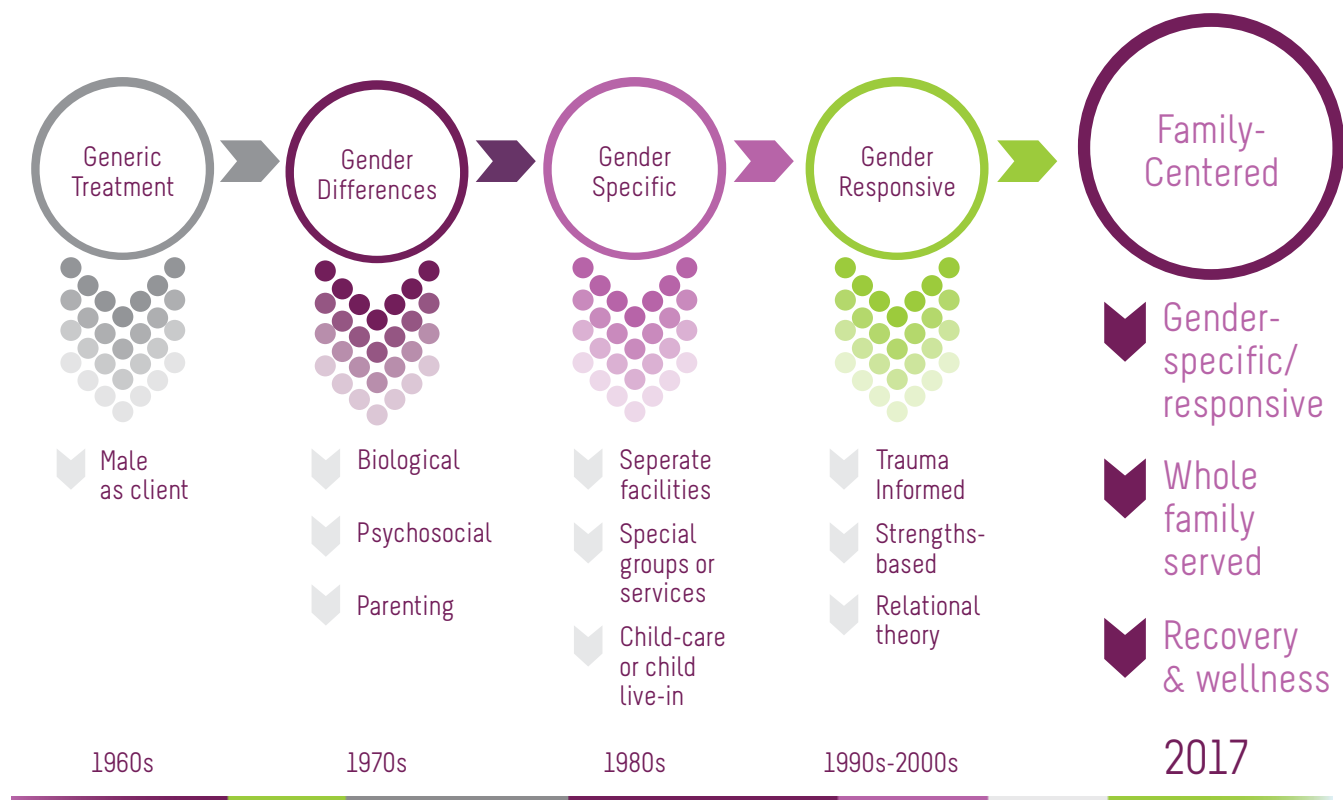
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Module 1

Resources

Expanding Gender-Specific and Responsive Approach to FAMILY-CENTERED CARE (2017)



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Based on Grella, 2008

LANGUAGE MATTERS: Using Affirmative Language to Inspire Hope and Advance Family Recovery

Words have power. People First.

Stigmatizing Language	Preferred Language
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
Crack Babies	Substance-exposed infant or Substance-affected 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 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
Substance Abuse	Substance Use Disorder
Substance abuse/abuser	Person with a substance use disorder
Substance abusing mother	Mother with a substance use disorder
Substance Misuse	Substance use / non-medical use
Victims / "tiny victims"	Prenatally exposed to [drug name]
Other:	
Other:	

Adapted from: Office of National Drug Control Policy (2015)



The Culture Conversation (Module 1)

Background:

SAMHSA definition of culture:

Cultural competence is the ability to interact effectively with people of different cultures. In practice, both individuals and organizations can be culturally competent. Culture must be considered at every step. “Culture” is a term that goes beyond just race or ethnicity. It can also refer to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession.

Culture is an integrated pattern of human behavior, which includes but is not limited to: communication, thoughts, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, spirituality, and expected behaviors of racial, ethnic, religious, social, or political groups.

The Culture Conversation:

Understanding the importance of language and culture is key in eliminating health disparities.

- Health, healing, and wellness belief systems; *how health services are delivered and created for the populations they serve.*
- How illness, disease, and their causes are perceived; *both by the individual and the healthcare system.*
- How treatment is sought; *the behaviors of individuals seeking healthcare and their attitudes toward healthcare providers.*
- The delivery of healthcare services by the providers *who look at the world through their own set of values, which can compromise access for individuals from other cultures.*

Special Populations:

We have all at some point in our lives been part of the underserved or underrepresented populations. Family-Centered programming matters because it impacts all of us and brings a voice to those who may not have one. We all have some form of family and as we work together to ensure health equity and access to services, we will support the unique cultural needs of the individuals and families we see and serve on a daily basis, which in turn impacts our own families and communities.

Next Steps:

By understanding, valuing, and incorporating the cultural differences of diverse populations and examining one's own values and beliefs, healthcare organizations, practitioners, and others can support a whole healthcare system which responds appropriately to and directly serves the unique needs of populations.

Reference:

<http://minorityhealth.hhs.gov/>

Open Letter to the Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opioid Use by Pregnant Women

March 11, 2013

To whom it may concern:

A substantial increase has been noted in the number of pregnant women and newborns who test positive for illegal as well as legal opioids, including those utilized as prescribed as well as those misused and/or diverted. A great deal of experience has been gained over the course of almost 50 years regarding the effects of prenatal opioid exposure on expectant mothers and their babies, and guidelines have been established for optimal care of both. And yet, reporting in the popular media continues to be overwhelmingly inaccurate, alarmist and decidedly harmful to the health and well-being of pregnant women, their children, and their communities.

As medical and psychological researchers and as treatment providers with many years of experience studying and treating prenatal exposure to psychoactive substances, as well as treatment providers and researchers with many years of experience studying addictions and addiction treatment, we are writing to urge that policies addressing prenatal exposure to opioids, and media coverage of this issue, be evidence-based rather than perpetuate and generate misinformation and prejudice.

No newborn is born “addicted”

Popular media repeatedly and inaccurately describe children exposed to various drugs *in utero* as “addicted,” a term that is incorrect and highly stigmatizing. Addiction is a technical term that refers to compulsive behavior that continues in spite of adverse consequences. In fact, babies cannot be born “addicted” to anything regardless of drug test results or indicia of physical dependence. Evidence of physiologic dependence on (not addiction to) opiates has been given the name neonatal abstinence syndrome (NAS), a condition that is diagnosable and treatable. And yet, as the following examples demonstrate, news reports typically and inaccurately describe newborns as addicted (emphasis added).

- “In Broward County, there has been an alarming jump in the number of babies born to pill-using mothers; *babies who are themselves born addicted.*” (KTHV Television, [More Pill-Using-Mothers Delivering Addicted Babies](#), July 29, 2011)
- “There's a growing epidemic of *babies being born addicted to prescription drugs* ingested by young mothers...” (Bradentown Herald, [Prescription-Abuse Babies a Growing ‘Crisis’ in Manatee, Say Advocates](#), Nov. 9, 2011)
- “The number of *babies born addicted* to the class of drugs that includes prescription painkillers has nearly tripled in the past decade...” (USA Today, [Addicted Infants Triple in a Decade](#), May 1, 2012)

- “In the past decade, the number of *babies born addicted to opiates* has tripled.” (The Huffington Post, [More Babies Born Addicted to Painkillers, Multiple Reports Show Growing Epidemic](#), July 13, 2012)
- “Once, every hour in the U.S. a *baby is born addicted to the painkillers* that swallowed up its mother.” (WKYC Television, [Tiniest Victims of Ohio’s Painkiller Epidemic](#), Aug. 1, 2012)
- “10 percent of the *babies born are addicted to opiates*.” (WSAZ News Channel, [Scioto County and Portsmouth Make Strides in the War on Drugs](#), Oct. 31, 2012)
- “A new study showing a major increase in Tennessee *babies born addicted to drugs* has prompted the state Health Department to require hospitals to report that information.” (WFPL News, [Tennessee Requiring Hospitals to Report Babies Born Addicted to Drugs](#), Dec. 5, 2012)

In addition to labeling newborns addicted when they are not, major news outlets have also drawn parallels between children born to women who have used opioids during their pregnancy and those who, a decade ago, were branded “crack babies.” For example, Brian Williams began an NBC news report by saying, “For those of us who were reporters back in the 1980s, it was an awful new trend we were covering at the time, and it was the first time our viewers were hearing about the young, innocent infants. A generation of crack babies, born addicted to drugs because of their mothers’ habit. Sadly, a new generation has meant a new habit – prescription pain meds, Oxycontin, Vicodin; other powerful drugs in that same category. And now we are seeing the infants born to mothers abusing these drugs.” (NBC News, [Prescription Drug Addiction Among Pregnant Women Becoming ‘Monstrous Tidal Wave’](#), July 5, 2012) An ABC news report likewise claimed: “The increasing numbers of women who abuse prescription painkillers while pregnant are delivering the crack babies of the 21st century, specialists say.” (ABC News Medical Unit, [Newborns Hooked on Mom’s Painkillers Go Through Agonizing Withdrawal](#), Nov. 14, 2011) And The Wall Street Journal described newborns exposed prenatally to cocaine and methadone treatment as “reminiscent of the ‘crack babies’ of the 1980s and 1990s.” (Wall Street Journal, [Pain Pills’ Littlest Victims](#), Dec. 28, 2012)

In more than 20 years of research, none of the leading experts in the field have identified a recognizable condition, syndrome, or disorder that should be termed “crack baby” (See [Open Letter To the Media](#), February 25, 2004). Rather than learning from its alarmist and false reporting about pregnant women and cocaine use (e.g., New York Times, [The Epidemic That Wasn’t](#), Jan. 26, 2009), media outlets have now irresponsibly revived the term “crack baby” and created new, equally unfounded and pejorative labels such as “oxy babies” or “oxy tots.” (FoxNews, [‘Oxytots’ Victims of Prescription Drug Abuse](#), October 28, 2011; The Examiner, [“Oxytots”: A National Disgrace](#), Oct. 30, 2011)

Equally unjustified is the suggestion that some women who become pregnant and carry their pregnancies to term give birth not to babies but rather to “victims.” As noted above, a story in The Wall Street Journal was headlined *Pain Pills’ Littlest Victims*. (Wall Street Journal, Dec. 28, 2012) Another recent article in USA Today referred to newborns prenatally exposed to prescription opiates as “the tiniest victims.” (USA Today, [Kentucky Sees Surge in Addicted Infants](#), Aug. 27, 2012) Of course, where there are victims, there also are perpetrators – in this case, pregnant women and mothers. None of these women – whether receiving methadone or

other opioids for the management of pain, obtaining federally-recommended treatment of dependence, or misusing opioids and experiencing a dependency problem – may fairly be characterized as perpetrators or victimizers.

The most respected and objective authorities in the U.S. and throughout the world, including the World Health Organization, have determined that drug addiction is not a “bad habit” or willful indulgence in hedonism, but a chronic medical condition that is treatable but – as yet – not curable. Demonizing pregnant women creates an environment where punishment rather than support is the predominant response, and will inevitably serve to discourage women from seeking care.

Long-term implications for offspring misrepresented

News media also typically report or suggest that “those born dependent on prescription opiates ... are entering a world in which little is known about the long-term effects on their development.” (New York Times, [*Newly Born, and Withdrawing from Painkillers*](#), April 9, 2011) And yet, when controlling for factors such as economic status, access to healthcare, and concomitant medical problems, including use of nicotine products and alcohol, decades of studies reported in the professional literature have failed to demonstrate *any* long-term adverse sequelae associated with prenatal exposure to opioids, legal or illegal. On the other hand, it is not an exaggeration to state that labels such as “victim” or “tiny addict” or “born addicted” carry with them severe negative consequences, both medical and social. Children so labeled are at substantial risk of stigma and discrimination in educational contexts starting at the pre-school level. They may be subject to medical misdiagnosis and unnecessary, detrimental separation from loving and supportive families as a result of ill-informed and inappropriate child welfare interventions.

It should be clear from the above that we are not preoccupied with semantic niceties, but deeply concerned about reporting that, very literally, threatens the lives, health, and safety of children.

Neonatal abstinence syndrome, when it occurs, is treatable and has not been associated with long-term adverse consequences

Both the occurrence and severity of NAS have been shown to be affected by a variety of factors that are unrelated to possible pharmacological effects of prenatal exposure to opioids. For example, a 2006 study demonstrated that babies who stayed in their mothers’ room while in hospital (i.e., “rooming in”) rather than being placed in neonatal intensive care units (NICU) had less need for treatment of NAS, shorter length of hospital stay, and significantly greater likelihood of being discharged home in the custody of their mothers. Similarly, a 2010 study found that only 11% of babies who boarded with their mothers required treatment of NAS compared to more than four times as many who were placed in an NICU.

Moreover, it has long been known that NAS, when it occurs, can be treated effectively. NAS can be evaluated and managed with scoring systems and treatment protocols that have been available for decades in standard textbooks and in numerous articles in the professional literature. Appropriate care, which may include breastfeeding and “comfort care” (e.g.,

swaddling and skin-to-skin contact between mother and baby), is often sufficient to prevent or minimize signs of distress in the baby. There simply is no reason why babies should as stories report “go through agonizing withdrawal” or demonstrate “...merciless screams, jitters and unusually stiff limbs.” News reports describing newborns suffering suggest lack of appropriate medical training and the failure to provide optimal medical care rather than inevitable, untreatable, effects of prenatal exposure to opioids. (e.g., The Gadsen Times, [Our View: Addicted at Birth](#), Nov. 15, 2011; PBS Newshour, [Painkiller ‘Epidemic’ Deepens in U.S.](#), Nov. 2, 2011; Knoxville News Sentinel, [Drug-addicted Babies Difficult to Treat](#), Nov. 1, 2011)

Media misinformation and stigmatizing characterizations discourage appropriate, federally recommended treatment

Recent reporting also frequently dangerously mischaracterizes methadone maintenance treatment as harmful and unethical. For example, a CNN story irresponsibly portrays a woman’s decision to follow recommended treatment as a form of abuse:

Narrator 1: Guided by her doctor, April did what she thought was best for her baby and stayed on methadone for her entire pregnancy. The end result? Mariah was born dependent on drugs.

Narrator 2: What did that feel like to know that your use of methadone had caused her so much suffering?

April Russell: Oh it’s, I mean, I can’t explain it. I mean, it killed me. I mean, still today I mean it’s, it’s hard (April starts to cry). But, (stops talking due to crying), sorry.

(CNN video broadcast, [One Baby Per Hour Born Already in Withdrawal](#), April 12, 2012) Similarly, NBC News reported that a pregnant woman in treatment “can’t save her baby from going through withdrawal. Because methadone is another form of medication similar to painkillers, there is a good chance her baby will be born addicted to that drug.” (NBC News, July 5, 2012) And The New York Times reported that “those who do treat pregnant addicts face a jarring ethical quandary: they must weigh whether the harm inflicted by exposing a fetus to powerful drugs, albeit under medical supervision, is justifiable.” (New York Times, April 9, 2011)

The evidence for the efficacy of methadone maintenance treatment – most particularly its use in the care of pregnant women – has been overwhelmingly consistent for almost half a century. The highest U.S. government authority on drug abuse treatment, the Substance Abuse and Mental Health Services Administration, summed it up in a pamphlet it produced several years ago and continues to distribute. It is directed to pregnant, opioid-dependent women and states in unusually clear and concise terms: “If you’re pregnant and using drugs such as heroin or abusing opioid prescription pain killers, it’s important that you get help for yourself and your unborn baby. Methadone maintenance treatment can help you stop using those drugs. It is safe for the baby, keeps you free of withdrawal, and gives you a chance to take care of yourself ... Methadone maintenance treatment can save your baby’s life.” Recently, buprenorphine treatment has also been used effectively to treat opiate addiction in pregnant women.

There are, however, enormous financial, regulatory, and cultural barriers to this treatment that

are exacerbated by misinformed and inaccurate news reporting. Indeed, we are aware of numerous cases in which judges and child welfare workers have sought to punish as child abusers pregnant women and mothers who are receiving methadone maintenance treatment.

Conclusion

It is deeply distressing that US media continue to vilify mothers who need and those who receive treatment for their opioid dependence, and to describe their babies in unwarranted, highly prejudicial terms that could haunt these babies throughout their lives. Such reporting, judging, and blaming of pregnant women draws attention away from the real problems, including barriers to care, lack of medical school and post-graduate training in addiction medicine, and misguided policies that focus on reporting women to child welfare and law enforcement agencies for a treatable health problem that can and should be addressed through the health care system. It fosters inappropriate, punitive, expensive, and family-disruptive responses by well-meaning but misinformed criminal justice and child protective agencies, creating a reluctance on the part of healthcare professionals to recommend and offer the services that evidence clearly indicates are best for their patients.

We would be happy to furnish additional information, including references to research material discussed. Please feel free to contact Dr. Robert Newman (rnewman@icaat.org), who will coordinate response to such requests.

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BULLETIN FOR PROFESSIONALS

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Parental Substance Use and the Child Welfare System

Many families receiving child welfare services are affected by parental substance use. Identifying substance abuse and meeting the complex needs of parents with substance use disorders and those of their children can be challenging. Over the past two decades, innovative approaches coupled with new research and program evaluation have helped point to new directions for more effective, collaborative, and holistic service delivery to support both parents and children. This bulletin provides child welfare workers and related professionals with information on the intersection of substance use disorders and child maltreatment and describes strategies for prevention, intervention, and treatment, including examples of effective programs and practices.

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The Relationship Between Substance Use Disorders and Child Maltreatment

It is difficult to provide precise, current statistics on the number of families in child welfare affected by parental substance use or dependency since there is no ongoing, standardized, national data collection on the topic. In a 1999 report to Congress, the U.S. Department of Health and Human Services (HHS) reported that studies showed that between one-third and two-thirds of child maltreatment cases were affected by substance use to some degree (HHS, 1999). More recent research reviews suggest that the range may be even wider (Barth, 2009; Traube, 2012). The variation in estimates may be attributable, in part, to differences in the populations studied and the type of child welfare involvement (e.g., reports, substantiation, out-of-home placement); differences in how substance use (or substance abuse or substance use disorder) is defined and measured; and variations in State and local child welfare policies and practices for case documentation of substance abuse.

Children of Parents With Substance Use Disorders

An estimated 12 percent of children in this country live with a parent who is dependent on or abuses alcohol or other drugs (HHS, Substance Abuse and Mental Health Services Administration [SAMHSA], Office of Applied Studies, 2009). Based on data from the period 2002 to 2007, the National Survey on Drug Use and Health (NSDUH) reported that 8.3 million children under 18 years of age lived with at least one substance-dependent or substance-abusing parent.¹ Of these children, approximately 7.3 million lived with a parent who was dependent on or abused alcohol, and about 2.2 million lived with a parent who was dependent on or abused illicit drugs. While many of these children will not experience abuse or neglect, they are at increased risk for maltreatment and entering the child welfare system.

¹ NSDUH is an annual SAMHSA survey of a representative sample of the national population. It defines dependence and abuse using criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, which includes symptoms such as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference in major obligations at work, school, or home over the past year. The most recent data analyzed related to children of substance abusing or dependent parents are from the 2002 to 2007 surveys.

For more than 400,000 infants each year (about 10 percent of all births), substance exposure begins prenatally (Young et al., 2009). State and local surveys have documented prenatal substance use as high as 30 percent in some populations (Chasnoff, 2010). Based on NSDUH data from 2011 and 2012, approximately 5.9 percent of pregnant women aged 15 to 44 were current illicit drug users. Younger pregnant women generally reported the greatest substance use, with rates approaching 18.3 percent among 15- to 17-year-olds. Among pregnant women aged 15 to 44 years old, about 8.5 percent reported current alcohol use, 2.7 percent reported binge drinking, and .3 percent reported heavy drinking (HHS SAMHSA, 2013a).

Parental Substance Abuse as a Risk Factor for Maltreatment and Child Welfare Involvement

Parental substance abuse is recognized as a risk factor for child maltreatment and child welfare involvement (Institute of Medicine and National Research Council, 2013). Research shows that children with parents who abuse alcohol or drugs are more likely to experience abuse or neglect than children in other households (Dube et al., 2001; Hanson et al., 2006). One longitudinal study (Dubowitz et al., 2011) identified parental substance abuse (specifically, maternal drug use) as one of five key factors that predicted a report to child protective services (CPS) for abuse or neglect. Once a report is substantiated, children of parents with substance use issues are more likely to be placed in out-of-home care and more likely to stay in care longer than other children (Barth, Gibbons, & Guo, 2006; HHS, 1999). The National Survey of Child and Adolescent Well-Being (NSCAW) estimates that 61 percent of infants and 41 percent of older children in out-of-home care are from families with active alcohol or drug abuse (Wulczyn, Ernst, & Fisher, 2011).

According to data in the Adoption and Foster Care Analysis and Reporting System (AFCARS), parental substance abuse is frequently reported as a reason for removal, particularly in combination with neglect (Correia, 2013). For almost 31 percent of all children placed in foster care in 2012, parental alcohol or drug use was the documented reason for removal, and in several States

that percentage surpassed 60 percent (National Data Archive on Child Abuse and Neglect, 2012). Nevertheless, many caregivers whose children remain at home after an investigation also have substance abuse issues. NSCAW found that the need for substance abuse services among in-home caregivers receiving child welfare services was substantially higher than that of adults nationwide (29 percent as compared with 20 percent, respectively, for parents ages 18 to 25, and 29 percent versus 7 percent for parents over age 26) (Wilson, Dolan, Smith, Casanueva, & Ringeisen, 2012).

