tools for treatment
Family-Centered Behavioral Health Support for Pregnant & Postpartum Women
ATTC | Center of Excellence

EASIER TOGETHER

Partnering with Families to Make Recovery Possible

Trainer Manual

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

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About Us
The ATTC Center of Excellence on Behavioral Health for Pregnant and Postpartum Women and Their Families (ATTC CoE PPW) is funded by SAMHSA as a supplement to the Mid-America Addiction Technology Transfer Center, in partnership with the Great Lakes, New England, and Southeast Regional ATTCs. The Center was established to develop a family-centered national curricula, web-based toolkit, and provide support for national training and resource dissemination to diverse stakeholders.

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

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INTRODUCTION

Training Goals and Objectives

This curriculum contains six, 45-minute modules. The goals and objectives of the modules are as follows.

Module 1: Introduction

Goal: 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.

Module 2: Family-Centered Care

Goal: 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.

Module 3: Building Programs for Fathers

Goal: 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.

Module 4: Implementing Family-Centered Programming

Goal: 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.

Module 5: Family-Centered Clinical Interventions

Goal: 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.

Module 6: Case-Based Application

Goal: 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.

Audience

The primary intended 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, and other community partners.

An optimal number of participants of 20-35 is suggested to facilitate authentic and open discussion, interaction, exploration of challenges, and brainstorming solutions. Ideally, the training group should be large enough to split into at least three small groups of six-plus members each. The training materials can be adjusted for smaller or larger groups as needed.

Training Overview

This six module, four and a half hour curriculum describes a family-centered approach to treatment, care, and supervision of pregnant and postpartum women (PPW) with a substance use/mental health disorder(s) and their families. The definition of family-centered care in this context is:

> **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.

Training Philosophy

Adult learning occurs best when information is presented in an interactive and participatory fashion that respects the knowledge of both facilitators and participants. The experienced trainer will recognize that minor modifications may be necessary since this training will have diverse audiences. The trainer manual has been designed to allow flexibility in the presentation where possible, while remaining faithful to the curriculum goals and objectives. Discussion questions and activities are intended to help participants connect the material to their practice and to encourage higher order learning. In most cases, the trainer is urged to customize the more didactic review of information to allow full time for discussion and activities.

Trainer Preparation

Prior to the training, you will need to download the module slides and print a trainer manual and participant manuals. Each participant will need a participant manual so they can access slides, resources, and handouts used during the training. All materials are available at http://attcppwtools.org/LearnASkill/TrainingCurricula.aspx (or from www.attcppwtools.org home page, select "Learn a Skill" tab and then select "Training Curricula").

The trainer manual contains the following for each module: training goals and objectives, module design and time allotted for content throughout module, slides with presenter notes, resource section with handouts, and reference list. Throughout the presenter notes, keep an eye out for statements labeled ***"Note to trainer."*** These statements provide important trainer instructions. Keep in mind that page numbers in the trainer and participant manuals vary due to the added information in the trainer manual for each module. Make sure to reference the page numbers in the participant manual so participants can follow along (corresponding participant manual page numbers are indicated in the trainer notes and on the slides).

The trainer manual is designed for delivery by clinical supervisors with their staff and a mixture of community partners (i.e. addiction treatment and health care providers; child welfare professionals; justice representatives; housing or vocational specialists; and/or community organizations that provide ongoing recovery supports for families). This training can give clinical supervisors insight into the range of approaches and potential conflicts that exist among multiple agencies, programs, and service systems within a particular community. It can assist the clinical supervisor in assessing the need for more program enhancements or modifications and identify those gaps and barriers that most affect service coordination for families in recovery.

Customizing Modules

There is more information in most modules than can be delivered in the allotted 45 minutes. This gives the trainer an opportunity to adjust delivery to the participants' needs and preferences. Groups may wish to know more about certain topics relevant to their practice, and less about others.