Role of Co-occurring Issues

While the link between substance abuse and child maltreatment is well documented, it is not clear how much is a direct causal connection and how much can be attributed to other co-occurring issues. National data reveal that slightly more than one-third of adults with substance use disorders have a co-occurring mental illness (HHS SAMHSA, 2013b). Research on women with substance abuse problems shows high rates of posttraumatic stress disorder (PTSD), most commonly stemming from a history of childhood physical and/or sexual assault (Najavits, Weiss, & Shaw, 1997). Many parents with substance abuse problems also experience social isolation, poverty, unstable housing, and domestic violence. These co-occurring issues may contribute to both the substance use and the child maltreatment (Testa & Smith, 2009). Evidence increasingly points to a critical role of stress and reactions within the brain to stress, which can lead to both drug-seeking activity and inappropriate caregiving (Chaplin & Sinha, 2013).

Impact of Parental Substance Use on Children

The way parents with substance use disorders behave and interact with their children can have a multifaceted impact on the children. The effects can be both indirect (e.g., through a chaotic living environment) and direct (e.g., physical or sexual abuse). Parental substance use can affect parenting, prenatal development, and early childhood and adolescent development. It is important to recognize, however, that not all children of parents with

substance use issues will suffer abuse, neglect, or other negative outcomes.

Parenting

A parent's substance use disorder may affect his or her ability to function effectively in a parental role. Ineffective or inconsistent parenting can be due to the following:

- Physical or mental impairments caused by alcohol or other drugs
- Reduced capacity to respond to a child's cues and needs
- Difficulties regulating emotions and controlling anger and impulsivity
- Disruptions in healthy parent-child attachment
- Spending limited funds on alcohol and drugs rather than food or other household needs
- Spending time seeking out, manufacturing, or using alcohol or other drugs
- Incarceration, which can result in inadequate or inappropriate supervision for children
- Estrangement from family and other social supports

Family life for children with one or both parents that abuse drugs or alcohol often can be chaotic and unpredictable. Children's basic needs—including nutrition, supervision, and nurturing—may go unmet, which can result in neglect. These families often experience a number of other problems—such as mental illness, domestic violence, unemployment, and housing instability—that also affect parenting and contribute to high levels of stress (National Abandoned Infants Assistance Resource Center [AIA], 2012). A parent with a substance abuse disorder may be unable to regulate stress and other emotions, which can lead to impulsive and reactive behavior that may escalate to physical abuse (Chaplin & Sinha, 2013).

Different substances may have different effects on parenting and safety (Testa & Smith, 2009). For example, the threats to a child of a parent who becomes sedated and inattentive after drinking excessively differ from the threats posed by a parent who exhibits aggressive

side effects from methamphetamine use. Dangers may be posed not only from use of illegal drugs, but also, and increasingly, from abuse of prescription drugs (pain relievers, anti-anxiety medicines, and sleeping pills). (For more information on effects of various substances, see <http://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs/health-effects>.) Polysubstance use (multiple drugs) may make it difficult to determine the specific and compounded effects on any individual. Further, risks for the child's safety may differ depending upon the level and severity of parental substance use and associated adverse effects.²

Prenatal and Infant Development

The effects of parental substance use disorders on a child can begin before the child is born. Maternal drug and alcohol use during pregnancy have been associated with premature birth, low birth weight, slowed growth, and a variety of physical, emotional, behavioral, and cognitive problems (AIA, 2012; National Institute on Drug Abuse [NIDA], 2011). Research suggests powerful effects of legal drugs, such as tobacco, as well as illegal drugs on prenatal and early childhood development (HHS SAMHSA, 2014).

Fetal alcohol spectrum disorders (FASD) are a set of conditions that affect an estimated 40,000 infants born each year to mothers who drank alcohol during pregnancy (Prevention First, n.d.). Children with FASD may experience mild to severe physical, mental, behavioral, and/or learning disabilities, some of which may have lifelong implications (e.g., brain damage, physical defects, attention deficits) (National Organization on Fetal Alcohol Syndrome, 2012). In addition, increasing numbers of newborns—approximately 3 per 1,000 hospital births each year—are affected by neonatal abstinence syndrome (NAS), a group of problems that occur in a newborn who was exposed prenatally to addictive illegal or prescription drugs (Patrick et al., 2012).

The full impact of prenatal substance exposure depends on a number of factors. These include the frequency,

² The *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) states that substance use disorders are measured on a continuum from mild to severe determined by the presence of adverse effects associated with substance use. For more information on the DSM-5 classification of substance-related disorders, see <http://www.psychiatry.org/dsm5>.

timing, and type of substances used by pregnant women; co-occurring environmental deficiencies; and the extent of prenatal care (AIA, 2012). Research suggests that some of the negative outcomes of prenatal exposure can be improved by supportive home environments and positive parenting practices (NIDA, 2011).

Child and Adolescent Development

Children and youth of parents who use or abuse substances and have parenting difficulties have an increased chance of experiencing a variety of negative outcomes (Felitti et al., 1998; HHS, 1999; Staton-Tindall et al., 2013):

- Poor cognitive, social, and emotional development
- Depression, anxiety, and other trauma and mental health symptoms
- Physical and health issues
- Substance use problems

Parental substance use can affect the well-being of children and youth in complex ways. For example, an infant who receives inconsistent care and nurturing from a parent engaged in addiction-related behaviors may suffer from attachment difficulties that can then interfere with the growing child's emotional development. Adolescent children of parents with substance use disorders, particularly those who have experienced child maltreatment and foster care, may turn to substances themselves as a coping mechanism. In addition, children of parents with substance use issues are more likely to experience trauma and its effects, which include difficulties with concentration and learning, controlling physical and emotional responses to stress, and forming trusting relationships (Staton-Tindall et al., 2013).

Child Welfare Laws Related to Parental Substance Use

In response to concerns over the potential negative impact on children of parental substance abuse and illegal drug-related activities, approximately 47 States and the District of Columbia have child protection laws that address some aspect of parental substance use. Some States have expanded their civil definitions of child abuse

and neglect to include a caregiver's use of a controlled substance that impairs the ability to adequately care for a child and/or exposure of a child to illegal drug activity (e.g., sale or distribution of drugs, home-based meth labs). Exposure of children to illegal drug activity is also addressed in 33 States' criminal statutes (Child Welfare Information Gateway, 2012). (For information on different States' statutes, visit https://www.childwelfare.gov/systemwide/laws_policies/statutes/drugexposed.cfm.)

Federal and State laws also address prenatal drug exposure. The Child Abuse Prevention and Treatment Act (CAPTA) requires States receiving CAPTA funds to have policies and procedures for health-care personnel to notify CPS of substance-exposed newborns and to develop procedures for safe care of affected infants. As yet, there are no national data on CAPTA-related reports for substance-exposed newborns. In some State statutes, substance abuse during pregnancy is considered child abuse and/or grounds for termination of parental rights. State statutes and State and local policies vary widely in their requirements for reporting suspected prenatal drug abuse, testing for drug exposure, CPS response, forced admission to treatment of pregnant women who use drugs, and priority access for pregnant women to State-funded treatment programs (Guttmacher Institute, 2014).

Service Delivery Challenges

Despite the fact that a large percentage of parents who are investigated in child protection cases require treatment for alcohol or drug dependence, the percentage of parents who actually receive services is limited, compared to the need. Also, many parents who begin treatment do not complete it (Traube, 2012). Historically, insufficient collaboration has hindered the ability of child welfare, substance abuse treatment, and family/dependency court systems to support these families.

Child welfare agencies face a number of difficulties in serving children and families affected by parental substance use disorders, including:

- **Insufficient service availability** or scope of services to meet existing needs
- **Inadequate funds** for services and/or dependence on client insurance coverage
- **Difficulties in engaging** and retaining parents in treatment
- **Knowledge gaps** among child welfare workers to meet the comprehensive needs of families with substance use issues
- **Lack of coordination** between the child welfare system and other services and systems, including hospitals that may screen for drug exposure, treatment agencies, mental health services, criminal justice system, and family/dependency courts
- **Differences in perspectives and timeframes**, reflecting different guiding policies, philosophies, and goals in child welfare and substance abuse treatment systems (for example, a focus on the safety and well-being of the child without sufficient focus on parents' recovery)

A critical challenge for child welfare professionals is meeting legislative requirements regarding child permanency while allowing for sufficient progress in substance abuse recovery and development of parenting capacity. The Adoption and Safe Families Act (ASFA) requires that a child welfare agency file a petition for termination of parental rights if a child has been in foster care for 15 of the past 22 months, unless it is not in the best interest of the child. Many agencies struggle with adhering to this timeframe due to problems with accessing substance abuse services in a timely manner. In addition, treatment may take many months (often longer than the ASFA timeline allows), and achieving sufficient stability to care for children may take even longer. Addressing addiction can require extended recovery periods, and relapses can occur.

Innovative Prevention and Treatment Approaches

While parental substance abuse continues to be a major challenge in child welfare, the past two decades have witnessed some new and more effective approaches and innovative programs to address child protection for families where substance abuse is an issue. Some

examples of promising and innovative prevention and treatment approaches include the following:

Promotion of protective factors, such as social connections, concrete supports, and parenting knowledge, to support families and buffer risks

Early identification of at-risk families in substance abuse treatment programs and through expanded prenatal screening initiatives so that prevention services can be provided to promote child safety and well-being in the home

Priority and timely access to substance abuse treatment slots for mothers involved in the child welfare system

Gender-sensitive treatment and support services that respond to the specific needs, characteristics, and co-occurring issues of women who have substance use disorders

Family-centered treatment services, including inpatient treatment for mothers in facilities where they can have their children with them and programs that provide services to each family member

Recovery coaches or mentoring of parents to support treatment, recovery, and parenting

Shared family care in which a family experiencing parental substance use and child maltreatment is placed with a host family for support and mentoring

Find more information on specific programs and service models:

- National Center on Substance Abuse and Child Welfare (NCSACW), *Regional Partnership Grant (RPG) Program: Overview of Grantees' Services and Interventions*
https://www.ncsacw.samhsa.gov/files/RPG_Program_Brief_2_Services_508_reduced.pdf
- NRC for In-Home Services, *In-Home Programs for Drug Affected Families*
<https://www.nrc-ihs.org/sites/default/files/drugaffectedmemo.pdf>

- SAMHSA's National Registry of Evidence-Based Programs and Practices
<http://www.nrepp.samhsa.gov/>

Program Highlight: Illinois Recovery Coaches

As part of Illinois' title IV-E waiver demonstration, recovery coaches provide intensive outreach and engagement services for families whose children have been placed in foster care due to parental substance abuse and maltreatment. Recovery coaches work with parents, child welfare caseworkers, and treatment agencies to remove barriers to treatment, engage parents in treatment, and provide ongoing support following reunification. An experimental evaluation (Ryan and Huang, 2012) found that, compared to families who received standard services, parents working with recovery coaches were more likely to access substance abuse treatment and did so more quickly. In addition, they achieved safe family reunification and reduced the length of time children spent in out-of-home care. Enhanced services to address co-occurring issues were found to be particularly important. (See http://cfrc.illinois.edu/pubs/rp_20120701_IllinoisAODAIV-EWaiverDemonstrationFinalEvaluationReport.pdf.)

Promising Child Welfare Casework Practices

In working with families affected by substance abuse, child welfare workers can use a variety of strategies to help meet parents' needs while also promoting safety, permanency, and well-being of their children. To begin, workers need to build their understanding of parental substance use issues, its signs, the effects on parenting and child safety, and what to expect during a parent's treatment and recovery. Specific casework practice strategies reflect:

Family engagement. Engagement strategies that help motivate parents to enter and remain in substance abuse services are critical to enhancing treatment outcomes (Wisdom, Pollock, & Hopping-Winn, 2011). An essential part of this process is partnering with parents to develop plans that address individual needs, such as a woman's own trauma history, as well as needs for support services like child care and transportation. Child welfare workers can help create supportive environments, build nonjudgmental relationships, and implement evidence-based motivational approaches, such as motivational interviewing.³

Routine screening and assessment. Screening family members for possible substance use disorders with the use of brief, validated, and culturally appropriate tools should be a routine part of child welfare investigation and case monitoring. Once a substance use issue has been identified through screening, alcohol and drug treatment providers can conduct more indepth assessments of its nature and extent, the impact on the child, and recommended treatment. Find more information on screening tools and collaborative strategies:

- *Screening and Assessment for Family Engagement, Retention and Recovery* at <http://www.ncsacw.samhsa.gov/files/SAFERR.pdf>
- *Protecting Children in Families Affected by Substance Use Disorders* at <https://www.childwelfare.gov/pubs/usermanuals/substanceuse/chapterfour.cfm>

Individualized treatment and case plans. Caseworkers can help match parents with evidence-based treatment programs and support services that meet their specific needs. Working collaboratively with families, alcohol and drug treatment professionals, and the courts, caseworkers can help develop and coordinate case and treatment plans.

Support of parents in treatment and recovery. Child welfare workers can support parents in their efforts to build coping and parenting skills, help them pay attention

to triggers for substance-using behaviors, and work collaboratively on safety plans to protect children during a potential relapse (Breshears, Yeh, & Young, 2009). Workers also can help coordinate services, make formal and informal connections, and encourage parents in looking forward to their role as caregivers (DiLorenzo, 2013).

Providing services for children of parents with substance use issues. Given the developmental and emotional effects of parental substance abuse on children and youth in child welfare, it is important that child welfare workers collaborate with behavioral/mental health professionals to conduct screenings and assessments and link children and youth to appropriate, evidence-based services that promote wellness. Individualized services should address the child or youth's strengths and needs, trauma symptoms, effects associated with prenatal or postnatal exposure to parental substance use, and risk for developing substance use disorders themselves.

Permanency planning. ASFA and treatment timeframes become significant considerations in permanency plans and reunification goals in families affected by substance abuse. Concurrent planning, in which an alternative permanency plan is pursued at the same time as the reunification plan, can play an important part in ensuring that children achieve permanency in a timely manner. For instance, guardianship by a relative or adoption by foster parents might be the concurrent goal if family reunification is not viable. (For more information, read Information Gateway's *Concurrent Planning: What the Evidence Shows* at https://www.childwelfare.gov/pubs/issue_briefs/concurrent_evidence/.)

For child welfare training and other resources related to improving the safety, permanency, well-being, and recovery outcomes for children and families, visit the NCSACW website at <https://www.ncsacw.samhsa.gov>.

Systems Change and Collaboration

Since the late 1990s, systems-level collaboration and service integration strategies have been increasingly implemented to coordinate services from child welfare, treatment, dependency courts, and other service systems for families affected by substance use. Communication

³ For general information about motivational interviewing, visit <http://motivationalinterview.org/>; see also the Rocky Mountain Quality Improvement Center's Pre-Treatment Program Curriculum Guide: Motivational Interviewing at <http://www.americanhumane.org/assets/pdfs/children/pc-rmqic-ptp-guide.pdf>.

and active collaboration across systems help ensure that parents in need of substance abuse treatment are identified and receive appropriate treatment in a timely manner, while children's intervention needs are also addressed. To meet complex needs, collaborative practice provides access to a wider array of resources than is traditionally available from an individual system (Children and Family Futures, 2011). Collaborative and integrated strategies have shown promising results—women remain in treatment longer, are more likely to reduce substance use, and are more likely to remain or reunite with their children (HHS, 2014; Marsh & Smith, 2011).

Family treatment drug courts (also known as family drug courts and dependency drug courts) represent a cross-system approach with demonstrated success. These courts use judicial system authority and collaborative partnerships to support timely substance abuse treatment for parents, provision of a wide range of services for families, and monitoring of recovery components. Evaluations have linked these courts with improvements in treatment enrollment, treatment completion, and family reunification (Marlowe & Carey, 2012). The following websites provide additional information:

- Learn more about existing family treatment drug court programs at <https://www.ncsacw.samhsa.gov/resources/resources-drug-courts.aspx>.
- Find guidelines to develop or enhance drug court programs in *Guidance to States: Recommendations for Developing Family Drug Court Guidelines*, available from <http://www.cffutures.org/files/publications/FDC-Guidelines.pdf>.

Examples of other cross-systems changes to overcome traditional “siloeed” approaches include:

Cross-training of child welfare and substance abuse treatment professionals to build an understanding of each other's systems, legal requirements (e.g., ASFA), goals, approaches, and shared interests

Collocation of substance abuse specialists in child welfare offices to assess and engage parents, provide services to families, and offer training and consultation

Program Highlight: King County Family Treatment Court

Begun in 2004, Washington State's King County Family Treatment Court was designed to improve the safety and well-being of children in child welfare by providing parents with access to drug and alcohol treatment, judicial monitoring, and individualized services. Program components include early intervention, comprehensive services for the entire family, and a holistic approach to strengthening family functioning. A quasi-experimental evaluation found that, compared to parents served by a regular dependency court, family treatment court parents entered treatment sooner and were more likely to successfully complete treatment. In addition, children in the family treatment court group spent less time in out-of-home care and were more likely to permanently reunite with their parents (Bruns, Pullman, Weathers, Wirschem, & Murphy, 2012). For more information, visit <http://www.kingcounty.gov/courts/JuvenileCourt/famtreat.aspx>.

services to child welfare workers (see *Substance Abuse Specialists in Child Welfare Agencies and Dependency Courts Considerations for Program Designers and Evaluators*, <http://www.ncsacw.samhsa.gov/resources/resources-Substance-Abuse-Specialists.aspx>)

Cross-system partnerships, based on shared principles that ensure coordinated services through formal linkages (such as interagency agreements) between child welfare, treatment, and other community agencies

Cross-system information sharing related to screening and assessment results, case plans, treatment plans, and progress toward goals, which can support professionals in each system to make informed decisions, while still adhering to confidentiality parameters (see <https://www.ncsacw.samhsa.gov/resources/information-sharing.aspx>)

Joint planning and case management to help safeguard against parents becoming overwhelmed by multiple and potentially conflicting requirements of different systems

Wraparound and comprehensive community services that address multiple service needs of parents and children, including those related to parenting skills, mental health, health, domestic violence, housing, employment, income support, education, and child care

Flexible financing strategies that leverage or combine various funding streams to address the needs of substance abuse treatment for families involved in child welfare

Linked data systems that track progress toward shared system objectives and achievement of desired outcomes while also promoting shared accountability

For more information on collaborative practices and tools, see these NCSACW resources:

- *The Collaborative Practice Model for Family Recovery, Safety and Stability*, at <http://www.cffutures.org/files/PracticeModel.pdf>
- Webpages related to In-Depth Technical Assistance (IDTA), at <https://www.ncsacw.samhsa.gov/technical/idta.aspx>

Grant Programs

The Children's Bureau has funded several discretionary grant programs that support demonstration projects with the goal of improving outcomes for children and families in which one or more parents have a substance use problem. Recent grant programs include:

Regional Partnership Grants (RPGs) to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Substance Abuse. Since 2012, 70 grants⁴ have been awarded to regional partnerships nationwide to foster cross-system collaboration and service integration for families with children who are in or at risk of entering foster care as a

⁴ Authorized by the Child and Family Services Improvement Act of 2006, the Children's Bureau awarded 53 first round RPGs. The Child and Family Services Improvement and Innovation Act of 2011 reauthorized the program (dropping the earlier focus on methamphetamine abuse) and enabled the funding of 17 new second round RPGs and 2-year extensions for 8 first round grants.

result of a parent's substance abuse. The grants address common challenges, such as engagement and retention of parents in treatment, service shortages, and conflicting approaches and timeframes across systems. Evaluation findings show evidence of enhanced collaboration and changed practice models, improvements in parental capacity to care for children, and promising results for safety, permanency, and child and family well-being (DeCerchio, Rodi, & Stedt, 2014). (For more information, visit <https://www.ncsacw.samhsa.gov/technical/rpg-i.aspx>.)

Comprehensive Support Services for Families Affected by Substance Abuse and/or HIV/AIDS. Authorized by the Abandoned Infants Assistance Act, these grants offer services to support infants and young children who have been exposed to a dangerous drug or HIV/AIDS and are at risk of out-of-home placement. Services provided to children and their caregivers include prevention and early intervention services, family-based substance abuse treatment, child and family counseling, referrals to mental health services, and parenting skills training. (For more information, visit <http://aia.berkeley.edu/aia-projects/general-information/>.)

Family Connection Grants: Comprehensive Residential Family Treatment Projects. Part of a larger cluster of demonstration grants to help reconnect family members with children in or at risk of entering foster care, these projects provide services for chemically dependent women, their children, extended family members, and partners. Services include intensive substance abuse treatment, mental health and health services, parenting skills, employment support, child care, and other services that support comprehensive family needs.

In addition, a few Children's Bureau **title IV-E child welfare waiver demonstration projects** have provided opportunities to develop and test innovative substance abuse interventions. For example, Illinois and Oregon have implemented mentoring and coaching programs for parents in child welfare in need of substance abuse treatment. Previous projects in Delaware and New Hampshire colocated substance abuse counselors within child welfare agencies. (For information on child welfare

waivers, see http://www.acf.hhs.gov/sites/default/files/cb/waiver_profiles_vol1.pdf.)

SAMHSA also funds grant programs with the goal of enhancing services and improving outcomes for families affected by parental substance abuse. Recent programs include **Services Grant Program for Residential Treatment for Pregnant and Postpartum Women** and **Grants to Expand Services to Children Affected by Methamphetamine in Families Participating in Family Treatment Drug Court** (see <https://www.ncsacw.samhsa.gov/technical/cam.aspx>).

Conclusion

As new demonstration and innovation projects continue to be implemented, expanded, and evaluated, the field continues to learn more about promising and effective approaches to holistically address the complex needs of families with substance use issues. In particular, there is a continuing call for and movement toward enhanced collaboration among child welfare, substance abuse treatment, courts, and other systems to provide coordinated and comprehensive services to both children and their parents. Further, the use of enhanced and linked information systems will improve the collective ability to track and share the results of collaborative efforts to achieve better outcomes for these families and children.