Facility and Materials Needed

Participants will need space to move around for small group work and activities. PowerPoint slides will be used in didactic presentations. An internet connection and speakers will be required to show videos, including the documentary included in Module 2 and video clip in Module 3. Other materials needed include:

- Trainer Manual
- Participant Manuals
- Computer with presentation slides loaded
- Screen or blank wall to project presentation slides
- Projector and speakers
- Name tags or table tents
- Evaluation forms
- Pens/pencils
- Chart paper for group note-taking (optional)

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:

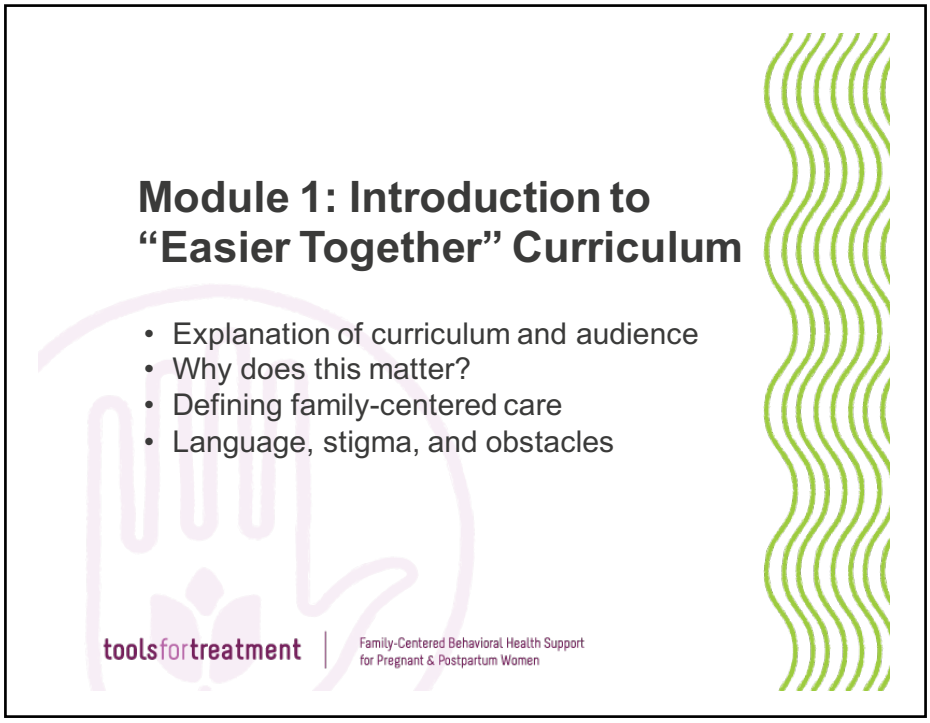
1. Explain why family-centered care matters.
2. Define family-centered care in the context of pregnant/postpartum women's (PPW) addiction treatment.
3. Evaluate the impact of language, myths, and stigma on care for PPW with substance use disorders and their families.

Design and Time

Section	Description	Components	Time
Introductions and how sessions work	Overview of curriculum.	•Title & acknowledgements •Participant introductions •Overview of "Easier Together" curriculum, manual, and PPW website •Goal & objectives	10 minutes
Why does this matter?	Explores treatment facility data and availability of family-centered services for PPW and family members. Provides research rationale for family-centered approach.	•Data regarding family-centered treatment for PPW and their families	5 minutes
What is family-centered care for PPW with substance use disorders?	Defines family-centered care and reviews cultural and historical influences to demonstrate interdisciplinary development of this approach. Demonstrates how family-centered care is building on gender-specific and responsive approach.	•Family-centered care definition •Historical influences •Expanding gender-specific and responsive approach to family-centered care	10 minutes
Language, myths, stigma, and obstacles	Fact or myth exercises reveal common stigmatizing language and beliefs that affect the care of PPW with substance use disorders. Leads into a discussion of the importance of language.	•Fact or myth exercises •Language matters	15 minutes
Wrap up	Conclusion of module.		5 minutes

Slide 1

Welcome to "Easier Together: Partnering with Families to Make Recovery Possible." This curriculum contains six modules that will describe a family-centered approach to treatment. It will allow you to consider how you might use this approach in your work to improve care for pregnant and postpartum women and their families.



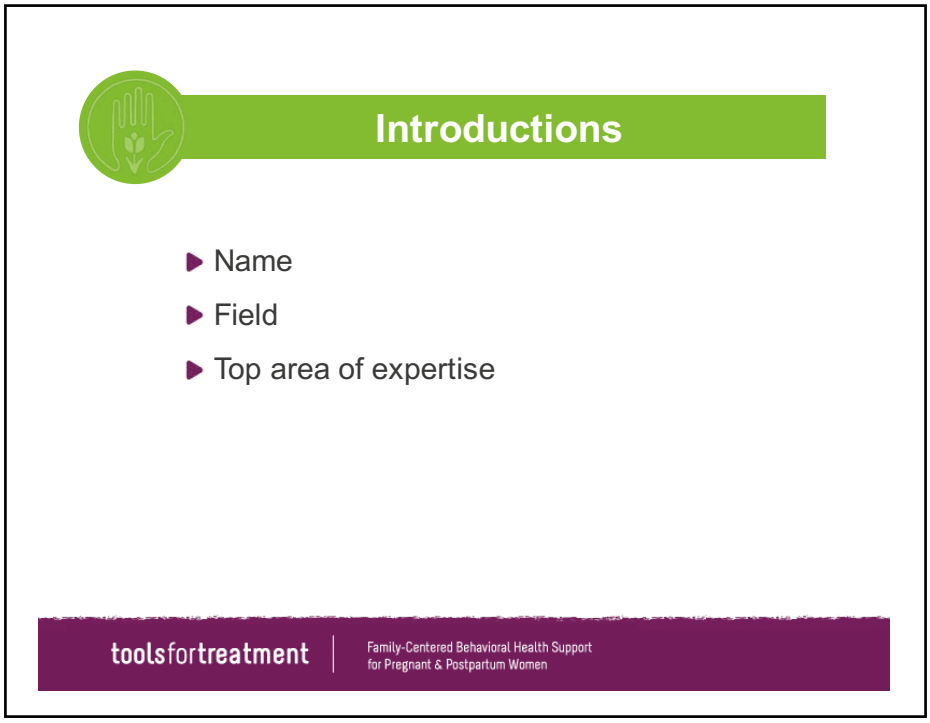
Slide 2

During module 1 of the "Easier Together" curriculum, I will:

- provide an introduction to this training series
- discuss why this topic is important
- describe the definition of family-centered care, and
- review language, stigma, and obstacles.

Slide 3

Our thanks to Kathryn Icenhower, PhD, CEO and Co-founder of SHIELDS for Families, for her expertise and many contributions in the development of this module. Dr. Kathryn Icenhower is the Co-founder and Chief Executive Officer of SHIELDS for Families, a private non-profit organization with 340 staff, a $30-million-dollar budget and 38 programs that serve over 10,000 families annually in South Los Angeles. She received her BSSW from Ohio State University and her MSW and PhD from the University of Southern California. Dr. Icenhower sits on numerous local, state, and federal coalitions and advisory boards, including the California State Child Welfare Council and SAMHSA'S Advisory Council for Women's Services. She has been recognized by numerous entities for her piloting work in the substance use and child welfare fields including an Innovator Award from CSAT for her work in Family Centered Treatment, the James Irvine Foundation Leadership Award, the Visionary Award from the National Association
of Minority Contractors, and named as one of the 50 most influential women in Los Angeles by Los Angeles Magazine.