Resources for Further Information

- Child Welfare Information Gateway
<https://www.childwelfare.gov/systemwide/substance/>
- Children and Family Futures
<http://www.cffutures.org/>
- National Abandoned Infants Assistance Resource Center
<http://aia.berkeley.edu>
- National Center on Substance Abuse and Child Welfare
<https://www.ncsacw.samhsa.gov/>
- National Institute on Drug Abuse
<http://www.nida.nih.gov>

- National Registry of Evidenced-Based Programs and Practices
<http://www.nrepp.samhsa.gov/>
- Substance Abuse and Mental Health Services Administration
<http://www.samhsa.gov/>

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U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau



Family-Centered Treatment for Women with Substance Use Disorders – History, Key Elements, and Challenges

As part of its commitment to ensure that people have access to effective treatment and supportive services that promote their recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) has prepared two papers on family-centered treatment for women with substance use disorders. *Family-Centered Treatment for Women with Substance Use Disorders – History, Key Elements and Challenges* introduces, defines, and discusses the concepts and implementation challenges of an evolving family-centered treatment approach for women with substance use disorders. The companion paper, *Funding Family-Centered Treatment for Women with Substance Use Disorders*, identifies and discusses potential sources of funding for comprehensive family-centered treatment, and provides suggestions for how States and substance abuse treatment providers can strengthen their overall financing strategies.

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

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Module 2

Family-Centered Care

Training Goals and Objectives

Help programs learn the intricacies and philosophy of family-centered care so they can apply its principles to their work.

By the end of this module, participants will be able to:

1. Demonstrate understanding of family-centered, recovery and wellness principles.
2. Identify family and staff outcomes of family-centered care.
3. Analyze how the principles of the family-centered, recovery and wellness approach were applied to a program in California.
4. Examine application of family-centered, recovery and wellness principles in your own work.



Easier Together:
Partnering with Families to
Make Recovery Possible



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Please complete checklist:
“Is it Family-Centered Care?”
Pages 67-68 in participant manual



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Module 2: Family-Centered Care

- More about family-centered care
- “Bring Them All” documentary discussion

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Kathryn Icenhower, PhD
CEO and Co-founder

SHIELDS for Families
Compton, CA

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Introductions

- ▶ Name
- ▶ Where you were born

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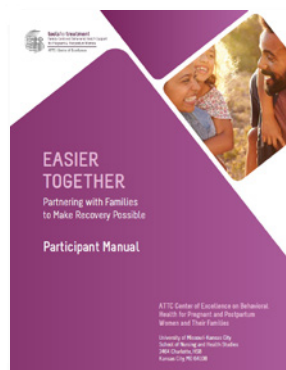


Hands-On Review of Participant Manual

▶ Participant Manual

Each module contains:

- Training goals and objectives
- Copy of slides
- Resources – worksheets, activities, assessments, recommended reading
- Reference list



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Visit www.attcppwtools.org for More Resources

- ▶ Training Curriculum
- ▶ Online Courses
- ▶ 300+ Program Resources Library
- ▶ Recorded Presentations
- ▶ Videos



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Goal and Objectives

Goal: Help programs learn the intricacies and philosophy of family-centered care so they can apply its principles to their work.

Objectives: Participants will be able to:

- ▶ Demonstrate understanding of family-centered, recovery and wellness principles.
- ▶ Identify family and staff outcomes of family-centered care.
- ▶ Analyze how the principles of the family-centered, recovery and wellness approach were applied to a program in California.
- ▶ Examine application of family-centered, recovery and wellness principles in your own work.

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Family-Centered Care and Culture

Aren't we already doing it?



Diana Kramer, MA, BHT
SAMHSA PPW Program Manager
Native American Connections
Phoenix, AZ



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The Culture Conversation



**The Family
as a Mobile**



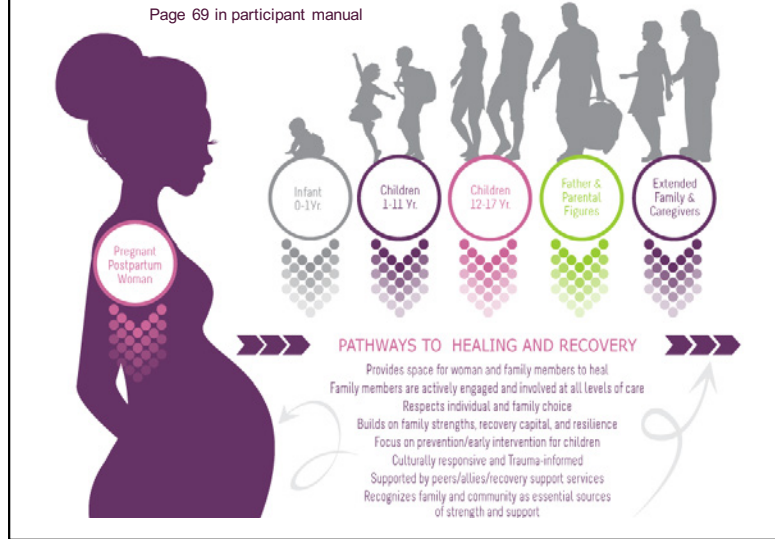
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Pages 70-71 of participant manual

Family-Centered, Recovery & Wellness Principles

Page 69 in participant manual



Core Principles of Family-Centered Care, Recovery, and Wellness

- Provides space for family healing
- Family members are actively engaged
- Respects individual and family choice
- Builds on family strengths
- Focus on prevention/early intervention for children
- Culturally responsive and trauma-informed
- Supported by peers/allies/recovery support services
- Recognizes family and community are essential sources of strength and support

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Outcomes of Family-Centered Care, Recovery, and Wellness

► Family Outcomes

- Focus on (re)building a life in the community
- Improve client and family engagement
- Promote recovery, health and well-being
- Address psychosocial and developmental needs of children
- Increase client and family satisfaction
- Build family and community strength
- Activated clients

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Outcomes of Family-Centered Care, Recovery, and Wellness

► Staff Outcomes

- Stronger partnership with client/family
- Increased understanding of families' and communities' recovery capital
- Improved care planning
- Improved communication with clients, coworkers, and partner organizations
- Reduced burnout
- Stronger linkages/partnerships with the natural supports in the community

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www.BringThemAll.org

BRING

— them all —

A FAMILY-CENTERED APPROACH TO ADDICTION TREATMENT

[Link to Video](#)

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Tying it all Together:
Family-Centered Care Principles
and “Bring Them All”

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Discussion

- ▶ What are your first impressions after watching that?
- ▶ What did you learn about family-centered care that surprised you?

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Discussion

- ▶ **Family-Centered Principle:** Family members are actively engaged and involved at all levels of care
- ▶ What are some examples from the documentary of this principle in action?

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Discussion

Please turn to your completed “Is it Family-Centered Care?” checklist on pages 67-68 of the manual.

- ▶ How does your agency compare to the family-centered items on the checklist?
- ▶ How are your current program approaches similar and/or different to what you saw in the documentary?

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Discussion

- ▶ The documentary showed an approach that works for families in Compton, CA.
- ▶ In a perfect world, what adaptations would you make in your program or community to better serve the needs of its families?

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Tales from the Field



Kimberly Craig, BA, BS, LSAT
CEO, CHEEERS Recovery Center
Former PPW grantee
Phoenix, AZ



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Wrap-Up






Next Modules

- ▶ **Module 3:** Building Programs for Fathers
- ▶ **Module 4:** Implementing Family-Centered Programming
- ▶ **Module 5:** Family-Centered Clinical Interventions
- ▶ **Module 6:** Case-Based Application

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Module 2

Resources

Is It Family-Centered Care?

Instructions: Review the items below and check each box if your program does it (or connects clients with a partnering agency that does it).

Does your program include:

- ☐ Comprehensive services including addiction treatment, child development services, youth development services, educational and vocational services, medical services, legal services, transportation, and housing?
- ☐ Services to the whole family as defined by the client and by the treatment process?
- ☐ Family-wide assessments whereby each family member is assessed and then paired with appropriate programs and services?
- ☐ Family-wide treatment plans where the client and multidisciplinary team of staff members from each program component create the plan to address the needs of the entire family with equal emphasis on the children as on the mother/parent?
- ☐ Developmentally appropriate services and programs for children and youth with child development experts who ensure that child and youth developmental needs are recognized and addressed alongside parent's treatment needs? This is NOT childcare.
- ☐ Case conferences where the progress of clients and families is monitored at least monthly by a multidisciplinary team of staff members from each program component?
- ☐ Parenting classes and structured support/learning opportunities that include classroom lessons, hands-on training, and coaching on attachment/bonding, parenting, and household operation matters?
- ☐ Individual and family therapy for all family members?
- ☐ Housing: an environment for learning and support where families can be together and learn to live a drug- and alcohol-free life?
- ☐ Educational and vocational services that develop parents so they can become providers?
- ☐ A reunification mission so that parents are provided with the support, education and resources to create a healthy family and home environment including working with child welfare or child protective services with parent in cases where child has been removed in order to reunite parent and child?
- ☐ Culturally competent services where staff reflect the culture and race of the people served and the cultural orientation of clients is integrated into the organization and program components?

- ☐ Strong community partnerships with child welfare, school districts, social services, local attorneys, educational institutions, and business (potential employers)?
- ☐ Opportunities to develop client leadership through structures such as Client Councils that formulate some of the program policies relating to daily client procedures and rules, address issues of cultural sensitivity and program responsiveness, and have the power to make changes?
- ☐ An organizational culture that feels like family, where policies model to both staff and clients that relationships matter, making them feel they are cared for and have opportunities for growth?

(Adapted from SHIELDS for Families Exodus Program Replication Manual, p. 41-51)

FAMILY-CENTERED, RECOVERY AND WELLNESS PRINCIPLES



The Culture Conversation (Module 2)

Background:

SAMHSA shares with us: Across cultures, the family unit is recognized as the cornerstone of society. Families serve as the basis for most households, as economic units, as well as providing child-rearing, human interactions, and cultural traditions. Yet, families are complex in their definitions, roles, responsibilities, and interactions. In “What Is a Family?” Edith Schaeffer (2001) compares the family with a mobile. She writes:

What is a family? A family is a mobile. A family is the most versatile, ever-changing mobile that exists. A family is a living mobile that is different from the handcraft mobiles and the art-museum mobiles. . . . A family is an intricate mobile made up of human personalities. . . . A mobile is a moving, changing collection of objects constantly in motion, yet within the framework of a form. The framework of a family gives form. . . . A family is a grouping of individuals who are affecting each other intellectually, emotionally, spiritually, physically, psychologically. No two years, no two months, or no two days is there the exact same blend or mix within the family, as each individual person is changing. If people are developing in a variety of creative areas, coming to deeper understanding spiritually, adding a great deal of knowledge in one area or another, living through stimulating discoveries of fresh ideas or skills—they are affecting each other positively. . . . mobiles that can reproduce. constantly changing patterns, affected by each other, inspired by each other, helped by each other. (pp. 17–22)

Substance use by one family member affects the whole family mobile. When a parent has a substance use disorder, it can corrupt the harmonious spinning of all of the parts, break some of the strings that tie the mobile together, and fracture individual sculptures as they fall. Substance use disorders are family diseases because there can be an intergenerational transmission that affects the entire family unit and its individual members. Family-centered care promotes the delivery of comprehensive services that can transform these families into healthy, functioning entities that can raise children, reach their economic goals, and support the wellbeing of all members. Family-centered care offers a solution to the intergenerational cycle of substance use and related consequences by helping families reduce substance use and improve child health and safety.

The Culture Conversation:

Families are diverse in landscape, constantly in flux, and dynamic in nature. Culturally, it is important to understand that all families are not the same. There may be acknowledgment of this concept, however, looking at the levels within these cultural constructs takes us to the depths of levels within the families and populations we work and serve.

For example:

- Individualistic and Collective cultures/families
- Mainstream and Non-Mainstream cultures/families
- Nuclear and Extended Family cultures/families
- Multi-generational cultures/families within one house

Special Populations:

Family-centered care offers whole family services that build on family members' strengths to improve family management and functioning. The family-centered care process offers families a structure for interactions that aids in role identification, boundary clarification, and addressing external stressors and areas of concern. The role of service providers is not to “fix” the family but to address the whole family system and assist members in developing the communication, power, boundaries, roles, flexibility, and cohesion they need to create a healthy family ecosystem. These activities involve developing successful family coping strategies—assisting families in identifying and responding (rather than reacting) to the effect of transitions.

Next Steps:

There are no assumptions to make and there are no judgements to establish. It is defining with the individual who and what family is and means to them. It is having the conversation from their perspective and working from there. Defining the family is the beginning of family-centered care.

Reference:

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



A FAMILY-CENTERED APPROACH TO ADDICTION TREATMENT

A look inside the family recovery journey

The ATTC Center of Excellence on Behavioral Health for Pregnant and Postpartum Women and Their Families (ATTC CoE-PPW) produced a documentary as part of its curricula development to promote a family-centered approach to treatment and recovery. “Bring Them All” tells the story of family-centered care through the perspectives of clients and staff at SHIELDS for Families, a treatment program in Compton, CA. A pioneer in this model of care, Co-founder and CEO Kathryn Icenhower, PhD and her team describe what it’s like to work in a program that lets women bring their whole family, including fathers/partners and children, to experience the recovery journey as a family. In addition to the short documentary, five vignettes were produced to provide additional information on these topics: Empowering Parents, How They Did It: Building a Family-Centered Program, Partnering with Child Welfare, Services for Children, and Services for Fathers & Partners.

Learn more at

BringThemAll.org



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IBKIMAGES

Discussion Questions for “Bring Them All: A Family-Centered Approach to Addiction Treatment”

1. What are your first impressions after watching that? What did you learn about family-centered care that surprised you?
2. Family-Centered Principle: “Family Members are actively engaged and involved at all levels of care.” What are some examples from the documentary of this principle in action?
3. Please turn to your completed “Is it Family-Centered Care?” checklist. How does your agency compare to the family-centered items on the checklist? How are your current program approaches similar and/or different to what you saw in the documentary?
4. The documentary showed an approach that works for families in Compton, CA. In a perfect world, what adaptations would you make in your program or community to better serve the needs of its families?



Module 3

Building Programs for Fathers

Training Goals and Objectives

Help programs begin to meet expectations for programming that addresses the needs of fathers/male partners and co-parents.

By the end of this module, participants will be able to:

1. Explain why engaging fathers is important.
2. Describe the evidence base for involving fathers, male co-parents, and male partners.
3. List considerations and cautions when developing programming.



Easier Together:
Partnering with Families to
Make Recovery Possible



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**Please complete questionnaire:
“What do we know about men as
partners and parents?”**

What Do We Know about Men as Partners and Parents?
HANDOUT

Please choose the best answer for each question: (These will not be handed in)

Item #1: Among couples with a substance use problem, satisfaction with an intimate partnership is lowest when both partners are actively using alcohol or drugs.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #2: Most fathers with a substance use problem have not made much of an effort to parent their children in a socially responsible manner.


☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #3: The single best predictor of the quality of men's relationship with their children is their employment status.


☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Pages 92- 93 in participant manual

Module 3: Building Programs for Fathers



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Acknowledgements



Thomas McMahon, PhD
Yale University
School of Medicine

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Introductions

- ▶ Name
- ▶ Field
- ▶ One word to describe “father”

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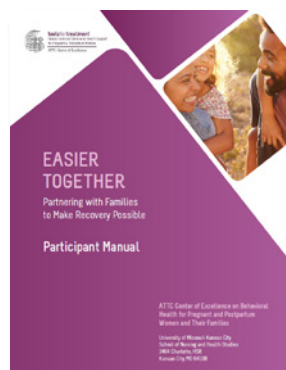


Hands-On Review of Participant Manual

▶ Participant Manual

Each module contains:

- Training goals and objectives
- Copy of slides
- Resources – worksheets, activities, assessments, recommended reading, reference list



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Visit www.attcppwtools.org for More Resources

- ▶ Training Curriculum
- ▶ Online Courses
- ▶ 300+ Program Resources Library
- ▶ Recorded Presentations
- ▶ Videos



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Goal and Objectives

Goal: Help programs begin to meet expectations for programming that addresses the needs of fathers/male partners and co-parents.

Objectives: Participants will be able to:

- ▶ Explain why engaging fathers is important.
- ▶ Describe the evidence base for involving fathers, male co-parents, and male partners.
- ▶ List considerations and cautions when developing programming.

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New PPW Goals

► From Purpose (2017 FOA p.5)

"...Services should be extended, when deemed appropriate, to **fathers** of the children..."

► From Required Activities (2017 FOA p.7)

"Implement service(s) or practice(s), including strategies to stabilize, strengthen, preserve, and reunite families, for the women, their minor children, **fathers of the children...**"

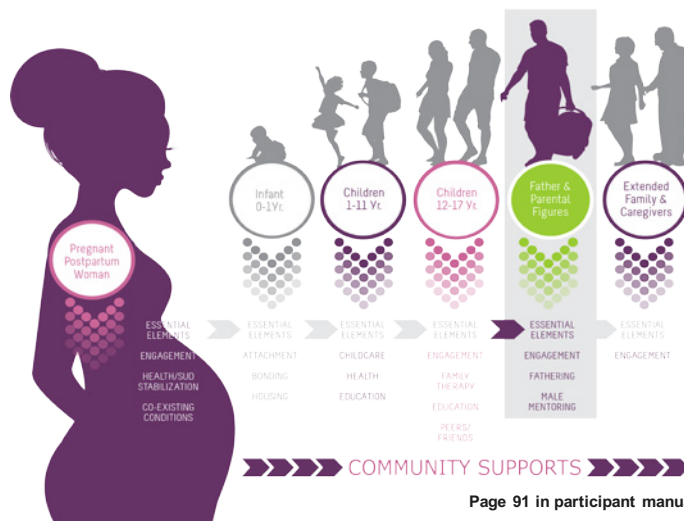
► From Purpose (2017 FOA p.5)

"Increase the number of fathers reunited with their children... Increase the number of individualized/family service plans that include engagement and active involvement of fathers of the children..."


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FAMILY-CENTERED, RECOVERY AND WELLNESS APPROACH

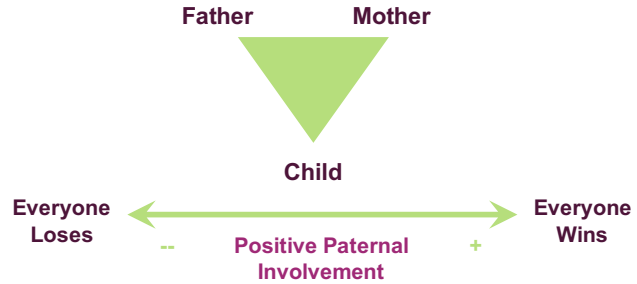


Page 91 in participant manual



Why Engage Fathers?

Father Mother




Child

Everyone Loses Positive Paternal Involvement Everyone Wins

Page 96 in participant manual for benefits of including fathers

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Where to Begin?

Values, Stereotypes, Stigma

- ▶ Dispensable
- ▶ Disinterested
- ▶ Irresponsible
- ▶ Incompetent
- ▶ Dangerous

- *Throwaway Dads* (Parke & Brott, 1999)

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Tales from the Field



Kimberly Craig, BA, BS, LSAT
CEO, CHEEERS Recovery Center
Former PPW grantee, Phoenix, AZ

"Men were often viewed as so dangerous to women seeking services that we didn't allow them to enter the campus of a residential treatment program, regardless as to whether or not there was a history that supported the concern..."

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**What do we know
about fathers that has
implications for treatment?**

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About Fathers

- ▶ Fathering is a developmental concern for men.
- ▶ Fathering affects the behavioral health of men and the behavioral health of men affects fathering.
- ▶ Men have less social support for fathering than women do for mothering.

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About Fathers Cont.

- ▶ Fathering is vulnerable to:
 - The quality of the co-parenting relationship(s),
 - Employment status of the father, and
 - The biological status of the child.
- ▶ Absent fathers are often more present than policymakers and providers believe.
- ▶ Human service systems more actively engage women in their roles as mothers than they engage men in their roles as fathers.

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Activity - Questionnaire

► On pages 108-115 in the participant manual are the answers to the **“What do we know about men as partners and parents?”** questionnaire you filled out at the start of our session.

- *How did your answer compare?*
- *Which of these answers do you think programs find most surprising?*

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Tales from the Field



Kimberly Craig, BA, BS, LSAT
CEO, CHEEERS Recovery Center
Former PPW grantee, Phoenix, AZ

“What if we made no assumptions or judgments regarding men who are not currently parenting their children? What if we approached all men with the same unconditional positive regard we have extended women for years? Would it change things in our program?”

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Services for Fathers and Partners



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Activity

Group 1: What were your thoughts as you listened to the staff perspectives about including fathers/partners in their program?

Group 2: If these staff members spent a few days observing your program, what would the procedures and language of your program reflect about the attitudes toward the fathers?

Jot down 3-5 key words and be prepared to explain them when timer goes off.


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Considerations and Cautions: Things to Keep in Mind Regarding Interventions and Materials

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General Considerations

- ▶ Clarify risk and create safe environments
- ▶ Couples → Co-Parenting → Parenting → Family
- ▶ Group vs. individual format
- ▶ Specific, realistic goals

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General Considerations Cont.

- ▶ Traditional masculine ideology (see page 97 of participant manual)
- ▶ Ghosts from the past
- ▶ Guilt and shame
- ▶ Relational vs. behavioral focus
- ▶ Cultural considerations

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Consider Prior to Implementation

- ▶ Political ideology
- ▶ Secular focus
- ▶ Cost
- ▶ Training
- ▶ Efficacy
- ▶ Effectiveness

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The Culture Conversation



- Removing barriers to care
- Increasing successful engagement
- Culturally adaptive services
- Recovery does not only occur with the individual in treatment

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See page 94 of participant manual



Wrap-Up





Next Modules

- ▶ **Module 4:** Implementing Family-Centered Programming
- ▶ **Module 5:** Family-Centered Clinical Interventions
- ▶ **Module 6:** Case-Based Application

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References

For complete reference list, please
see pages 168-171 in Participant
Manual.

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Module 3

Resources

FAMILY-CENTERED, RECOVERY AND WELLNESS APPROACH



What Do We Know about Men as Partners and Parents?

HANDOUT

Please choose the best answer for each question: (These will not be handed in)

Item #1: Among couples with a substance use problem, satisfaction with an intimate partnership is lowest when both partners are actively using alcohol or drugs.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #2: Most fathers with a substance use problem have not made much of an effort to parent their children in a socially responsible manner.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #3: The single best predictor of the quality of men's relationship with their children is their employment status.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #4: A significant proportion of intimate partner violence is reciprocal in nature.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #5: Mothers and fathers generally agree in their report of paternal involvement.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #6: When men are actively involved in fathering in a positive manner, it is the child who usually benefits.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #7: Most children living in the same household as a substance-abusing parent are living with a substance-abusing mother rather than a substance-abusing father.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #8: Substance-abusing men are not able to establish a secure attachment with their children.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #9: Family transitions are associated with changes in substance use by men.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #10: Many low-income pregnant and parenting women are reluctant to involve their intimate or sexual partner in their treatment as they enter systems of care because of concern about legal sanctions pending against their male partner.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #11: Incarceration is a major threat to the stability of low-income families.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #12: Although common among women, postpartum depression in men is very rare.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #13: Our systems of care more effectively engage women in their role as mothers than men in their role as fathers.

☐ Definitely True ☐ Probably True ☐ Probably False ☐ Definitely False

Item #A: Substance abuse treatment programs for pregnant and parenting women should better engage fathers.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

The Culture Conversation (Module 3)

Background:

Historically, the literature outlines barriers to inclusion for various groups who are less likely to access services. With a focus on parents this may include: fathers, disabled parents, parents of teenagers, minority ethnic families, asylum-seeking parents, homeless or peripatetic families, and rural families (Katz, La Placa, & Hunter, 2007).

The Culture Conversation:

The hope of family-centered care is to increase inclusion of partners/fathers. We aim to remove the following barriers to care:

- Stigma
- Biases
- Cultural misconceptions
- Labeling of parents
- Defining family systems through our/practitioner lens vs. the family/parents/fathers lens

We know recovery is not just about the individual in treatment—it also is about the family/partners/fathers. As the individual in treatment heals, they must establish new ways of communicating in healthy approaches for their family and partnerships. As a result, the natural step is inclusion of the partners/fathers in treatment to allow for a sharing of activities in healthy ways. In addition, it is the identification of unhealthy partners/fathers in their lives. Through treatment planning and activities, clients can work on better ways to manage these individuals.

Special Populations/Next Steps:

The focus is on successful engagement and inclusion of culturally responsive/adaptive services for individuals, families, and fathers. The role of the partner/father has different meanings in every family and culture. Simply by listening to the story of the individual and working with them, we take the steps toward more inclusive services.

References:

<https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/barriers-inclusion-parents.pdf>
<https://store.samhsa.gov/shin/content//SMA14-4126/SMA14-4126.pdf>

Potential Benefits of Fathering

Research done from several different perspectives indicates that there are potential benefits for children, mothers, and fathers associated with the men being actively involved in the social, academic, and emotional lives of their children. Most of the potential benefits for children, mothers, and fathers are listed below.

It is important to note that it is very difficult to untangle cause and effect relationships in much of this research, and there are some unanswered questions about the potential benefits of fathering for mothers, fathers, and children. For example, some of the advantages for children may be attributed directly to the presence of a father, some of the advantages may be attributed more generally to the presence of two adults in a household, and some of the advantages may be attributed to the indirect effect of fathering on children through support of mothering.

Although men have much more to offer as fathers, some of the potential benefits may follow from the financial support involved fathers provide which may have indirect effects on other aspects of family life that represent potential benefits for mothers and children.

Finally, it is important to note that some of the advantages for fathers and children may be attributed, at least in part, to the common genetic heritage fathers share with their children. Genetic heritage may create common advantages for both fathers and children because father and child share characteristics known to be influenced in complex ways by genetics.

Potential Benefits for Children	Potential Benefits for Mothers	Potential Benefits for Fathers
Emotional and Social development More emotional security More confidence to explore their environment More age-appropriate independence More sociability Better emotional control Better behavioral control More flexible gender roles Later first sexual activity Better physical health Less disruptive behavior Less anxiety Less substance use	More stable employment More job satisfaction More self esteem Greater sense of competence More satisfaction with life More financial support More support with child care More help with household tasks Better marital-partner relationship Better co-parenting relationship Better mother-child relationship	More stable employment More job satisfaction More income More self esteem Greater sense of competence More satisfaction with life More social support More community involvement Better marital-partner relationship Better co-parenting relationship Better father-child relationship
Cognition and Educational Achievement Better language skills Better problem-solving skills Better school readiness Better school behavior Higher academic achievement Less school failure Better vocational development	Better relations with extended family More effective parenting More optimism Less financial stress Less parenting stress Less depression Less anxiety	Better relations with extended family Better physical health Less guilt Less shame Less depression Less substance use

References:

- Sarkadi, A., Kristiansson, R., Oberklaid, F., & Bremberg, S. (2008). Fathers' involvement and children's developmental outcomes: a systematic review of longitudinal studies. *Acta Paediatrica*, 97(2), 153-158.
- Allen, S. & Daly, K. (2007). *The effects of father involvement: An updated research summary of the evidence inventory*. Guelph, Ontario, Canada: University of Guelph Centre for Families, Work, and Well-Being
- Eggebeen, D. J., & Knoester, C. (2001). Does fatherhood matter for men?. *Journal of Marriage and Family*, 63(2), 381-393.

On Men and Masculinity

Although scholars agree that there is no single definition of masculinity, they also agree that there are commonly accepted values, attitudes, and standards that are endorsed to a different degree by men depending on their age, ethnicity, socioeconomic status, geographic location, work setting, sexual orientation, and other characteristics.

Two researchers, Ronald Levant and James Mahalik, have developed measures designed to document the degree to which men and women endorse common male gender role norms. The labels for the dimensions of these two conceptualizations of masculinity ideology are listed below. What would they mean for you in terms of your understanding of commonly held beliefs about men and masculinity?

Male Role Norms (Levant, Rankin, Williams, Hasan, & Smalley, 2010)	Masculine Norms (Mahalik et al., 2003)
<ul style="list-style-type: none"> • Avoidance of Femininity • Negativity Toward Sexual Minorities • Self-Reliance • Toughness • Dominance • Importance of Sex • Restrictive Emotionality 	<ul style="list-style-type: none"> • Winning • Emotional Control • Risk-Taking • Violence • Dominance • Playboy • Self-Reliance • Primacy of Work • Power Over Women • Disdain for Homosexuals • Pursuit of Status

References

- Levant, R. F., Rankin, T. J., Williams, C. M., Hasan, N. T. B. (2010). Evaluation of the factor structure and construct validity of scores on the Male Role Norms Inventory-Revised (MRNI-R). *Psychology of Men & Masculinity*, 11(1), 25
- Mahalik, J. R., Locke, B. D., Ludlow, L. H., Diemer, M. A., Scott, R. P., Gottfried, M., & Freitas, G. (2003). Development of the Conformity to Masculine Norms Inventory. *Psychology of Men & Masculinity*, 4(1), 3-25.

Resources

- Levant, R. F. (2011). Research in the psychology of men and masculinity using the gender role strain paradigm as a framework. *American Psychologist*, 66(8), 765-776.
- Mahalik, J. R., Talmadge, W. T., Locke, B. D., & Scott, R. P. (2005). Using the Conformity to Masculine Norms Inventory to work with men in a clinical setting. *Journal of Clinical Psychology*, 61(6), 661-674.
- Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*, 58(1), 5-14.



FATHER-FRIENDLINESS ORGANIZATIONAL SELF-ASSESSMENT AND PLANNING TOOL

This self-assessment package can help Head Start and other family service programs assess their organization's readiness to provide services to fathers and father figures. It was developed by:

**The National Center for Strategic Nonprofit Planning and Community
Leadership (NPCL)**

In Partnership With

**The National Head Start Association (NHSA)
The U.S. Dept. of Health and Human Services Administration for Children
and Families, Region V
The Illinois Department of Public Aid, Division of Child Support
Enforcement**

There are three parts to the self-assessment package:

- ◆ Organizational Self-Assessment
- ◆ Action Plan for Becoming More Father Friendly
- ◆ Feedback on Usefulness of Tool.

NHSA and NPCL are FATHERHOOD PARTNERS

We are working in partnership to develop and enhance the provision of fatherhood services by Head Start agencies. The goal is to create an environment where staff, mothers, and fathers respect each other's roles, work together, and collaborate with other community organizations to ensure the availability of comprehensive services that support the role of fathers in the lives of their children. We do this in order to promote and enhance the well-being of every child.

For more information, contact:

**Nigel Vann, NPCL's Director of Partnership Development, at (202) 822-6725
JoAnn Nelson-Hooks, NHSA's Fatherhood Coordinator, at (703) 739-7560.**



FATHER-FRIENDLINESS ORGANIZATIONAL SELF-ASSESSMENT AND PLANNING TOOL

Directions:

- ◆ Select a team or committee to complete the self-assessment. Ideally this team will include at least one decision-maker, various staff levels, and mothers and fathers of children in the program.
- ◆ The team will consider seven categories — Organizational Support; Position and Reputation in the Community; Agency Policies and Procedures; Staffing/Human Resources; Program Services; Physical Environment; and Communication and Interaction. Use the following scale to rate your organization for each of the statements included in the assessment:

1 = Haven't even thought about this/completely disagree with statement.
2 = We've started to think about this but haven't made much progress.
3 = We've made some good efforts but still have some work to do.
4 = We have successfully completed this step/completely agree with statement.
- ◆ After completing the assessment, use the action plan to identify the steps that need to be taken for your agency to be more fully ready to serve fathers and father figures.
- ◆ If you have any questions about use of the self-assessment tool or need any technical assistance or staff development training to help implement your action plan, you can contact Nigel Vann, NPCL's Director of Partnership Development, at (202) 822-6725, or JoAnn Nelson-Hooks, NHSA's Fatherhood Coordinator, at (703) 739-7560.
- ◆ After completing the self-assessment process, please complete the Feedback Form and return it to NPCL, attention of Nigel Vann. This will help us assess the usefulness of the tool and make any necessary adaptations.



FATHER-FRIENDLINESS ORGANIZATIONAL SELF-ASSESSMENT AND PLANNING TOOL

Use the following scale to rate your organization for each of the statements included in the assessment:

- 1 = Haven't even thought about this/completely disagree with statement.*
- 2 = We've started to think about this but haven't made much progress.*
- 3 = We've made some good efforts but still have some work to do.*
- 4 = We have successfully completed this step/completely agree with statement.*

1. ORGANIZATIONAL SUPPORT

How much support is there in your organization for providing services to fathers/father figures?

- ☐ The organization's documented mission is inclusive of serving fathers.
- ☐ The board of directors, policy council, and policy committee are committed to serving fathers and father figures.
- ☐ The board of directors, council, and/or committees have members who are fathers with children in the program.
- ☐ Literature and publicity about the organization reflect a commitment to serving fathers.
- ☐ Funding for serving fathers is consistent and ongoing.

2. POSITION AND REPUTATION IN THE COMMUNITY

How does the community view the organization with respect to serving fathers/father figures?

- ☐ The organization is recognized by community partners as a good resource for fathers.
- ☐ The organization participates in community partnerships and collaborations concerned with providing services to fathers and families.
- ☐ Fathers in the community view the organization as a place they can come to for assistance.
- ☐ The organization is called on by the media or others for information about fathers.



3. AGENCY POLICIES AND PROCEDURES

Are the organization's policies and procedures uniformly inclusive of fathers?

- ___ Agency procedures have been assessed to determine if the interests of fathers are uniformly represented.
- ___ Intake and other data collection methods are standardized for both parents rather than just modified from the forms for mothers.
- ___ Program hours are scheduled to accommodate the time constraints of working fathers.
- ___ Policies that make it harder for fathers to be involved in the agency have been changed.
- ___ Policies have been instituted to facilitate male involvement. For example, instead of simply encouraging father involvement, the agency establishes a clear expectation that fathers of children should and will participate.
- ___ Agency policy allows services to be provided to both parents, regardless of how the other parent feels about that involvement (except in cases of domestic violence).
- ___ Personnel policies are friendly to both parents (for example, paternity leave and medical leave to care for sick children).

4. STAFFING/HUMAN RESOURCES

How prepared are staff to provide services to fathers?

General Staff:

- ___ The entire staff has received training on the issue of working with men, in general, and on fatherhood specifically.
- ___ Staff time and resources have been allocated for recruitment and outreach to fathers.
- ___ Staff are aware of issues faced by low-income fathers.
- ___ The majority of front-line program staff is open and receptive to the idea of providing services to fathers.
- ___ Staff working with fathers are fully integrated into the overall agency (for example, staff meetings, communication, decision-making, and socializing).
- ___ The ability to provide services to fathers is included on performance appraisals of all key staff.
- ___ Staff meet with other organizations serving fathers on a regular basis to enable cross learning about the most effective strategies for engaging and retraining fathers in parent involvement programs.



Specific Staff:

- ___ Specific staff have been designated to work with fathers, and they fully understand their roles and responsibilities.
- ___ Men are represented on the staff (paid and/or unpaid) at all levels.
- ___ Male staff are available to work with fathers, especially in the area of recruitment.
- ___ Male staff feel comfortable and respected within the agency.
- ___ Female and male staff work as a team.
- ___ Female staff (case managers, counselors, group facilitators) are comfortable working with fathers.
- ___ Fathers of children in the center serve as volunteers in the program.

5. PROGRAM SERVICES

Has a program for fathers been clearly articulated?

Approaches To Mothers:

- ___ Family goal-setting activities are inclusive of fathers.
- ___ Counseling with mothers includes a consistent focus on encouraging her to work cooperatively with the father of her child(ren).
- ___ When mothers don't want the fathers of their children involved, efforts are still made to gain her support and to work with that father (except in domestic violence and abusive situations).

Services To Fathers:

- ___ Fathers have opportunities to help design/feel ownership of the services being provided to them.
- ___ A needs and assets assessment has been completed in order to plan programs for fathers.
- ___ Program services that are clearly tied to outcomes have been planned and implemented specifically for fathers. The program involves more than just incorporating fathers into existing services for mothers.
- ___ Parenting groups for fathers have been designed with male psychological issues in mind and focus on empowering men by helping them grasp their essential role in their children's healthy development. Groups attend to beliefs and emotional issues that are barriers to active parenting. Groups address the development of key skills (listening, anger management, and positive discipline) and help fathers understand the specific needs of boys and girls at different developmental phases.
- ___ Information about community services for fathers (legal assistance, education and



- _____ employment assistance, batterers' programs, and so on) has been collected.
- _____ Relationships have been forged with key people in these agencies.
- _____ A relationship has been forged with the local child support enforcement agency.
- _____ Staff make, or are prepared to make, referrals for fathers to other agencies (domestic violence, substance abuse, employment/training, and so on).
- _____ Sufficient funding exists to provide services to fathers.
- _____ Fathers who have completed the program are to work as mentors, recruiters, group facilitators, and so forth.

6. PHYSICAL ENVIRONMENT

How inviting and welcoming is the physical environment for men and fathers?

- _____ Focus groups or individual fathers (from the target population) have been invited to the agency to assess father-friendliness and make suggestions for making the space more welcoming to them.
- _____ The physical environment has a general feel that is inviting to men/fathers.
- _____ Positive and diverse images of men and fathers are displayed.
- _____ Literature available for parents to pick up and read is appealing to fathers and reflects services or programs that they might participate in.
- _____ There is a room or area in the agency that has been designated as a space for men/fathers (at least during designated weekly hours) that contains resources for them and provides a space for just socializing or participating in group activities.
- _____ The designated program space for mothers includes positive images of men/fathers.
- _____ Men are present and it doesn't seem like a place just for women and children.

7. COMMUNICATION AND INTERACTION

How are fathers treated and communicated with inside the agency?

Interaction With Fathers:

- _____ Fathers who drop off children are greeted warmly.
- _____ Efforts are made to interact with fathers who accompany mothers to the program even when they tend to hang back
- _____ When mothers and fathers come to the agency together, communication is directed equally to both and not primarily to the mother.
- _____ Contact information is systematically taken on the father of children regardless of the father's marital status or living arrangements.



- ___ Written announcements, newsletters, and the like are addressed to both parents if they live together and if they don't, the communication is sent to both.
- ___ Staff interact with fathers in a style that demonstrates respect, empathy, and high expectations.

Staff Attitudes:

- ___ The message is given to fathers that their role as active parents is critical to their children's development.
- ___ Input is sought from fathers about what they want and need from the agency.
- ___ Positive comments about men are expressed in both formal and informal settings.



ACTION PLAN FOR BECOMING MORE FATHER FRIENDLY

DIRECTIONS: Once you have completed the self-assessment tool, you will have a clearer idea of what your agency still needs to do. Turn the checklist items that received ratings of 1, 2, or 3 into action steps. Once you have completed this form, go back and put asterisks beside your top three priorities, both short-term and long-term.

ORGANIZATIONAL SUPPORT

Short-term action steps:

- 1.
- 2.

Long-term action steps:

- 1.
- 2.

POSITION AND REPUTATION IN COMMUNITY

Short-term action steps:

- 1.
- 2.

Long-term action steps:

- 1.
- 2.

AGENCY POLICIES AND PROCEDURES

Short-term action steps:

- 1.
- 2.

Long-term action steps:

- 1.
- 2.



STAFFING/HUMAN RESOURCES

Short-term action steps:

- 1.
- 2.

Long-term action steps:

- 1.
- 2.

PROGRAM SERVICES

Short-term action steps:

- 1.
- 2.

Long-term action steps:

- 1.
- 2.

PHYSICAL ENVIRONMENT

Short-term action steps:

- 1.
- 2.

Long-term action steps:

- 1.
- 2.

COMMUNICATION AND INTERACTION

Short-term action steps:

- 1.
- 2.

Long-term action steps:

- 1.
- 2.

If you need Technical Assistance or Staff Development Training to help implement this plan, please contact Nigel Vann, NPCL's Director of Partnership Development, at (202) 822-6725, or JoAnn Nelson-Hooks, NHSA's Fatherhood Coordinator at (703) 739-7650.

The Effects of Father Involvement: An Updated Research Summary of the Evidence

(Allen & Daly, 2008)

This document presents an updated overview of the key trends in the father involvement literature. While we are unable to provide methodological detail in such a succinct summary, we endeavored to compile as accurately as possible, reliable research results that support these trends. It is clear from the research that father involvement has enormous implications for men on their own path of adult development, for their wives and partners in the coparenting relationship and, most importantly, for their children in terms of social, emotional, physical, and cognitive development.

<http://www.worklifecanada.ca/page.php?id=58&r=509>

What Do We Know about Men as Partners and Parents?

Item #1: Among couples with a substance use problem, satisfaction with an intimate partnership is lowest when both partners are actively using alcohol or drugs.

Assessment: Probably False

Explanation: Although the research is limited, several studies done with married and cohabitating couples drawn from the general population have shown that marital or relationship satisfaction seems to be lowest when one partner is actively using and the other is not.

References:

- Homish, G. G., & Leonard, K. E. (2007). The drinking partnership and marital satisfaction: The longitudinal influence of discrepant drinking. *Journal of Consulting and Clinical Psychology, 75*(1), 43-51.
- Homish, G. G., Leonard, K. E., & Cornelius, J. R. (2008). Illicit drug use and marital satisfaction. *Addictive Behaviors, 33*(2), 279-291.
- Leadley, K., Clark, C. L., & Caetano, R. (2000). Couples' drinking patterns, intimate partner violence, and alcohol-related partnership problems. *Journal of Substance Abuse, 11*(3), 253-263.
- Leonard, K. E., Smith, P. H., & Homish, G. G. (2014). Concordant and discordant alcohol, tobacco, and marijuana use as predictors of marital dissolution. *Psychology of Addictive Behaviors, 28*(3), 780-789.

Item #2: Most fathers with a substance use problem have not made much of an effort to parent their children in a socially responsible manner.

Assessment: Probably False

Explanation: Research done with fragile families suggests that, when couples conceive a child under challenging social circumstances, most men have intentions to parent their children in a socially responsible manner and make some effort to do so, particularly early in the life of the child. Over time, social, interpersonal, and psychological problems appear to temper their intentions and undermine their efforts. Although the research is limited, this appears to be true of men struggling with substance abuse. Like women with substance use problems, many men with substance use problems appear to make an effort to parent their children in a socially responsible manner. Over time, the substance abuse and related problems seem to undermine whatever capacity men may have to function effectively as a father.

References:

- McLanahan, S., & Beck, A. N. (2010). Parental relationships in fragile families. *Future of Children, 20*(2), 17-37.
- Carlson, M. J., & McLanahan, S. S. (2010). Fathers in fragile families. In M. E. Lamb (Ed.), *The role of the father in child development* (5th ed., pp. 241-269). New York: Wiley & Sons.

- McMahon, T. J., Winkel, J. D., Suchman, N. E., & Rounsaville, B. J. (2007). Drug-abusing fathers: Patterns of pair bonding, reproduction, and paternal involvement. *Journal of substance abuse treatment*, 33(3), 295-302.
- McMahon, T. J., Winkel, J. D., & Rounsaville, B. J. (2008). Drug-abuse and responsible fathering: A comparative study of men enrolled in methadone maintenance treatment. *Addiction*, 103(2), 269-283.

Item #3: **The single best predictor of the quality of men's relationship with their children is their employment status.**

Assessment: Definitely False

Explanation: Although men's ability to provide financial support may be an important predictor of the quality of their relationship with their children, many years of research done from several different perspectives indicates that, even when the couple does not live together, the quality of men's relationship with the mother of a child appears to be the best single predictor of the quality of their relationship with that child.

References:

- McLanahan, S., & Beck, A. N. (2010). Parental relationships in fragile families. *Future of Children*, 20(2), 17-37.
- Carlson, M. J., & McLanahan, S. S. (2010). Fathers in fragile families. In M. E. Lamb (Ed.), *The role of the father in child development* (5th ed., pp. 241-269). New York: Wiley & Sons.

Item #4: **A significant proportion of intimate partner violence is reciprocal in nature.**

Assessment: Probably True

Explanation: For many years, there has been intense debate about this topic in the research literature. Surveys of the general population suggest that one in five couples involved in an intimate relationship reports at least one episode of serious intimate partner violence. Both men and women who report having been the target of intimate partner violence frequently confirm more than one exposure. The occurrence of intimate partner violence among couples when one or both partners are using alcohol or drugs is clearly much more prevalent. When considered with other substances, alcohol abuse appears to be most clearly and consistently associated with intimate partner violence.