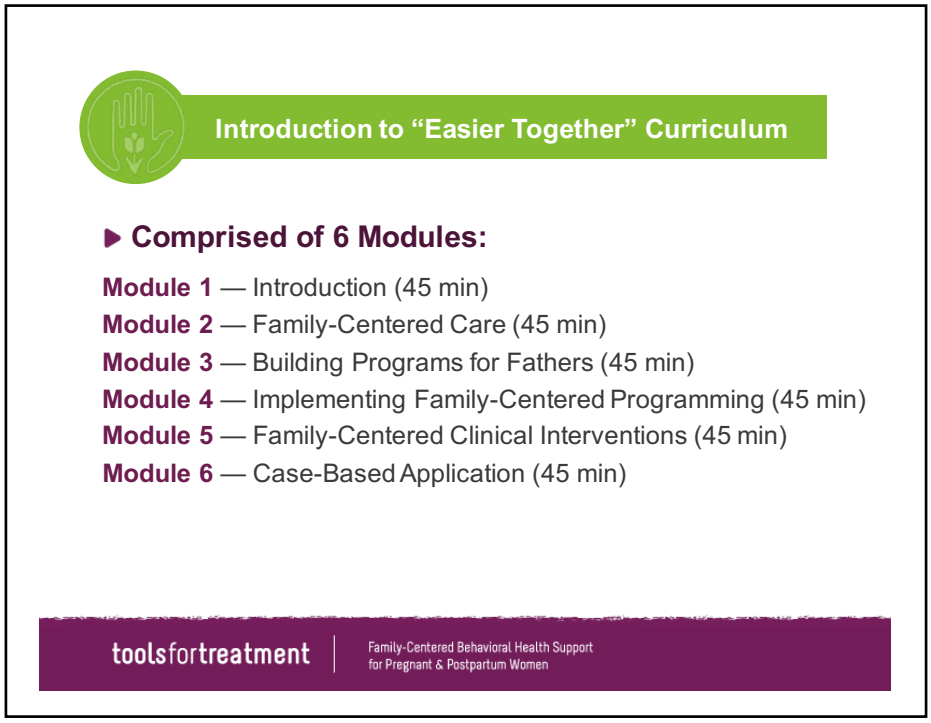


Slide 4

Before we get started, I'd like to do some brief introductions.

- Trainer: introduce yourself
- Now I'd like everyone to introduce yourself. This curriculum is meant to be interdisciplinary and collaborative, so it would also be helpful to learn about the field you work in and your top area of expertise. For instance, my name is Sarah, I work in child welfare, and my top area of expertise is family preservation.
- Have everyone say their name, field, and area of expertise.

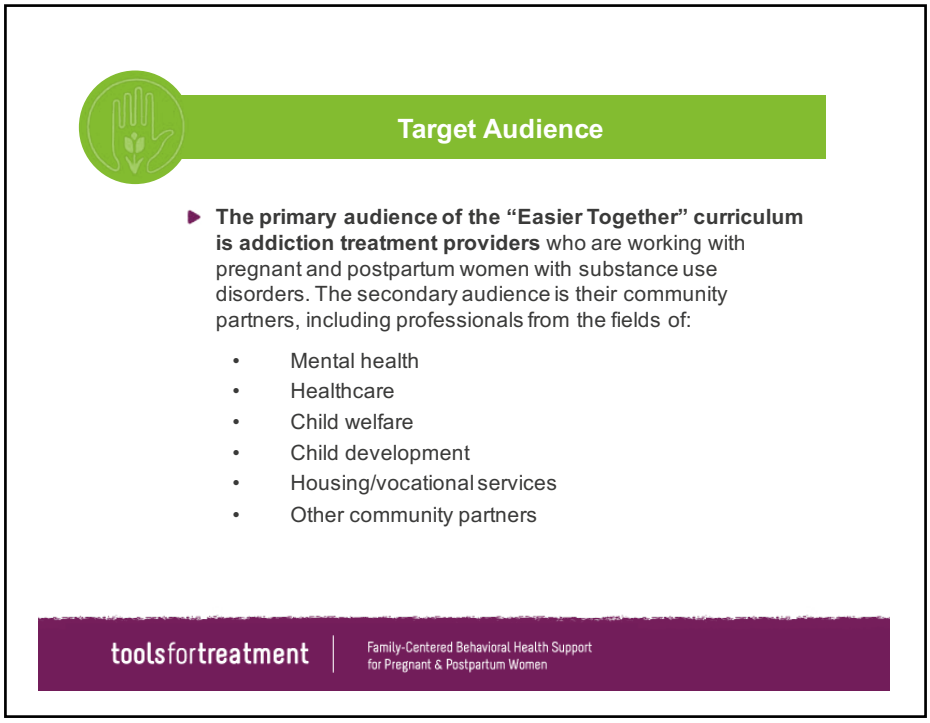
Note to trainer: *based on the group, you're welcome to modify this introduction activity.*



Slide 5

So let's get started with the "Easier Together" curriculum. It is comprised of 6, 45-minute modules:

- The first module is an introduction to this training series, why this topic is important, how we define family-centered care, and a review of language, stigma, and obstacles.
- In module 2, we will dive deeper into family-centered care by watching a documentary produced for this curriculum that tells the story of family-centered care through the perspectives of clients and staff at a treatment program in Compton, CA. We will go through a series of discussion questions to explore the central principles of family-centered care and see how they might apply to your work.
- In module 3, we will review why programs should involve fathers.
- In module 4, we will discuss how to implement family-centered programming at the agency level.
- In module 5, we will review the types of family-centered clinical interventions that can be implemented.
- In module 6, we will apply the content of modules 1-5 to a client case.



Slide 6

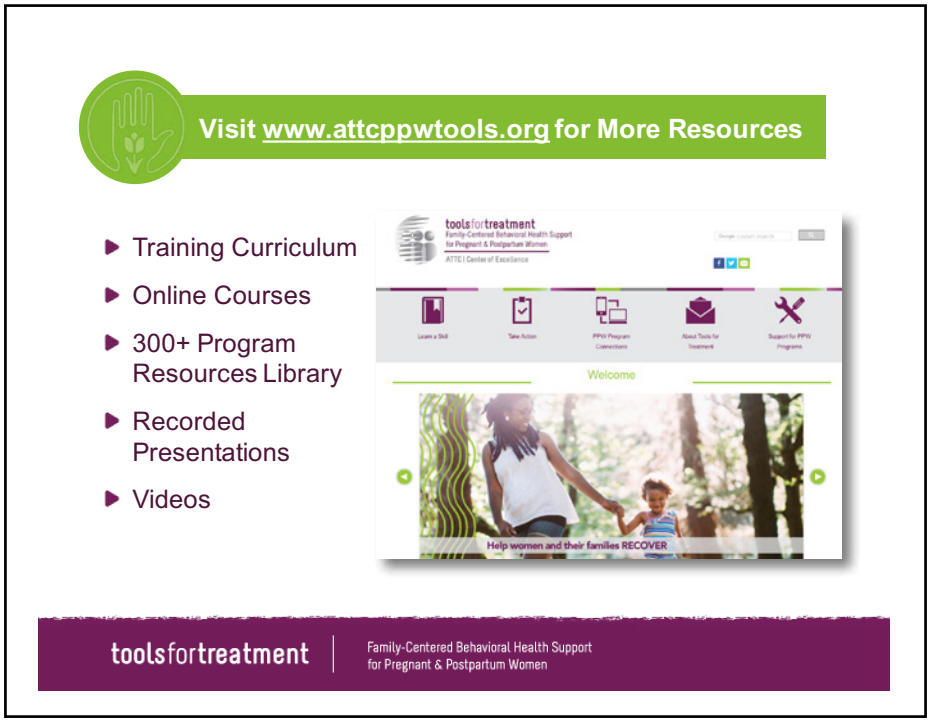
The primary audience of the "Easier Together" curriculum is addiction treatment providers who are working with pregnant and postpartum women with substance use disorders. The secondary audience is their community partners, including professionals from the fields of:

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

Slide 7

As part of this curriculum, you all have a participant manual. Please bring this manual with you to all sessions, as it will be referenced frequently. I'd like us to do a hands-on review on the manual so you are familiar with all of its content. Please turn to page 4 so we can review what's in the participant manual:

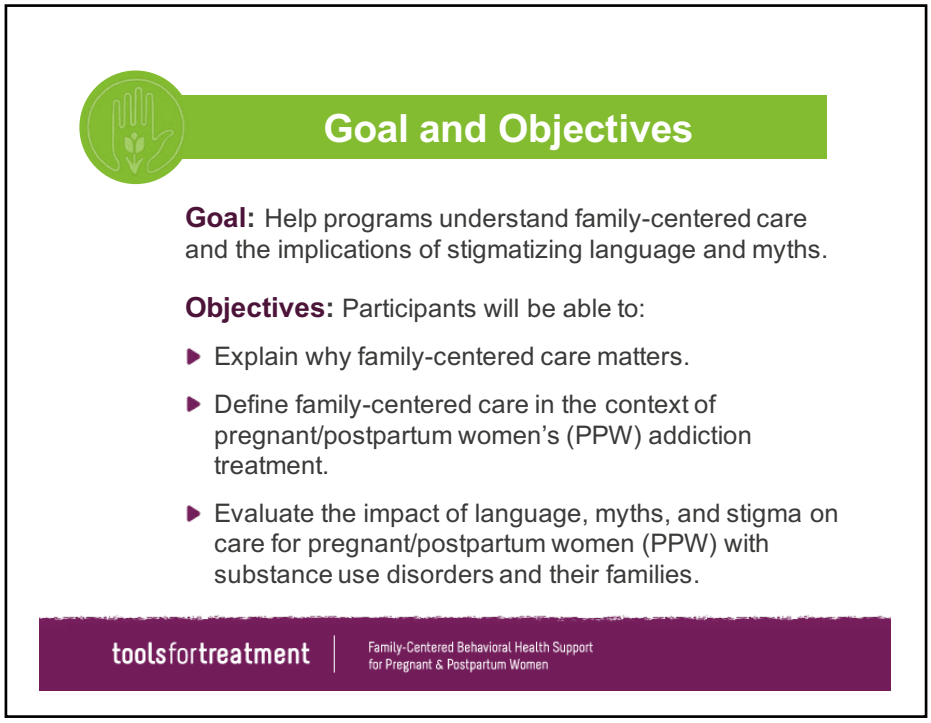
- On page 4, the module begins with the training goals and objectives.
- Next on page 5 you will find all of the presentation slides with room for taking notes.
- Then on page 24 you will find the resources section, which contains a collection of handouts, worksheets, activities, assessments, recommended reading, and a reference list for that module.
- This structure is repeated for each module.