Surveys that ask men and women about both perpetration and victimization of intimate partner violence suggest that up to 50% of the couples who report any intimate partner violence confirm a reciprocal pattern of psychological or physical abuse. Reciprocal violence appears to be more prevalent among younger couples. However, the same research suggests that some forms of intimate partner violence, like stalking and sexual abuse, are more frequently perpetrated by men. Women also consistently report more frequent exposure to more serious forms of psychological, physical, and sexual abuse; and women more frequently report psychological and physical injury. Reports of reciprocal intimate partner violence appears to be associated with more severe forms of aggression and greater probability of injury.

References:

- Archer, J. (2000). Sex differences in aggression between heterosexual partners: A metaanalytic review. *Psychological Bulletin*, 126(5), 651-680.
- Schafer, J., Caetano, R., & Clark, C. L. (1998). Rates of intimate partner violence in the United States. *American Journal of Public Health*, 88(11), 1702-1704.
- Schafer, J., Caetano, R., & Cunradi, C. B. (2004). A path model of risk factors for intimate partner violence among couples in the United States. *Journal of Interpersonal Violence*, 19(2), 127-142.
- Stuart, G. L., Meehan, J. C., Moore, T. M., Morean, M., Hellmuth, J., & Follansbee, K. (2006). Examining a conceptual framework of intimate partner violence in men and women arrested for domestic violence. *Journal of Studies on Alcohol*, 67(1), 102-112.
- Tjaden, P., & Thoennes, N. (2000). *Extent, nature, and consequences of intimate partner violence: Findings from the National Violence Against Women Survey*. Washington, DC: U.S. Department of Justice, National Institute of Justice.
- Whitaker, D., Haileyesus, T., Swahn, M., & Saltzman, L. S. (2007). Differences in frequency of violence and reported injury between relationships with reciprocal and nonreciprocal intimate partner violence. *American Journal of Public Health*, 97(5), 941-947.

Item #5: Mothers and fathers generally agree in their report of paternal involvement.

Assessment: Probably False

Explanation: Although the research is limited, the results of at least two studies done with low-income couples indicate that, although there may be some degree of agreement in the report of mother and fathers about the involvement of fathers, women consistently report less involvement than men. This discrepancy between the report of mothers and fathers may vary in response to the dimension of paternal involvement being asked about, the residential status of the father, the degree of conflict between the parents, the educational background of the parents, and the employment status of the parents.

References:

- Coley, R. L., & Morris, J. E. (2002). Comparing father and mother reports of father involvement among low-income minority families. *Journal of Marriage and Family*, 64(4), 982-997.
- Mikelson, K. S. (2008). He said, she said: Comparing mother and father reports of father involvement. *Journal of Marriage and Family*, 70(3), 613-624.

Item #6: When men are actively involved in fathering in a positive manner, it is the child who usually benefits.

Assessment: Definitely False

Explanation: When men are actively involved in fathering in a positive manner, father, mother, and child usually benefit, even when mothers and fathers does not live in the same household. Although there is a focus on the benefits for children, mothers generally receive more financial, instrumental, and emotional support that can minimize parenting stress and promote positive parenting. Similarly,

there is evidence that the psychosocial adjustment of men seems to increase as they become involved in fathering.

References:

- Choi, J. K., & Pyun, H. S. (2014). Nonresident fathers' financial support, informal instrumental support, mothers' parenting, and child development in single-mother families with low income. *Journal of Family Issues*, 35(4), 526-546.
- Knoester, C., & Eggebeen, D. J. (2006). The effects of the transition to parenthood and subsequent children on men's well-being and social participation. *Journal of Family Issues*, 27(11), 1532-1560.
- Knoester, C., Petts, R. J., & Eggebeen, D. J. (2007). Commitments to fathering and the well-being and social participation of new, disadvantaged fathers. *Journal of Marriage and Family*, 69(4), 991-1004.
- Schindler, H. S. (2010). The importance of parenting and financial contributions in promoting fathers' psychological health. *Journal of Marriage and Family*, 72(2), 318-332.
- Zhang, C., Cubbin, C., & Ci, Q. (2016). Parenting stress and mother-child playful interaction: The role of emotional support. *Journal of Family Studies*, 1-15.

Item #7: **Most children living in the same household as a substance-abusing parent are living with a substance-abusing mother rather than a substance-abusing father.**

Assessment: Definitely False

Explanation: Data from a large-scale survey of the general population found that approximately 12% of children less than 18 years of age are living with a biological, adoptive, step, or foster parent were living with at least one substance-abusing parent. A majority (65%) of those children were living with a substance-abusing father, most frequently an alcohol-abusing father.

Reference:

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009, April). *Children living with substance-dependent or substance-abusing parents: 2002 to 2007*. Rockville, MD: Author.

Item #8: **Substance-abusing men are not able to establish a secure attachment with their children.**

Assessment: Probably False

Explanation: Very little research has been done in this area. Although men with ongoing substance abuse may be less likely to establish a secure attachment with their children than men without ongoing substance abuse, the research that has been done suggests that, even in the context of ongoing substance use, some men are still able to establish a secure attachment with their young children. However, the quality of the father-child relationship probably deteriorates over time as children grow older and the substance abuse and related problems persist or worsen.

References:

- Eiden, R. D., Edwards, E. P., & Leonard, K. E. (2002). Mother-infant and father-infant attachment among alcoholic families. *Development and Psychopathology*, 14(2), 253-278.
- Edwards, E. P., Eiden, R. D., & Leonard, K. E. (2004). Impact of fathers' alcoholism and associated risk factors on parent–infant attachment stability from 12 to 18 months. *Infant Mental Health Journal*, 25(6), 556-579.
- El-Sheikh, M., & Buckhalt, J. A. (2003). Parental problem drinking and children's adjustment: attachment and family functioning as moderators and mediators of risk. *Journal of Family Psychology*, 17(4), 510-520.

Item #9: Family transitions are associated with changes in substance use by men.

Assessment: Probably True

Explanation: Research suggests that family transitions may, under different circumstances, be associated with both increases and decreases in substance use. For example, men's use of alcohol seems to decline with entry into marriage, increase or decrease during the birth of a child, increase with the loss of a job, and increase with marital separation. Even when men are having serious problems with the use of alcohol, family transitions may be associated with significant decreases in alcohol use.

References:

- Power, C., Rodgers, B., & Hope, S. (1999). Heavy alcohol consumption and marital status: Disentangling the relationship in a national study of young adults. *Addiction*, 94(10), 1477-1487.
- Curran, P. J., Muthen, B. O., & Harford, T. C. (1998). The influence of changes in marital status on developmental trajectories of alcohol use in young adults. *Journal of Studies on Alcohol*, 59(6), 647-658.
- Dawson, D. A., Grant, B. F., Stinson, F. S., & Chou, P. S. (2006). Maturing out of alcohol dependence: The impact of transitional life events. *Journal of Studies on Alcohol*, 67(2), 195-203.
- Waterson, E. J., Evans, C., & Murray-Lyon, I. M. (1990). Is pregnancy a time of changing drinking and smoking patterns for fathers as well as mothers? An initial investigation. *Addiction*, 85(3), 389-396.

Item #10: Many low-income pregnant and parenting women are reluctant to involve their intimate or sexual partner in their treatment as they enter systems of care because of concern about legal sanctions pending against their male partner.

Assessment: Probably True

Explanation: Although the research is limited, low-income pregnant and parenting women may be reluctant to identify or involve the fathers of their children in their treatment as they enter systems of care because they fear their involvement may somehow provoke legal action for (a) past due child support, (b) outstanding arrest warrants, (c) undocumented immigration status, (d) intimate partner violence, or (e) child abuse.

References:

Sonenstein, F., Malm, K., & Billing, A. (2002). Study of fathers' involvement in permanency planning and child welfare casework. Washington, DC: Urban Institute. (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation).

Item #11: **Incarceration is a major threat to the stability of low-income families.**

Assessment: Definitely True

Explanation: Research suggests that, although many fathers attempt to maintain contact with their partners and children while imprisoned, the incarceration of men has a dramatic effect on the stability of low-income families. Ethnic minority men with limited education living in urban settings are disproportionately affected. Economic stress and residential changes following the incarceration of fathers are common for mothers and children. Intimate partnerships frequently end and contact with children frequently deteriorates. Psychosocial stress for mothers usually increases; children often demonstrate an increase in behavioral difficulty and deterioration of school and social adjustment. Changes that begin while fathers are incarcerated often continue after their release.

References:

- Geller, A. (2013). Paternal incarceration and father-child contact in fragile families. *Journal of Marriage and Family*, 75(5), 1288-1303.
- Geller, A., Cooper, C. E., Garfinkel, I., Schwartz-Soicher, O., & Mincy, R. B. (2012). Beyond absenteeism: Father incarceration and child development. *Demography*, 49(1), 49-76.
- Geller, A., Garfinkel, I., Cooper, C. E., & Mincy, R. B. (2009). Parental incarceration and child well-being: implications for urban families. *Social Science Quarterly*, 90(5), 1186-1202.
- Geller, A., Garfinkel, I., & Western, B. (2011). Paternal incarceration and support for children in fragile families. *Demography*, 48(1), 25-47.
- Murray, J., Farrington, D. P., & Sekol, I. (2012). Children's antisocial behavior, mental health, drug use, and educational performance after parental incarceration: A systematic review and meta-analysis. *Psychological Bulletin*, 138(2), 175-210.
- Roettger, M. E., Swisher, R. R., Kuhl, D. C., & Chavez, J. (2011). Paternal incarceration and trajectories of marijuana and other illegal drug use from adolescence into young adulthood: Evidence from longitudinal panels of males and females in the United States. *Addiction*, 106(1), 121-132.
- Schwartz-Soicher, O., Geller, A., & Garfinkel, I. (2011). The effect of paternal incarceration on material hardship. *Social Service Review*, 85(3), 447-473.
- Swisher, R. R., & Waller, M. R. (2008). Confining fatherhood: Incarceration and paternal involvement among nonresident White, African American, and Latino fathers. *Journal of Family Issues*, 29(8), 1067-1088.

Item #12: **Although common among women, postpartum depression in men is very rare.**

Assessment: Definitely False

Explanation: Research done with couples suggests that depression during the perinatal period is relatively common among men. The estimates of prevalence vary significantly across studies, but approximately 10% of men seem to be affected. Some studies have documented rates similar to those for women. The prevalence of depression in men following the birth of a child does not appear to vary in response to sociodemographic characteristics, like age, ethnicity, and socioeconomic status. Depression in men seems to occur most frequently when they are living with a partner who is depressed and their relationship with the mother of their child has deteriorated.

References:

- Paulson, J. F., & Bazemore, S. D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: A meta-analysis. *JAMA*, 303(19), 1961-1969.
- Cameron, E. E., Sedov, I. D., & Tomfohr-Madsen, L. M. (2016). Prevalence of paternal depression in pregnancy and the postpartum: An updated meta-analysis. *Journal of Affective Disorders*, 206(December), 189-203.
- Paulson, J. F., Dauber, S., & Leiferman, J. A. (2006). Individual and combined effects of postpartum depression in mothers and fathers on parenting behavior. *Pediatrics*, 118(2), 659-668.
- Ramchandani, P., Stein, A., Evans, J., O'Connor, T. G., & ALSPAC Study Team. (2005). Paternal depression in the postnatal period and child development: a prospective population study. *Lancet*, 365(9478), 2201-2205.
- Underwood, L., Waldie, K. E., Peterson, E., D'Souza, S., Verbiest, M., McDaid, F., & Morton, S. (2017). Paternal depression symptoms during pregnancy and after childbirth among participants in the growing up in New Zealand study. *JAMA Psychiatry*, 74(4), 360-369.

Item #13: **Our systems of care more effectively engage women in their role as mothers than men in their role as fathers.**

Assessment: Definitely True

Explanation: Although attitudes and practices may be changing slowly, many policymakers, advocates, and professionals believe that our (a) employment, (b) healthcare, (c) educational, (d) child care, (e) social service, (f) child welfare, (g) family court, and (h) criminal justice systems do not effectively engage men as fathers. Many people believe that this is particularly true for low-income, non-resident fathers who may be experiencing social, economic, and psychological difficulty. Acknowledging the attitudes and behavior of some men make them difficult to engage, many people have argued that attitudes, policy, procedures, and practices within these systems contribute directly to men not being better engaged as parents.

References:

- Coleman, W. L., Garfield, C., & Committee on Psychosocial Aspects of Child and Family Health. (2004). Fathers and pediatricians: enhancing men's roles in the care and development of their children. *Pediatrics*, 113(5), 1406-1411.
- Garfield, C. F., Clark-Kauffman, E., & Davis, M. M. (2006). Fatherhood as a component of men's health. *JAMA*, 296(19), 2365-2368.
- Malm, K., Murray, J., & Geen, R. (2006). *What about the dads? Child welfare agencies' efforts to identify, locate and involve nonresident fathers*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.
- McMahon, T. J., & Giannini, F. D. (2003). Substance-abusing fathers in family court: Moving from popular stereotypes to therapeutic jurisprudence. *Family Court Review*, 41(3), 337-353.
- Palm, G., & Fagan, J. (2008). Father involvement in early childhood programs: Review of the literature. *Early Child Development and Care*, 178(7-8), 745-759.
- Phares, V., Fields, S., & Binitie, I. (2006). Getting fathers involved in child-related therapy. *Cognitive and Behavioral Practice*, 13(1), 42-52.

Item #A: **Substance abuse treatment programs for pregnant and parenting women should better engage fathers.**

☐ Strongly Agree

☐ Agree

☐ Disagree

☐ Strongly Disagree

References

See **page xx** of Module 5 for list of Modules 3-5 references.



Module 4

Implementing Family-Centered Programming

Training Goals and Objectives

Provide a basic blueprint for development of family-centered programming.

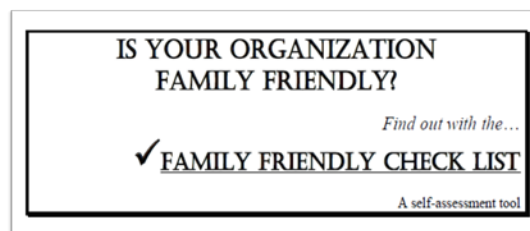
By the end of this module, participants will be able to:

1. Identify the steps programs need to consider when developing family-centered programming.
2. Describe some of the cultural considerations family-centered programming involves.
3. Identify important safety concerns.
4. Examine own work setting in terms of family-centered criteria.



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**Please complete checklist:
 “Is Your Organization Family Friendly?”**



Pages 133-138 in participant manual



Module 4: Implementing Family-Centered Programming

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Acknowledgements



Thomas McMahon, PhD
Yale University
School of Medicine

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Introductions

- ▶ Name
- ▶ Field
- ▶ One word to describe “family”

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Family-Centered Behavioral Health Support
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Hands-On Review of Participant Manual

▶ Participant Manual

Each module contains:

- Training goals and objectives
- Copy of slides
- Resources – worksheets, activities, assessments, recommended reading
- Reference list



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Goal and Objectives

Goal: Provide a basic blueprint for development of family-centered programming.


Objectives: Participants will be able to:

- ▶ Identify the steps programs need to consider when developing family-centered programming.
- ▶ Describe some of the cultural considerations involved in family-centered programming.
- ▶ Identify important safety concerns.
- ▶ Examine own work setting in terms of family-centered criteria.

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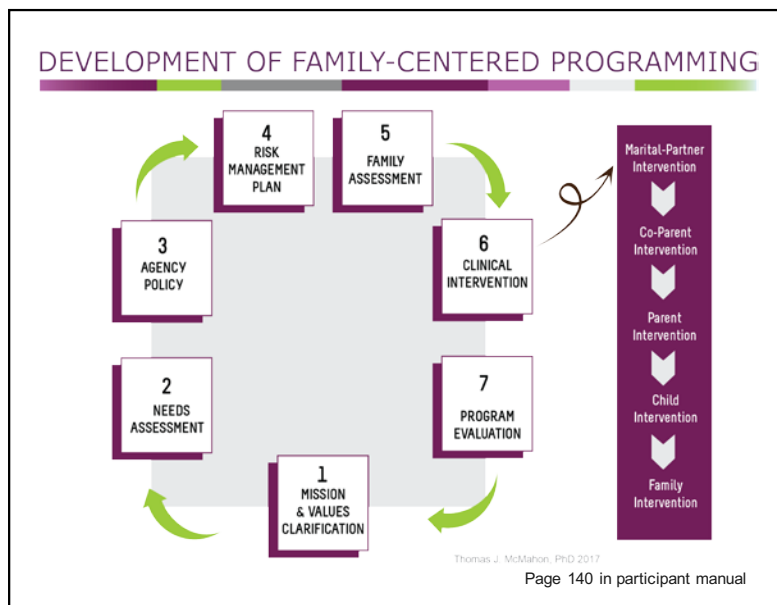
Discussion

Please turn to your completed “Is Your Organization Family Friendly?” checklist on pages 133-138 of the manual.

- ▶ How does your agency compare to the family-centered items on the checklist?
- ▶ In a perfect world, what adaptations would you make in your program or community to better serve the needs of its families?

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DEVELOPMENT OF FAMILY-CENTERED PROGRAMMING



DEVELOPMENT OF FAMILY-CENTERED PROGRAMMING





Tales from the Field



Kimberly Craig, BA, BS, LSAT
CEO, CHEERS Recovery Center
Former PPW grantee, Phoenix, AZ

“...we had to look at every aspect of our program... our environment, policies and even our language. For example, we used the word “screening” to describe a father’s first face-to-face interaction with the counseling staff... *Screening* definitely did not say, ‘Welcome, we are a father-friendly environment.’ ”

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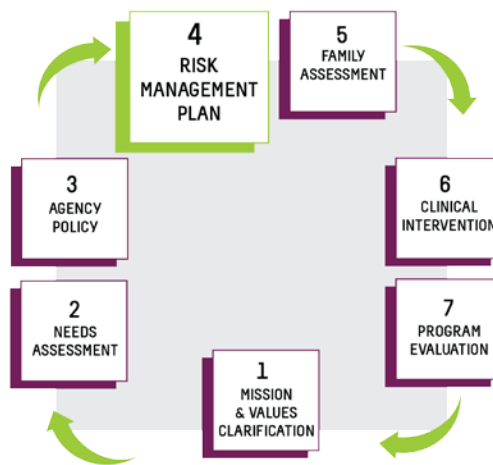
Family-Centered Behavioral Health Support
for Pregnant & Postpartum Women

DEVELOPMENT OF FAMILY-CENTERED PROGRAMMING



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The Culture Conversation

The Family-Centered Programming

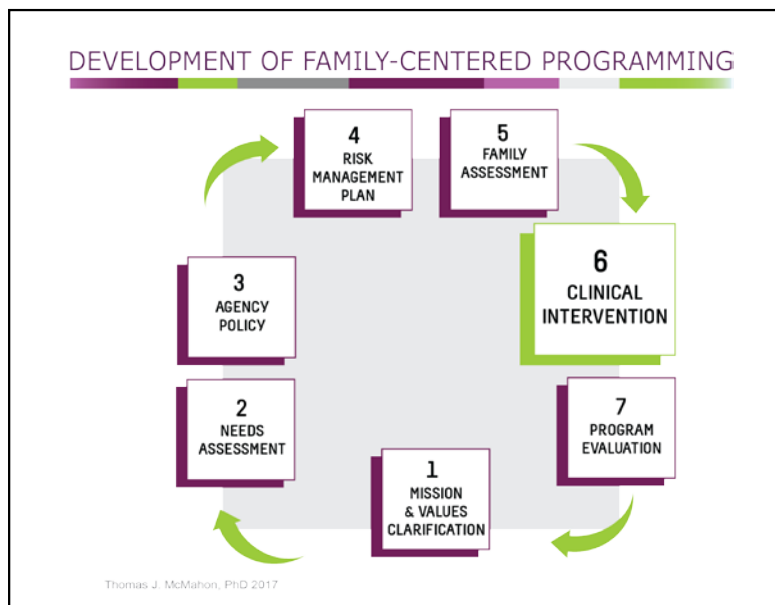
PATHWAYS TO HEALING AND RECOVERY

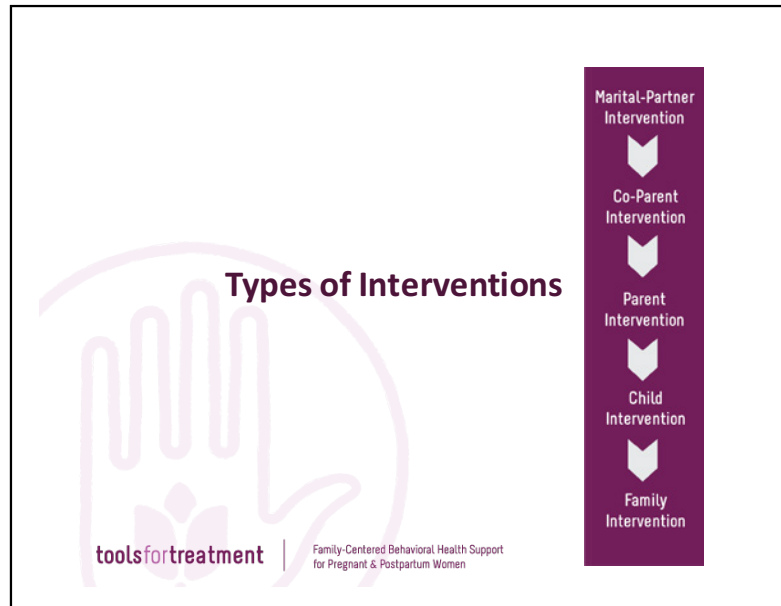
- Provide space for voices and perspectives to lead
- Recognize the unique experiences and needs of each
- Respect individual and family choices
- Build on family strengths, support, and resilience
- Form an interdisciplinary team for the whole
- Encourage integration and cross-cultural
- Provide ongoing support and resources

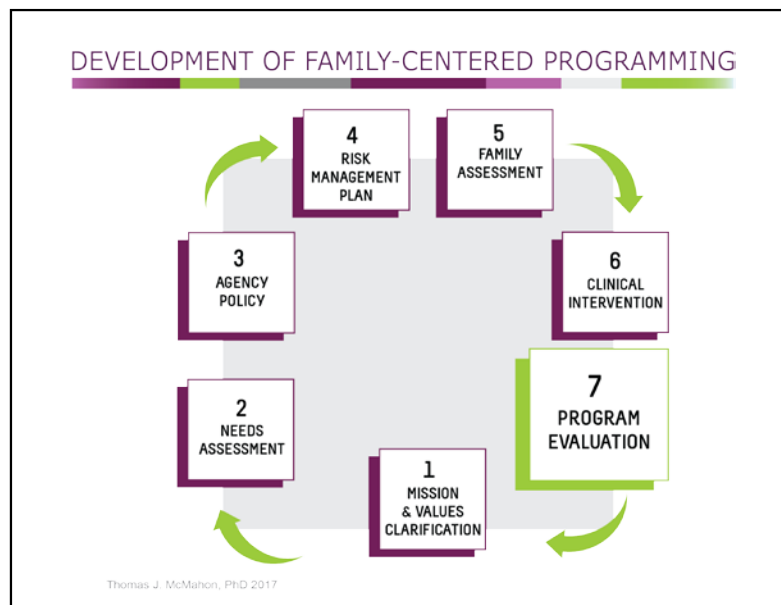
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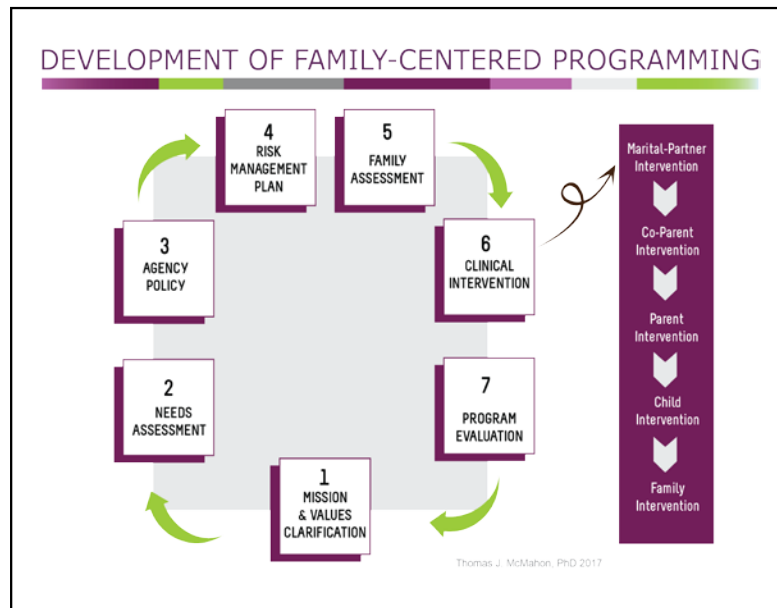
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Page 139 in participant manual









Discussion

- ▶ Which of the elements just covered are already in place at your agency?
- ▶ Which need to be developed?
- ▶ Why?


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Wrap Up

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Next Modules

- ▶ **Module 5:** Family-Centered Clinical Interventions
- ▶ **Module 6:** Case-Based Application

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References

For complete reference list, please see pages 168-171 in Participant Manual.

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Module 4

Resources

IS YOUR ORGANIZATION FAMILY FRIENDLY?

Find out with the...

✓ FAMILY FRIENDLY CHECK LIST

A self-assessment tool

The purpose of this survey is to help the Ohio Family and Children First to identify training needs for service providers on family engagement. This tool may be copied and used by any agency that would like to improve the family friendliness of its services.

This survey was adapted from the Family Friendly Check List developed by the Family Support Council funded by a grant from the Ohio Developmental Disabilities Council.

A family friendly agency gives families access to the agency so that families can help:

- ✓ decide how the agency runs
- ✓ decide how the agency is designed
- ✓ decide how the agency provides its services
- ✓ evaluate the agency's services

Answer the questions in the check list that follows to help you decide whether the agency's practices are family friendly. Then consider what the agency might do to increase family access and give families more opportunities to be part of agency decisions.

Together, as partners, the agency and the families it serves can use this self-assessment tool to make the agency family friendly.

Key to Notations:					
	Not at all				Very much so
	1	2	3	4	5

I am a: ☐ Staff member ☐ Consumer/caretaker

I am a member of the following service community:

- | | |
|---|---|
| <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> Pre-school |
| <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Elementary School |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Middle School |
| <input type="checkbox"/> Physical Health | <input type="checkbox"/> Higher Education |
| <input type="checkbox"/> Juvenile Justice | <input type="checkbox"/> Residential Service Provider |
| <input type="checkbox"/> Adult Corrections | <input type="checkbox"/> Child/Family Advocacy |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Rehabilitation Services |
| <input type="checkbox"/> Child Welfare | <input type="checkbox"/> Vocational Services |
| <input type="checkbox"/> Other _____ | |

Agency Administration

Not at all				Very much so	
1	2	3	4	5	
					Does the agency Mission Statement show that it encourages family input/participation?
					Are agency policies and procedures family centered/oriented?
					Does the agency train staff on the value of family input?
Yes	No	N/A			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are families on the agency's board of directors or advisory committee?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do families write and/or approve the agency's policies and procedures on an ongoing basis?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do families orient and train new staff?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are family members considered for employment opportunities?		

Information Sharing

Not at all					Very much so	
1	2	3	4	5		Does the agency write documents and other family materials in plain language and in alternative formats?
1	2	3	4	5		Does the agency talk with the family in a way they understand? (e.g., in sign language or in the family's native language)
1	2	3	4	5		Does the agency web site contain family friendly content?
Yes	No	N/A				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Does the agency give families information regularly and whenever asked?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Does the agency provide families with a glossary of acronyms?

Welcoming Environment

Not at all					Very much so	
1	2	3	4	5		Is the agency welcoming to families?
1	2	3	4	5		Are families comfortable giving honest feedback without fear of repercussion?
Yes	No	N/A				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Does the agency have an open door policy for families at any time?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Is there a person at the agency families can call to discuss concerns or file a complaint?

Family Involvement

Not at all				Very much so	
1	2	3	4	5	
					Does the agency encourage and facilitate family involvement on a frequent basis?
1	2	3	4	5	Does the agency have a plan to address specific cultural issues if they are a barrier to family involvement?
1	2	3	4	5	Does the agency plan activities that are family oriented and encourage families to become involved – giving families, children, and staff the chance to bond?
1	2	3	4	5	Does the agency frequently give families options of how to become actively involved in the operation of the agency?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>			Does the agency give families frequent opportunities to be actively involved?

Decision Making

Not at all				Very much so	
1	2	3	4	5	Do families get to make the final decision about their service plan?
1	2	3	4	5	Does the agency engage families in shared decision making on an ongoing basis?
1	2	3	4	5	Does the agency make it possible for families to make informed decisions?
1	2	3	4	5	Are the service plans built on the strengths of the family?

Meetings Inclusion

Not at all				Very much so	
1	2	3	4	5	
					Does the agency plan meetings at a time when families can attend?
1	2	3	4	5	Does the agency support families so they can attend meetings? (e.g. travel reimbursement, child care, etc.)
Yes		No		N/A	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Are families included on all committees and meetings?
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Do families receive meeting minutes and agendas?
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Does the agency cancel meetings if families are not represented?

Accessibility

Not at all				Very much so	
1	2	3	4	5	
					Is the entire agency physically accessible? (e.g., flat surface from parking lot into building, restroom larger, hallways wider, etc.)
1	2	3	4	5	Is the entire agency programmatically accessible? (e.g., Are alternative formats, specialized software for computers, etc. available upon request?)
1	2	3	4	5	Does the agency accommodate family members' special needs upon request?
1	2	3	4	5	Is the location of service delivery convenient to families?
1	2	3	4	5	Are the hours of operation convenient to families?
1	2	3	4	5	Does your agency often have a waiting list for families to receive services?
Yes		No		N/A	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Does your agency provide changing tables or a family restroom?

Service Evaluation

Not at all				Very much so	
1	2	3	4	5	Does the agency frequently ask families what they need and want?
1	2	3	4	5	Do families routinely evaluate services and supports?
1	2	3	4	5	Does the agency frequently ask families if they are satisfied with services?
1	2	3	4	5	Does the agency have an evaluation form to assess family satisfaction?

The Culture Conversation (Module 4)

Background:

SAMHSA supports families in a variety of ways:

- Develops and disseminates evidence-based practices that *help families and their loved ones learn more about behavioral health, treatment, and recovery.*
- Supportive of early intervention to treatment, *which can change the course of an individual's life.*
- Statewide Family Networks, which *help improve community-based services for children and adolescents with mental health challenges and their families.*
- Identification of multiple types of family-centered programs to *increase access to care.*

The Culture Conversation:

Understanding the populations and communities who are accessing services is paramount.

- This means more than knowing the demographics. It is looking at demographics and asking oneself, “What is missing?”
- It is recognizing the areas that are working effectively and saying, “What else can we do?”
- Setting aside the time to focus on what is not working and saying, “How can we do this better?”

Special Populations:

One example of family-centered programming is in family-run organizations. Family-run organizations:

- Were established by parents caring for children and youth with mental/behavioral health needs
- Are led by persons with shared experiences (similar lived experiences)
- Balance passion and business practices in an effort to strengthen the whole

“Family-run organizations have strong values of family-driven, youth-guided, community-based, and culturally respectful responsive care.” The Standards are intended to exist within an overall framework of the organization that is mission-driven and aligned with the organizational values.” (FREDLA 2014-2015). This how one cultural group ensures family-centered programming at all levels of the organization.

Next Steps:

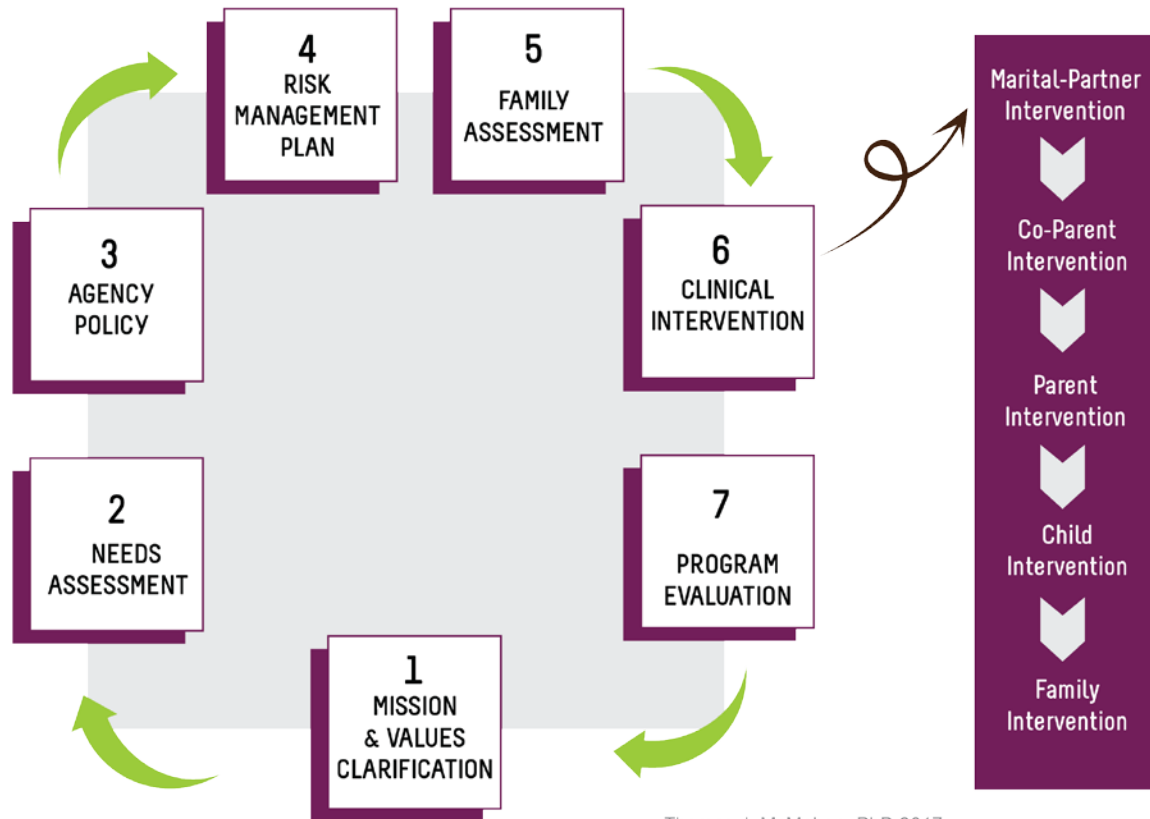
See “Development of Family-Centered Programming” graphic for steps on how this may work within your organization.

References:

<https://blog.samhsa.gov/2015/05/26/supporting-family-members-of-loved-ones-with-serious-mental-illnesses/#.WdZlSVtSypo>

http://www.fredla.org/wp-content/uploads/2015/09/StandardsOfExcel_final_063015SCR-1.pdf

DEVELOPMENT OF FAMILY-CENTERED PROGRAMMING



Risk, Safety and Recovery

(Boardmen & Roberts, 2014)

This briefing paper examines current approaches to risk assessment and management and how these need to be changed so as to be more supportive of people's personal recovery. In doing so we will identify means of moving towards recovery-oriented risk assessment and safety planning based on shared decision making and the joint construction of personal safety plans. We believe that this presents an approach which respects service users' needs, while recognizing everyone's responsibilities – service users, professionals, family, friends – to behave in ways which will uphold and maintain personal and public safety.

<http://www.slamrecoverycollege.co.uk/uploads/2/6/5/2/26525995/imroc-briefing-risk-safety-andrecovery.pdf>

Safety Assessment and Safety Planning: Key Concepts

Actuarial risk assessment is a statistical method of estimating the probability an adverse or undesirable event will reoccur for an individual over a specific period of time based upon a standardized rating of risk and protective factors.

Actuarial versus clinical risk assessment refers a controversy within the professional literature about the predictive value of actuarial versus clinical risk assessments.

Clinical risk assessment is a clinical method of estimating the probability an adverse or undesirable event will occur for an individual over a specific period of time based upon a clinical accounting of risk and protective factors, knowledge of the client, and professional judgment.

Dynamic risk or protective factor is one that can change or be changed through intervention. Dynamic risk or protective factors are sometimes referred to as *variable* risk or protective factors.

Harm is a social, psychological, or physical insult or injury. Specific types of harm can usually be classified as harm to self, harm to another, harm by another, and harm associated with treatment.

Protective factor is a characteristic or situation that precedes an event and is known to decrease the probability of an adverse or undesirable event.

Risk factor is a characteristic or situation that precedes an event and is known to increase the probability of an adverse or undesirable event in a specific population. Risk factors are sometimes referred to as *vulnerability factors*.

Risk is the probability of an adverse or undesirable event in a specific population, often over a specific period of time.

Safety assessment is a comprehensive evaluation pursued collaboratively with the client to document, as carefully as possible, risk for a specific adverse or undesirable event through careful consideration of risk and protective factors using all available sources of information.

Safety management plan is a formal, flexible system of policies and procedures designed to proactively minimize risk for harm.

Safety plan is a comprehensive plan developed collaboratively with the client, a treatment team, and significant others to decrease risk for a specific adverse or undesirable event. A safety plan usually focuses on using available resources to decrease, as much as possible, the potential influence of risk factors and increase, as much as possible, the potential influence of protective factors.

Static risk or protective factor is one that cannot change or be changed through intervention. Static risk or protective factors are sometimes referred to as *fixed* risk or protective factors.

See pages 168-171 of Module 5 for list of Modules 3-5 references.



Module 5

Family-Centered Clinical Interventions

Training Goals and Objectives

Provide a framework for development of family-centered interventions.

By the end of this module, participants will be able to:

1. Identify the steps for developing family-centered interventions.
2. Describe some of the cultural considerations family-centered interventions involve.
3. Identify important safety concerns.
4. Examine own practice in terms of family-centered criteria.




Easier Together:
Partnering with Families to
Make Recovery Possible



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**Module 5:
Family-Centered Clinical
Interventions**



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Acknowledgements



Thomas McMahon, PhD
Yale University
School of Medicine

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Introductions

- ▶ Name
- ▶ Field
- ▶ Favorite thing about working with families

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Hands-On Review of Participant Manual

► Participant Manual

Each module contains:

- Training goals and objectives
- Copy of slides
- Resources – worksheets, activities, assessments, recommended reading
- Reference list



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Visit www.attcppwtools.org for More Resources

- Training Curriculum
- Online Courses
- 300+ Program Resources Library
- Recorded Presentations
- Videos



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Goal and Objectives

Goal: Provide a framework for development of family-centered interventions.

Objectives: Participants will be able to:

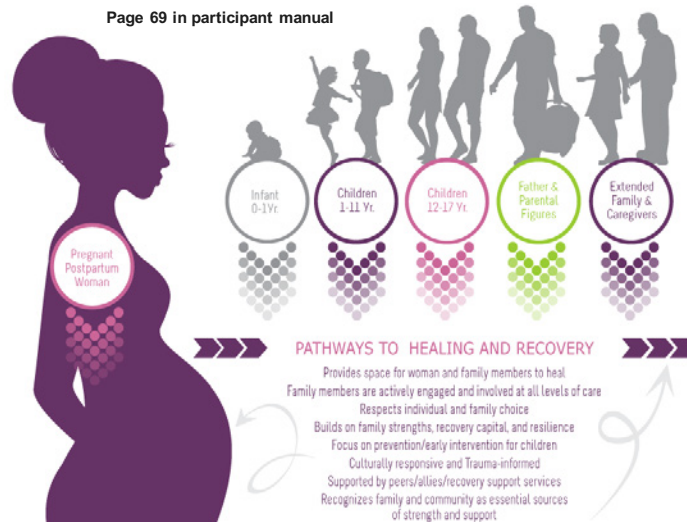
- ▶ Identify the steps for developing family-centered interventions.
- ▶ Describe some of the cultural considerations family-centered interventions involve.
- ▶ Identify important safety concerns.
- ▶ Examine own practice in terms of family-centered criteria.

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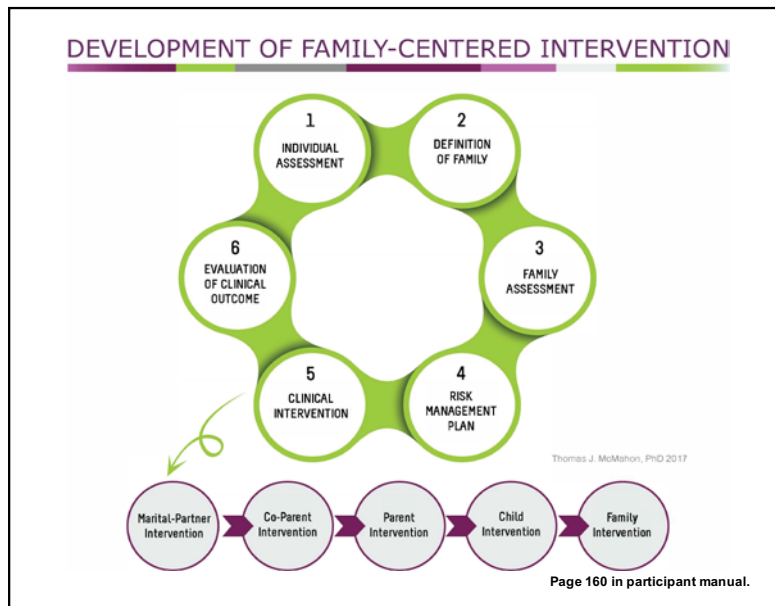
Family-Centered Recovery & Wellness Principles

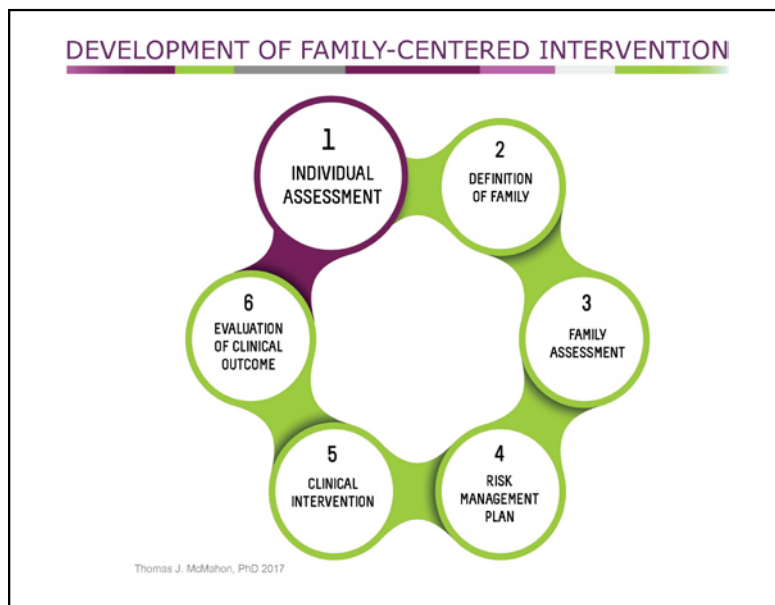
Page 69 in participant manual











DEVELOPMENT OF FAMILY-CENTERED INTERVENTION



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Definition of Family

- ▶ Who defines family?
- ▶ Who will be considered in the family assessment?