Slide 8

For additional resources, visit www.attcppwtools.org. Here you can download the "Easier Together" curriculum and access other resources such as:

- Training curriculum
- Online courses
- 300+ resources in the Program Resources library
- Recorded presentations
- Videos



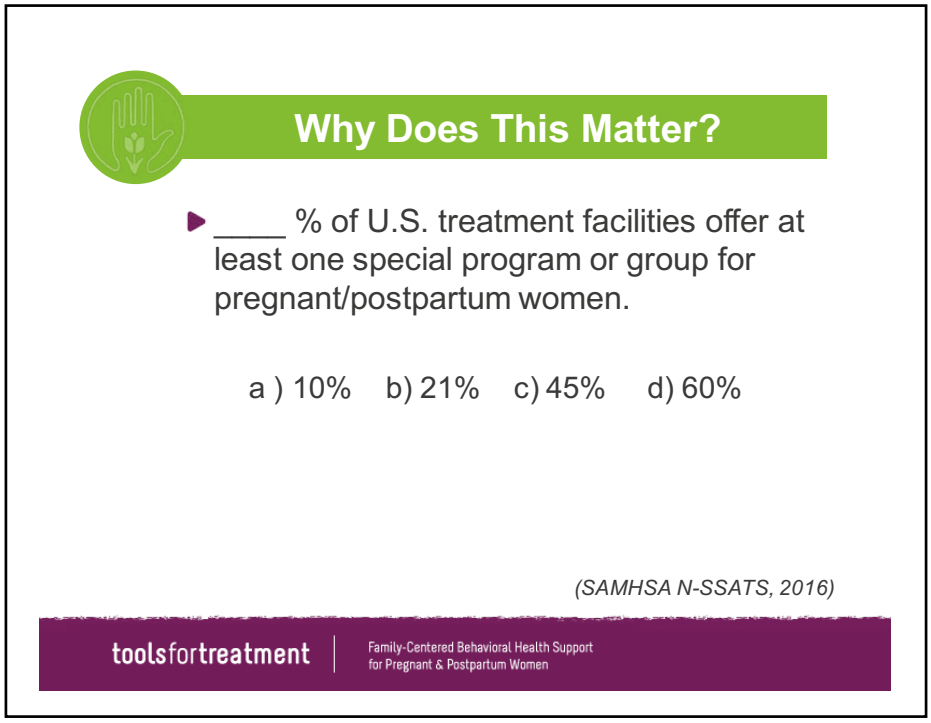
Slide 9

The goal for Module 1 is to help programs understand family-centered care and the implications of stigmatizing language and myths.

These are our learning objectives for Module 1.

Slide 10

So why does family-centered care matter? We're all at different levels of experience with it, and some of you may feel like you're doing much of this already. However, if we're still talking about it, we could always do it more effectively and enhance our services to be more family-centered. We're hoping this curriculum will provide new insights for even those of you who have worked in this area for a number of years.