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DEVELOPMENT OF FAMILY-CENTERED INTERVENTION



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Static and Dynamic Factors

► Static factors don't change:

- What has already happened
- Seriousness

► Dynamic factors can change:

- Increase or decrease the risk of previous behaviors being repeated

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DEVELOPMENT OF FAMILY-CENTERED INTERVENTION



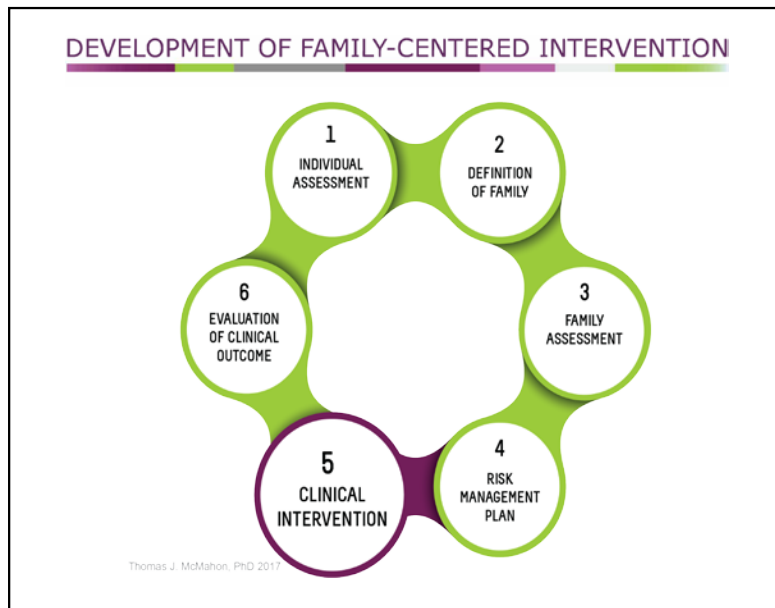
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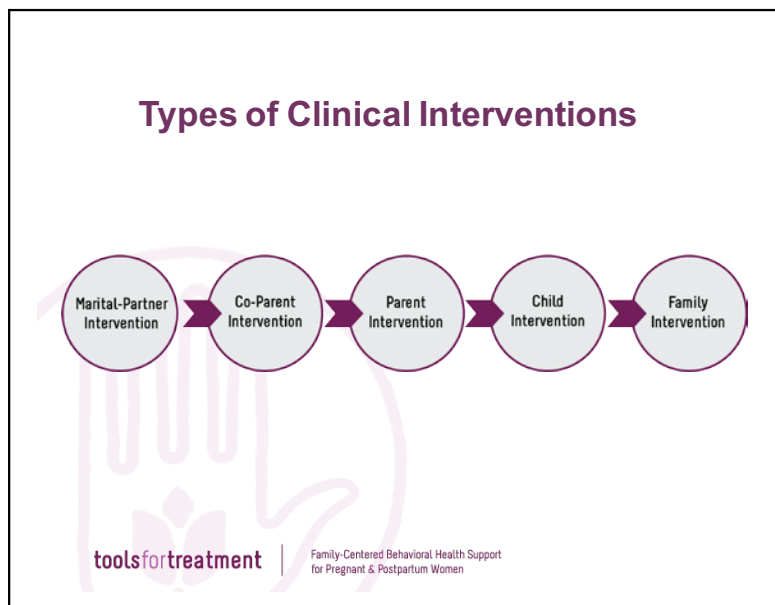
Partnering with Child Welfare



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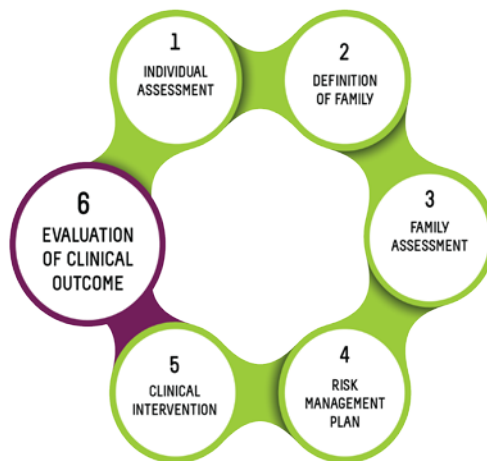
Services for Children



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DEVELOPMENT OF FAMILY-CENTERED INTERVENTION



Thomas J. McMahon, PhD 2017



Tales from the Field



Kimberly Craig, BA, BS, LSAT
CEO, CHEEERS Recovery Center
Former PPW grantee, Phoenix, AZ

“...In many ways we need to give ourselves permission to change with the times and accept that what was once the best we could do with the information we had, is now old information.”

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Discussion

- ▶ What are your thoughts regarding Kimberly's observations?
- ▶ Would you place your agency's level of family-centeredness closer to the past (how things used to be) or closer to the future?
- ▶ Where would you place the level of family-centeredness of your own practice?


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Wrap-Up


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Next Modules

► **Module 6:** Case-Based Application

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Module 5

Resources

The Culture Conversation (Module 5)

Background:

SAMHSA says the following about families and recovery: “As caregivers, navigators, and allies, family members play diverse roles and may require a variety of supports. Families and family-run organizations are vital components of recovery-oriented service systems. Family members train and support other families—sharing lived experiences and insights that instill hope, increase understanding, and contribute to systems transformation.”

The Culture Conversation:

Family-centered programming is all about the family. As we have shared previously, the family can encompass:

- Parents
- Partners
- Siblings
- Grandparents
- Aunts/Uncles
- Cousins
- Friends
- Neighbors
- Community Supports
- Biological Links and Non-Biological Links

The strength of the individual derives from the resiliency and/or impact of the family. Families may provide wellbeing, nurture and protect children, care for members who need it, offer material and emotional support, and pass on culture, knowledge, values, and attitudes (Mental Health Commission, 2009).

Special Populations/Next Steps:

As an example of how families are different, we can look at the concept of *Whānaungatanga*, which shares “strength is created through *Whānaungatanga*, *connections* with the Whānau (extended family group; to be born; modern meaning family) members; this encompasses everyone who is connected to the individual and recognizes the wide diversity of families within their communities. The family/whanau is crucial in developing and maintaining resilience.

Image of harakeke: The harakeke (flax) plant represents the whānau (family) in Māori thought. The rito (shoot) is the child. It is protectively surrounded by the awhi rito (parents). The outside leaves represent the tūpuna (grandparents and ancestors). This is an example of one culture, one community, and one understanding of family’s impact. The next steps are for us to discuss how this transpires within our agencies, communities, and families.

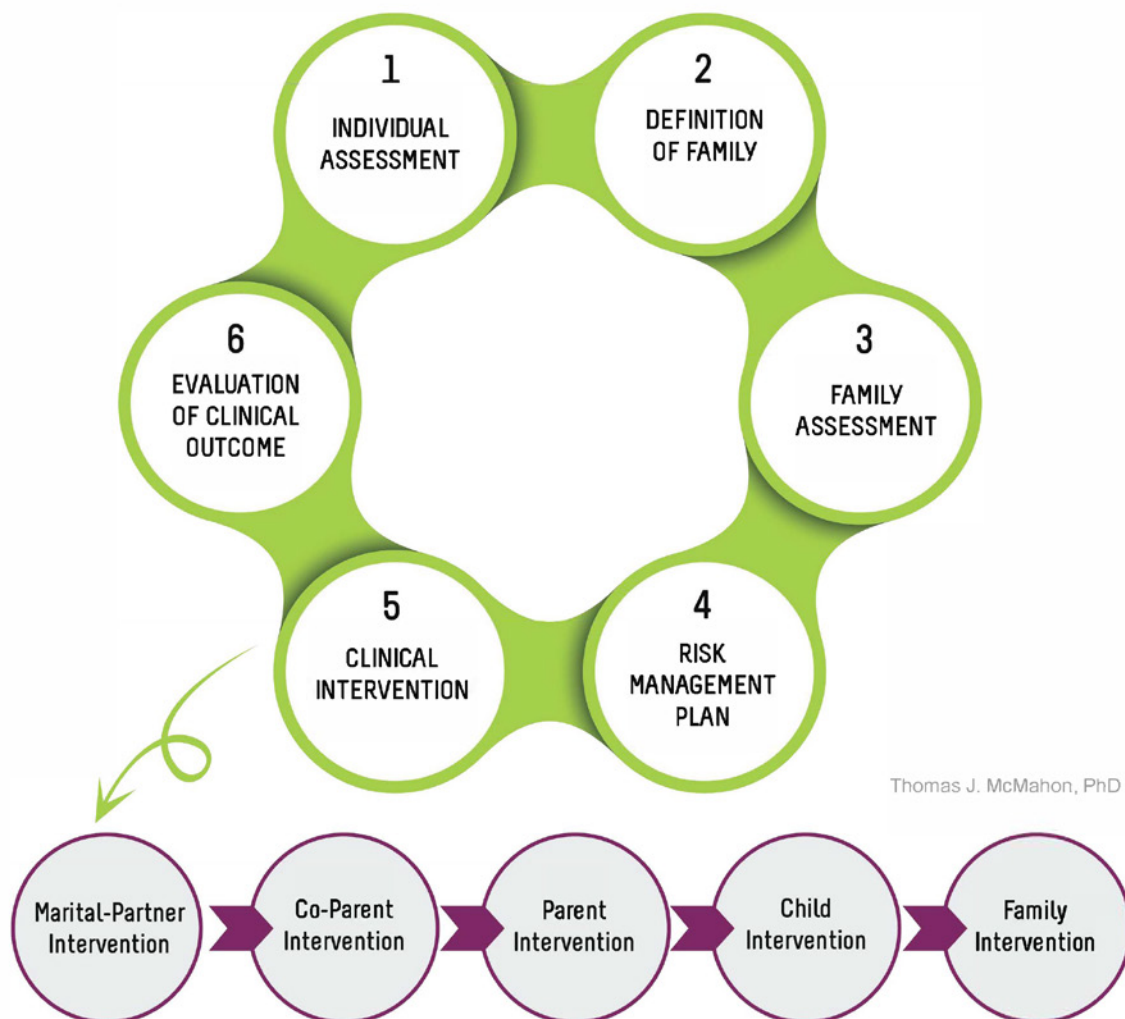


References:

<https://www.samhsa.gov/brss-tacs/recovery-support-tools/parents-families>

<http://www.hdc.org.nz/media/199086/family%20inclusion%20in%20mental%20health%20and%20addiction%20services%20for%20children%20and%20young%20people%20paper%201.pdf>

DEVELOPMENT OF FAMILY-CENTERED INTERVENTION



Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

Robert F. Forman, Ph.D.
Consensus Panel Chair

Paul D. Nagy, M.S., LCAS, LPC, CCS
Consensus Panel Co-Chair

A Treatment Improvement Protocol

TIP 47

Module 5

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

1 Choke Cherry Road
Rockville, MD 20857

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Disclaimer

The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of CSAT, SAMHSA, or DHHS. No official support of or endorsement by CSAT, SAMHSA, or DHHS for these opinions or for particular instruments, software, or resources described in this document is intended or should be inferred. The guidelines in this document should not be

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Originating Office

Practice Improvement Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

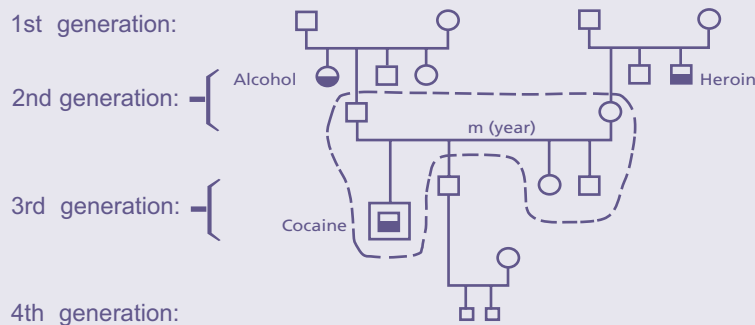
DHHS Publication No. (SMA) 06-4182
NCADI Publication No. BKD551
Printed 2006

Appendix 6-A. Format and Symbols for Family Genogram*

The genogram is useful for engaging the client and significant family members in a discussion of important family relationships. Squares and circles identify parents, siblings, and other household members, and an enclosed square or circle identifies the client.

Marital status is represented by unique symbols, such as diagonal lines for separation and divorce. Different types of connecting lines reflect the nature of relationships among household members. For instance, one solid line represents a distant relationship between

Format for Family Genogram

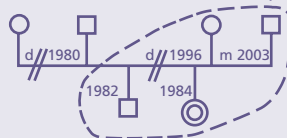


Symbols Useful for Genograms

Symbols

- = male
- = female
- ◻ ◯ = client
- ● = alcohol or drug abuse (indicate drug of abuse)
- ▣ ● = mental or physical illness
- ● = alcohol or drug abuse and mental or physical problems
- ☒ ☒ = deceased

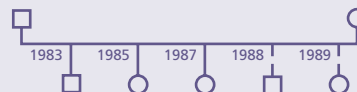
Members of client's household (dotted lines):



Relationships

- m 1981 ○ Marriage (give year)
- s / 1990 ○ Marital separation (give year)
- d // 1992 ○ Divorce (give year)
- - 1992 ○ Living together relationship or liaison (give year)
- x ○ Induced abortion

Children: List in birth order with birth year
Adopted or foster children = dotted line
Note any changes in custody

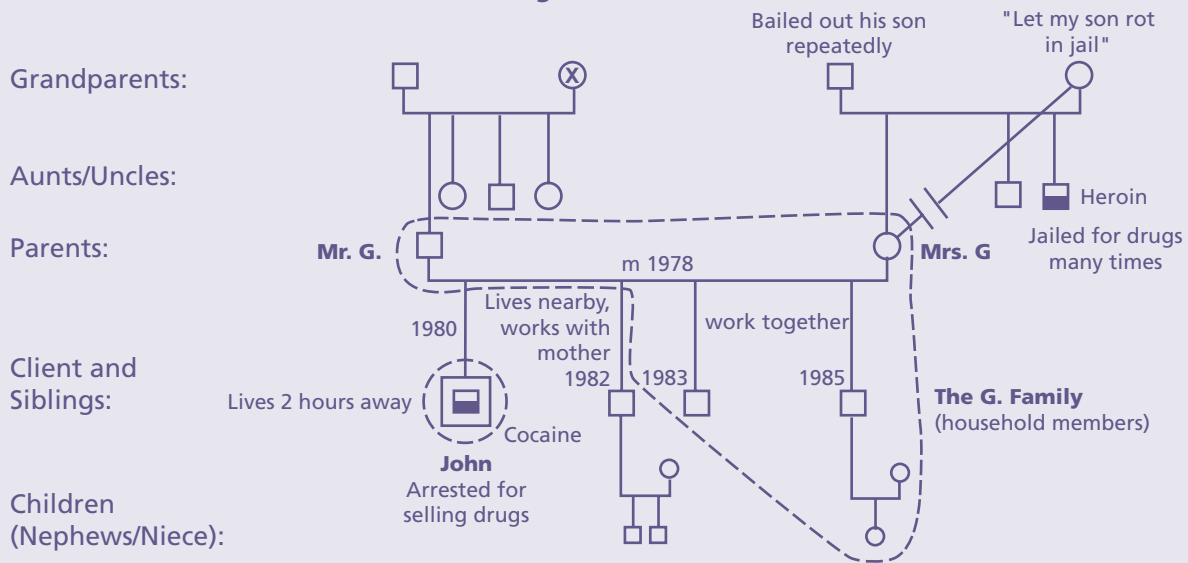


Family Interaction Patterns (nature of relationships)

- — ○ Distant
- —||— ○ Estranged/cut off
- —x— ○ Fused and conflictual (a bond of ongoing conflict that is mutually satisfying and/or rewarding)
- === ○ Very close
- ~~~ ○ Conflictual

*Source: New Jersey Division of Addiction Services, New Jersey Department of Health and Senior Services.

Client John G. and His Family



two individuals; three solid lines represent a very close relationship. Other key data, such as arrest information, are written on the genogram as appropriate.

This sample genogram depicts a family that initially was seen as a close, loving family unit. The son, John, had come under the influence of some “bad friends” and had become involved in abusing and selling substances. While expressing their willingness to help, the family denied the seriousness of the situation and minimized any problems in the nuclear or extended family.

When the discussion was extended to one of John’s maternal uncles, Mrs. G. admitted that her brother had been arrested a number of times for heroin possession. Questions about the maternal grandmother’s reaction to John’s “problem” caused the united family front to begin to dissolve. It became apparent that Mrs. G.’s mother took an

“insensitive position” regarding John’s substance use disorder and there was a serious estrangement between her and her daughter. In discussing the details of the uncle’s criminal activity (which was a family secret that even John and his brothers did not know), it emerged that Mrs. G. had for years agonized over her mother’s pain. Now, desperately afraid of reliving her parents’ experiences, Mrs. G. had stopped talking to her mother. John’s brothers felt free to open up and expressed their resentment of their brother for putting the family in this position.

Mr. G., who had been most adamant in denying any family problems, now talked about the sense of betrayal and failure he felt because of John’s actions. It was only through the leverage of the family’s experience that the family’s present conflict became evident.

Appendix 6-B. Family Social Network Map*

Designing a social network map is a practical strategy to survey various aspects of social support available to clients and their families. Mapping a client's social network is a two-stage process. First, the client uses a segmented circle to categorize people in the network (e.g., friends, neighbors). Then, a grid is used to record a client's specific responses about the supportive or non-supportive nature of relationships in the network (Tracy and Whittaker 1990). This approach allows both clinicians and clients to evaluate (1) existing informal resources, (2) potential informal resources not currently used by the client, (3) barriers to involving resources in the client's social network, and (4) whether to incorporate particular informal resources in the formal treatment plan. Mapping also can identify substance-using behaviors of individuals in the client's social network. The map takes an average of 20 minutes to complete and provides a concise but comprehensive picture of a family's social network. Practitioners report that the social network map identifies and assesses stressors, strains, and resources within a client's social environment (Tracy and Whittaker 1990). This interactive, visual tool allows clients to become actively engaged and gain new insight into how to find support within their social networks.

Instructions

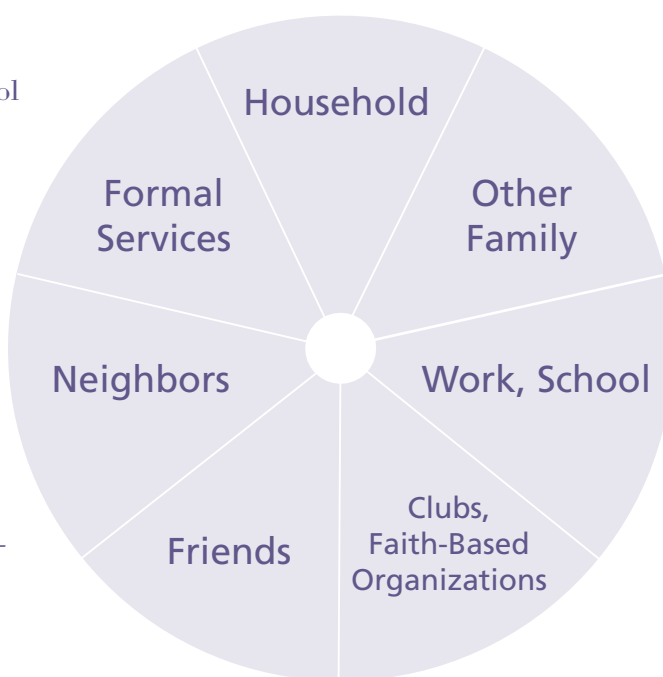
Step one. Explain to the client that you would like to take a look at who is in the client's social network by putting together a network map. The client can use a first name or initials for each important person in his or her life; either the clinician or the client can enter the names in the appropriate segment of the circle shown at right.

Sample script. Think back over this past month, say since [date]. What people have

been important to you? They may have been people you saw, talked with, or wrote letters to. This includes people who made you feel good, people who made you feel bad, and others who just played a part in your life. They may be people who had an influence on the way you made decisions during this time.

There is no right or wrong number of people to identify. Right now, just list as many people as you can think of. Do you want me to write, or do you want to do the writing? First, think of people in your household—whom does that include? Now, going around the circle, what other family members would you include in your network? How about people from work or school? (Proceed around each segment of the circle.) Finally, list professional people or people from formal agencies whom you have contact with.

Look over your network. Are these the people you would consider part of your social network this past month? (Add or delete names as needed.)



* Source: Tracy and Whittaker 1990, pp. 463–466. Reprinted with permission from *Families in Society* (www.familiesinsociety.org), published by the Alliance for Children and Families.

Step two. Number the sections of the circle 1 through 7, as shown in the Area of Life section of the grid (exhibit 6-3). If there are more than 15 names on the circle, the client selects the top 15 people to enter on the social network grid. Transfer the 15 names and the numbers that correspond to the sections of the map to the social network grid. Names of people in the network also should be put on individual slips of paper for the client to use in preparing the network grid.

Step three. After the names from the social network map have been added to the leftmost column of the social network grid, ask the client to consider the nine categories in the column headings. The client uses the 15 slips of paper with the names from the social network map to respond, sorting the slips into groups corresponding to the numerical options that accompany each category in the grid. For example, when considering how critical of the client each individual in his or her life is, the client sorts the slips into piles representing those who (1) hardly ever, (2) sometimes, or (3) almost always criticize. The name of each person and the appropriate number for his or her level of support are then entered onto the network grid in each life area. The finished grid gives an overall picture of support in the client's social network.

Sample script. Now, I'd like to learn more about the people in your network. I've put their names on this network grid with a number for the area of life. Now I'm going to ask a few questions about the ways in which they help you.

The first three questions have to do with the *types of support* people give you. Who would be available to help you out in *concrete* ways? For example, who would give you a ride if you needed one or pitch in to help you with a big chore or look after your belongings for a while if you were away? Divide your cards into three piles: those people you can hardly ever rely on for concrete help, those you can rely on sometimes, and those you'd almost always rely on for this type of help.

Now, who would be available to give you *emotional* support? For example, who would comfort you if you were upset or listen to you talk about your feelings? Again, divide your cards into three piles. (Proceed through remainder of the questions.)

Clinical Application

Mapping a client's social network provides a visual and numerical depiction of the client's significant relationships. The following aspects of social functioning are highlighted:

- Network size
- Availability of support
- Criticism client faces
- Closeness
- Reciprocity
- Direction of help
- Stability
- Frequency of contact

Best Practice in Managing Risk: Principles and Evidence for Best Practice in Assessment and Management of Risk to Self and Others in Mental Health Services (Department of Health, 2009)

This framework document is intended to guide mental health practitioners who work with service users to manage the risk of harm. It sets out a framework of principles that should underpin best practice across all mental health settings, and provides a list of tools that can be used to structure the often complex risk management process. The philosophy underpinning this framework is one that balances care needs against risk needs, and that emphasizes positive risk management; collaboration with the service user and others involved in care; the importance of recognizing and building on the service user's strengths; and the organization's role in risk management alongside the individual practitioner's.

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_076512.pdf

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Resources

Behavioral Couples Therapy

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Program Development

Caring Dads (<https://www.caringdads.org/>)

Circle of Security (<https://www.circleofsecurityinternational.com>)

DHHS Administration for Children and Families: Office of Planning, Research, and Evaluation (<https://www.acf.hhs.gov/opre/resource-library>)

Family Friendly Checklist: [http://www.fcf.ohio.gov/Portals/0/Home/Engaging%20Families/Family%20Engagement%20Self%20Assessment/Survey%20--%20IS%20YOUR%20ORGANIZATION%20FAMILY%20FRIENDLY%20\(Versions%20Clean\).pdf](http://www.fcf.ohio.gov/Portals/0/Home/Engaging%20Families/Family%20Engagement%20Self%20Assessment/Survey%20--%20IS%20YOUR%20ORGANIZATION%20FAMILY%20FRIENDLY%20(Versions%20Clean).pdf)

Father Engagement and Father Involvement Toolkit (<http://calswec.berkeley.edu/toolkits/father-engagement-and-father-involvement-toolkit-guide-implementing-monitoring-and-sustaining>)

Father-Friendliness Organizational Self-Assessment and Planning Tool: http://calswec.berkeley.edu/files/uploads/pdf/CalSWEC/Fatherhood_AssessTool.pdf

Father Friendly Check-Up Survey: <http://www.fatherhood.org/ffcuc?portalId=135704&hsFormKey=016e8e036eb1ce8> (includes how to video)

MDRC Responsible Fatherhood Project (http://www.mdrc.org/sites/default/files/full_573.pdf)

National Family Preservation Network (<http://www.nfpn.org/father-involvement>)

National Family Preservation Network: Basic and Advanced Fatherhood Training Curricula (<http://www.nfpn.org/father-involvement>)

National Fatherhood Initiative (<http://www.fatherhood.org>)

National Fatherhood Initiative: 24/7 Dads (<http://store.fatherhood.org/24-7-dad-am-3rd-ed-with-booster-sessions>)

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Module 6

Case-Based Application

Training Goals and Objectives

Help programs apply family-centered concepts, principles, and interventions through the use of a client case study.

By the end of this module, participants will be able to:

1. Apply steps for developing family-centered interventions using a fictional client case study.
2. Apply the principles and interventions to a case study using a culturally inclusive and family-centered approach.
3. Use a case study exercise to inform decisions at both an organizational and clinical level.




Easier Together:
Partnering with Families to
Make Recovery Possible




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**Module 6: Case-Based
Application**

- Where to begin
- Questions to consider
- Developing a family-centered case plan



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Introductions

- ▶ Name
- ▶ How many family members are in your family?
- ▶ Describe family using one word.

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Hands-On Review of Participant Manual

► Participant Manual

Each module contains:

- Training goals and objectives
- Copy of slides
- Resources – worksheets, activities, assessments, recommended reading
- Reference list



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Goal and Objectives

Goal: Help programs apply family-centered concepts, principles, and interventions through the use of a client case study.

Objectives: Participants will be able to:

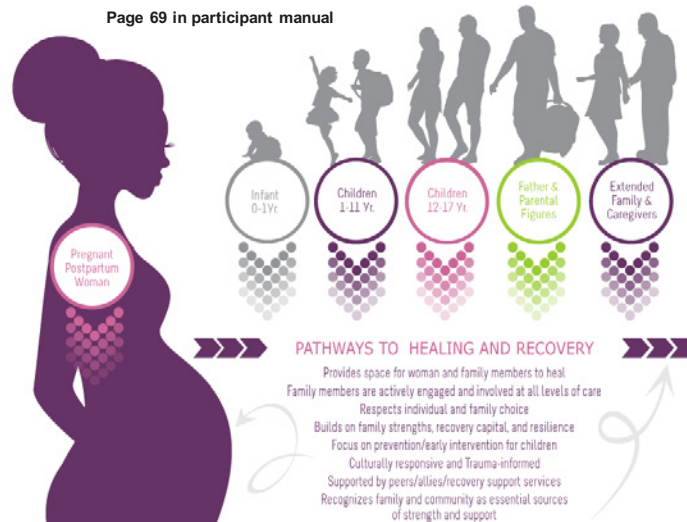
- ▶ Apply steps for developing family-centered interventions using a fictional client case study.
- ▶ Apply the principles and interventions to a case study using a culturally inclusive and family-centered approach.
- ▶ Use a case study exercise to inform decisions at both an organizational and clinical level.

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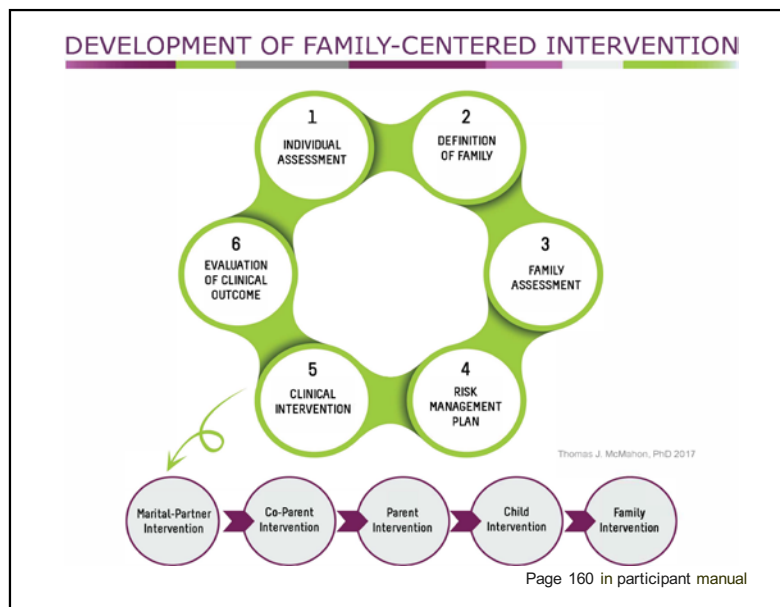
Family-Centered Behavioral Health Support
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Family-Centered Recovery & Wellness Principles

Page 69 in participant manual

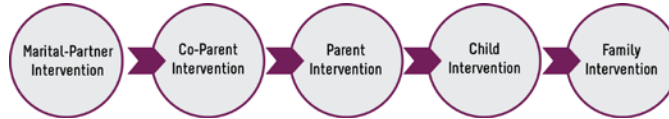








Types of Family-Centered Clinical Interventions



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The Culture Conversation




- ▶ Families are different and unique in every continent, state, county, city, community, and home.
- ▶ The people who come to see us bring us their stories, they hope they tell them well enough so that we understand the truth of their lives, they hope we know how to interpret their stories correctly, we have to remember that what we hear is their story. – Robert Coles

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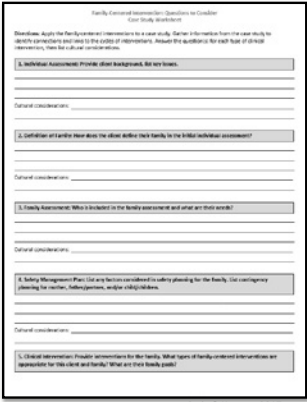
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Page 189 in participant manual





Worksheet: Questions to Consider



Family-Centered Intervention: Questions to Consider Worksheet

Pages 190-191 in participant manual

Craig & Kramer, 2017



Worksheet: Family-Centered Case Plan

Family-Centered Case Plan - Case Study Worksheet

Family-Centered Case Plan
Strengths and Needs List

Cultural Considerations: _____

Identified Strength or Need (statement of what the family may right be identified)	Information and Recommendations (statement of possible needs, assessment or recommendation for the family)	Strength or Challenge (Indicate with a "+" or "-")	Priority of Need/Issue (1 = immediate to 5 = least urgent) (Indicate with a "+" or "-")
Identified and Future Interventions:			
Upstream Interventions:			
Facilitating Interventions:			
Child and Adolescent:			
Family Interventions:			
Other Interventions:			

Intervention: is a priority to be addressed
is important, but the priority is to address with family-centered activity, in a time within a six-month period
is a long-term area for consideration, no action needed or recommended at this time

Craig & Kramer 2017

Family-Centered Case Plan Worksheet (blank)

Page 192 in participant manual

Example Family-Centered Case Plan Worksheet (completed with examples)

Pages 193-195 in participant
manual



Exercise: Review Case, Questions to Consider

Case Study: Review Case, Questions to Consider

Read the case study and answer the questions below.

1) Review case study:

Module 6 Case Study

Page 196 in participant manual

2) Complete this worksheet
in your group:

Family-Centered Intervention:
Questions to Consider

Page 190-191 in participant
manual

3) Larger group discussion

1) Review case study:

Module 6 Case Study
Page 196 in participant manual

2) Complete this worksheet in your group:

Family-Centered Intervention:
Questions to Consider
Page 190-191 in participant
manual

3) Larger group discussion



Debrief: Questions to Consider

Family-Centered Intervention Case Plan - Case Study Worksheet

Directions: Apply the family-centered intervention to a case study. Gather information from the case study to identify strengths and risks to the safety of intervention. Answer the questions for each type of (case) intervention. Also list cultural considerations.

1. Individual assessment: provide client background, set your goals.

Cultural considerations:

2. Assessment of needs: how does the client define their needs in the least restrictive environment?

Cultural considerations:

3. Needs Assessment: how is it related to the client assessment and what are their needs?

Cultural considerations:

4. Safety Management Plan: set up safety management in safety planning for the family. Let everyone plan for their safety, and set priorities.

Cultural considerations:

5. Case management: provide intervention for the family. Set up a system of intervention and support for the client and family and set their family goals?

Cultural considerations:

Page 190-191 in participant manual

Craig & Kramer, 2017



Exercise: Develop Family-Centered Case Plan

Family-Centered Case Plan - Case Study Worksheet

Family-Centered Case Plan
Strengths and Needs List

Cultural Considerations:

Identified Strengths or Risks (strengths or risks, strengths or risks might be considered)	Information and Recommendation (provide a possible action, intervention or recommendation that may work)	Strength or Challenge (include with a plan)	Strength or Challenge (include with a plan)
Medical and Family Information:			
Current Information:			
Pending Information:			
Other Information:			
Family Information:			
Other Information:			

1. A recommendation is a plan to be implemented.
2. A plan is a plan to be implemented with family-centered assessment. It is a plan within a plan. It is a plan to be implemented with family-centered assessment. It is a plan within a plan. It is a plan to be implemented with family-centered assessment. It is a plan within a plan.

Page 192 in participant manual



Debrief: Family-Centered Case Plan

1. What strengths and needs were you able to identify for the family?
2. What challenges did you find?
3. What information was missing?
4. How will you use this exercise to implement family-centered care in your work?

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Outcomes and Evaluation

In terms of applying outcomes to family-centered care, we want to think about it in two ways....

1. What are the outcomes we hope for the entire family?
2. What are the outcomes for the program?

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[illegible]




Resources

- ▶ SAMHSA Cultural Competency-
<https://www.samhsa.gov/capt/applying-strategic-prevention/cultural-competence>
- ▶ SAMHSA HRSA Center for Integrated Health Solutions-
<http://www.integration.samhsa.gov/workforce/cultural-competence-adaptation>

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Module 6

Resources

The Culture Conversation (Module 6)

Background:

SAMHSA on culture: Cultural competence is the ability to interact effectively with people of different cultures. In practice, both individuals and organizations can be culturally competent. Culture must be considered at every step. “Culture” is a term that goes beyond just race or ethnicity. It can also refer to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession.

Culture is an integrated pattern of human behavior which includes but is not limited to: Communication, thoughts, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, spirituality, and expected behaviors of racial, ethnic, religious, social, or political groups.

The Culture Conversation:

Our families are different and unique in every continent, state, county, city, community, and home. We must listen, be understanding, be open, and be willing to experience the discomfort of different!

Special Populations:

When we are working with different populations, we must begin the conversation with the individual and listen to their story of their family. Our family plan works in collaboration with the individuals we serve and the interventions we develop and refine together. Some examples of different cultural groups include:

- Various racial/ethnic communities (African-American, American Indian/Native American/Alaska Native, Asian-American, Hispanic, Multi-Race, Pacific Islander, White)
- Varying types of parents (single parent, multiple parent, co-parent, same sex, divorced, step parent)
- Income levels (low income/middle income/high income)
- Tribal and non-tribal communities
- Types of families (younger, communal, religions, patriarchal, matriarchal)

Next Steps:

Let's see how cultural considerations work across all of family-centered intervention steps within a case study and family-centered plan (see module 6 activity).

Reference:

<http://minorityhealth.hhs.gov/>

**Family-Centered Intervention: Questions to Consider
Case Study Worksheet**

Directions: Apply the family-centered interventions to a case study. Gather information from the case study to identify connections and links to the cycles of interventions. Answer the question(s) for each type of clinical intervention, then list cultural considerations.

1. Individual Assessment: Provide client background, list key issues.

Cultural considerations: _____

2. Definition of Family: How does the client define their family in the initial individual assessment?

Cultural considerations: _____

3. Family Assessment: Who is included in the family assessment and what are their needs?

Cultural considerations: _____

4. Safety Management Plan: List any factors considered in safety planning for the family. List contingency planning for mother, father/partner, and/or child/children.

Cultural considerations: _____

5. Clinical Intervention: Provide interventions for the family. What types of family-centered interventions are appropriate for this client and family? What are their family goals?

**Family-Centered Intervention: Questions to Consider
Case Study Worksheet**

Cultural considerations: _____

6. Evaluation of Clinical Outcome: How is family progress tracked? How are updates to the family plan identified?

Cultural considerations: _____

Other Questions:

What information is missing/lacking from the case history?

How might missing/lacking information be captured from the case study?

Are there are other tools, sources, or areas where the information could be gathered?

Family-Centered Case Plan – Case Study Worksheet

Family-Centered Case Plan Strengths and Needs List

Cultural Considerations: _____

Identified Strength or Need (examples of needs/strengths that might be identified)	Intervention and Recommendation (examples of possible service, intervention or recommendation that may apply)	Strength or Challenge (Indicate with + or -)	Priority of Identified Needs I = Immediate S = Significant N = Noted (Do not prioritize until list is finished)
Marital and Partner Interventions			
Co-parent Interventions			
Parenting Interventions			
Child(ren) Interventions			
Family Interventions			
Other Interventions			

I = Immediate, is a priority to be addressed

S = Significant, has the potential to interfere with family-centered recovery, is a focus within a six month period

N = Noted, an important area for consideration, no action needed or recommended at this time

Example Family-Centered Case Plan – Case Study Worksheet

Example Family-Centered Case Plan Strengths and Needs List

Cultural Considerations: May include cultural and linguistic needs, religious practices, any reported traditions, belief systems, socioeconomic status, homelessness, past incarceration, family composition, or belief systems around male/female roles, parental marital status, likes, dislikes, and preferences

Identified Strength or Need (examples of needs/strengths that might be identified)	Intervention and Recommendation (examples of possible service, intervention or recommendation that may apply)	Strength or Challenge (Indicate with + or -)	Priority of Identified Needs I = Immediate S = Significant N = Noted (Do not prioritize until list is finished)
Marital and Partner Interventions			
Committed to maintaining relationship	Couples counseling offered by primary agency or program	+	I
History of reported domestic violence	Both or one to attend DV classes	–	I
Poor communication skills	Education on communication styles and couples counseling	–	N
Anger and resentment, trust issues	Individual and couples counseling, both partners	–	N
Currently separated due to legal mandates, restraining order	Support of boundaries and couples counseling	–	I
Frequent fights or arguments that have escalated in the past	Safety planning, couples counseling	–	N
Indifference or undecided about intent to continue relationship or inequity in desire to commit	Explore pros/cons of relationship in individual counseling, establish boundaries		I
Reports strong feelings of love and admiration		+	N
Infidelity	Couples counseling	–	N
Used substances together	Intensive outpatient counseling for both with each attending family night sessions, establish boundaries and define new relationship rules	–	I
Shared values and support of extended family members for the relationship	Encourage supportive relationships	+	N
Co-Parent Interventions			
Different/conflicting parenting styles, values, beliefs	Parenting class, separately and together	–	I
Positive role models as children, with maternal grandparents having strong connection to children	Family outings and play time activities with parents, children, and maternal grandparents	+	N
Inconsistent boundaries and discipline, structure for children	Education on developmental stages and needs of children, offered at _____	–	S
Desire to parent together and share responsibilities	Support family interactions, daddy and me times	+	N

Example Family-Centered Case Plan – Case Study Worksheet

Difficulty with step children and sharing of responsibilities	Will be addressed in parenting curriculum	–	N
No intent to co-parent child	Develop parenting plan for children, engage father	–	I
Child safety involvement regarding both parents' ability to care for children	Establish the guidelines as established by child welfare regarding visitation, arrange for parenting risk assessment	–	I
Incarceration of one parent	Determine the degree of parental involvement	–	S
Parenting Interventions			
Father/mother lack knowledge and understanding of child's needs	Parenting and education class at _____ agency	–	I
Cultural background, community support for parenting	Outreach to individuals from their community	+	N
Reported neglect or concerns relating to welfare of children	Obtain child welfare report to establish understanding of concerns, recommend classes	–	I
Lacks skills, knowledge, or coping skills to manage stressors of parenting	Support group for new fathers	–	S
New baby in home, new infant care and support	Boot Camp for New Dads, Healthy Families Caseworker	–	I
Death of Child, loss or grief	Support groups for grieving parents offered at _____ Hospital	–	S
Parenting, step parenting of older children	Education and workshop	–	S
Difficulty with attachment and bonding as a result of trauma	Meet with counselor for parent-child observation and coaching	–	S
Previous child welfare involvement	Determine outcomes and history, focus on strengths	–	I
Multiple Fathers for children, incarceration of one parent, absent father	Parenting plan established for both fathers/mother	–	N
Child(ren) Interventions			
Developmental considerations of infant, toddler	Refer for developmental assessment of younger child	–	I
Neonatal exposure to substances	Assist parents in understanding care for neonatal exposed infants	–	I
Behavioral problems	Refer for child therapy	–	I
Loss, grief, socialization, failure to thrive, school difficulties	Arrange parent/teacher meeting, refer to pediatrician for recommendations	–	S
Family Interventions			
Use of substances by father, partner, parents' siblings	Family member in need of substance use disorder assessment and services, referred to _____	–	I
Family member(s) lack understanding of substance use disorders and recovery	Family programming and education regarding substance use disorders, family peer support services	–	S
Transportation difficulties	Provide resources and offer transportation to allow engagement in programming	–	I

Worksheet developed by Kimberly Craig, BA, BS, LSAT and Diana Kramer, MA, BHT (2017)

Example Family-Centered Case Plan – Case Study Worksheet

Conflict, strained relationships	Conflict resolution and anger management class for family members, family support groups offered at _____	–	S
Siblings, grandparents limited support	Provide family sessions to discuss safety planning and determine what support is available	–	I
Father reports history of mental health disorder and current symptoms with no current services in place	Assessment for MH with case management to obtain or maintain prescribed medications	–	I
Other Interventions			
Homeless or unstable housing	Referral to housing or move into supportive housing	–	I
Unemployed or lacks resources to support family	Job readiness or training programs, career coaching, job search, resume writing class	–	S

I = Immediate, is a priority to be addressed

S = Significant, has the potential to interfere with family-centered recovery, is a focus within a six month period

N = Noted, an important area for consideration, no action needed or recommended at this time

Easier Together: Partnering with Families to Make Recovery Possible
Module 6 Case Study

Basic Information/Demographics about Mother

Name: Jennifer Maydup

Age: 28

Race/ethnicity: African-American

Primary Language: English

Is client currently pregnant?: No

Is client currently breastfeeding?: Yes

Does client want to have more children?: No

History of perinatal or postpartum mood disorder?: Yes

Describe any special pregnancy issues: First pregnancy premature, second none

Presenting problem for which client accessed your treatment center: To prevent further use of substances, regulate emotions, and get stable housing

Diagnosis summary (substance use and mental health disorders): polysubstance dependence and major depressive disorder

ASAM Level of Care - 0.5 (early intervention) 1 (outpatient services), 2 (intensive outpatient), 3 (residential/inpatient), 4 (medically managed intensive inpatient services): 3

Family Information

Client's relationship with each family member, substance use among family members, family members' engagement in client's treatment, and any other relevant information (put N/A when appropriate)

Father/partner/significant other: Client is not married, an off-and-on romantic relationship with the father of her 2 month old child for 5 years. They lived together for 4 years. They separated 2 months ago after getting into a big argument. Client shared that a friend told her the father has started attending AA groups and now wants to work on improving his relationship with the client. He also wants to be actively involved in the lives of the children. The father of the 5 year old has no contact with the children and is currently in prison; recently has contacted the client through social media.

Child(ren) (include age(s), who child resides with, and who has custody of child): 5 year old female and 2 month old male residing in treatment with mother

Extended family: Client has limited contact with extended family, and a strained relationship with mother and brother.

Other: Client has limited contact with the families of her children's fathers

What are the top three wishes or desires of the client and/or family? What's their hope for the future?

1. Client desires the happily ever after, sitcom family scenario.
2. Client wishes that her children always feel loved.
3. Clients wants a stable family for her child, with a defined role for the father.

What are the main needs of the client's family members or family as a whole?

The main need is freedom to explore themselves and each other and grow.

Client History

Substance use history: History of using marijuana age 13, alcohol age 15, and methamphetamine/cocaine age 16

Mental health history: Major Depressive Disorder

Previous treatment for substance use/mental health: Previous treatment at 45-day treatment facility

Medical history (including current medications): No current medications

Sexual health history: Multiple partners prior to first child, currently only son's father involvement

Trauma history: Rape at age of 15

Social history: GED, unemployed

Justice system involvement (periods of incarceration): N/A

Current or previous child welfare system involvement: With first child, no longer involved

Recovery and natural supports: Strained family supports and limited family connections

Cultural needs/preference (for example: spiritual, language, racial/ethnic, traditional, disability, dietary, gender identity, sexual orientation, nationality, tribal, gender preference practitioner, etc.): Client says she "believes in a higher power, but doesn't go to any church." Heterosexual, does not eat pork, prefers female practitioner and someone who understands her cultural history.





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