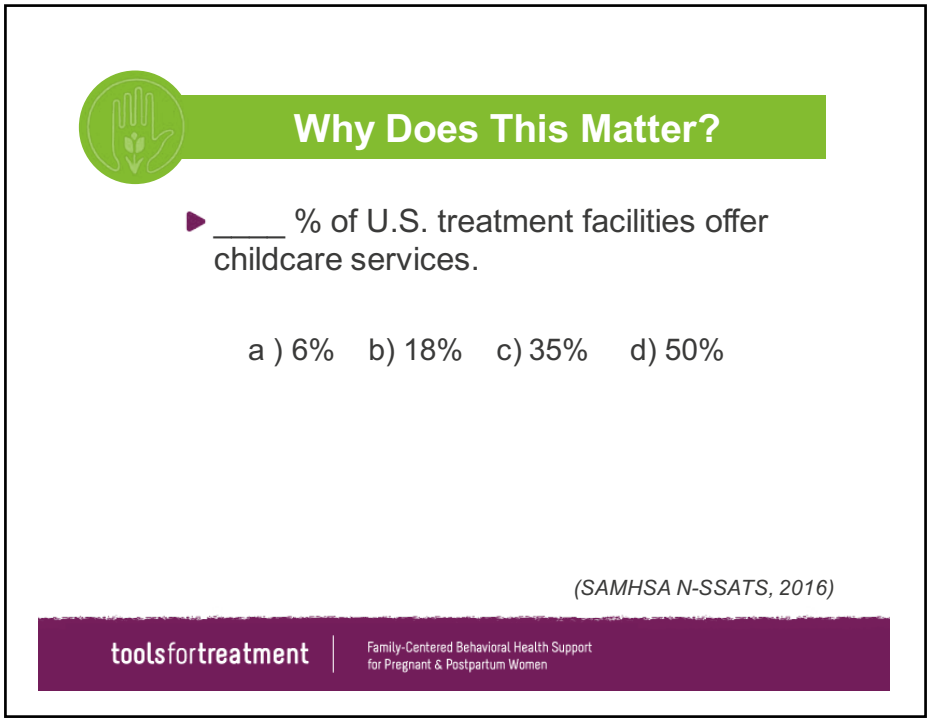


Slide 11

Does anyone know what percentage of U.S. treatment facilities offer at least one special program or group for pregnant/postpartum women?

Answer: b – 21%

Treatment services tailored for pregnant/postpartum women are surprisingly limited, despite the importance of addressing substance use during this time period.

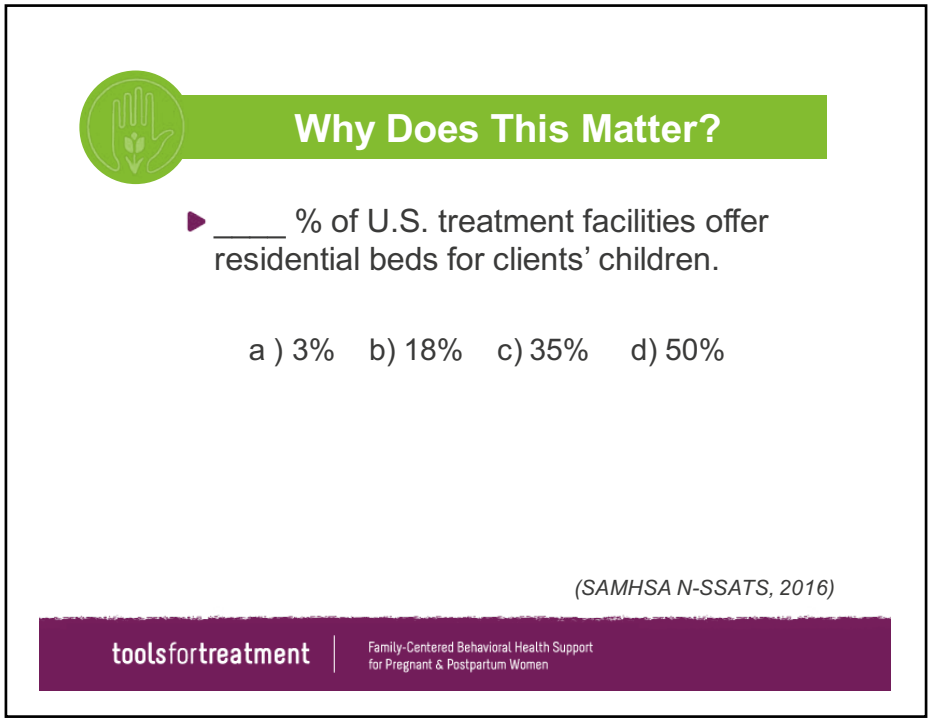


Slide 12

Does anyone know what percentage of U.S. treatment facilities offer childcare services?

Answer: b – 6%

So few programs offer childcare services, making it extremely challenging for women to participate in treatment. And this number only includes childcare services; therapeutic and child development services for clients' children are even scarcer.

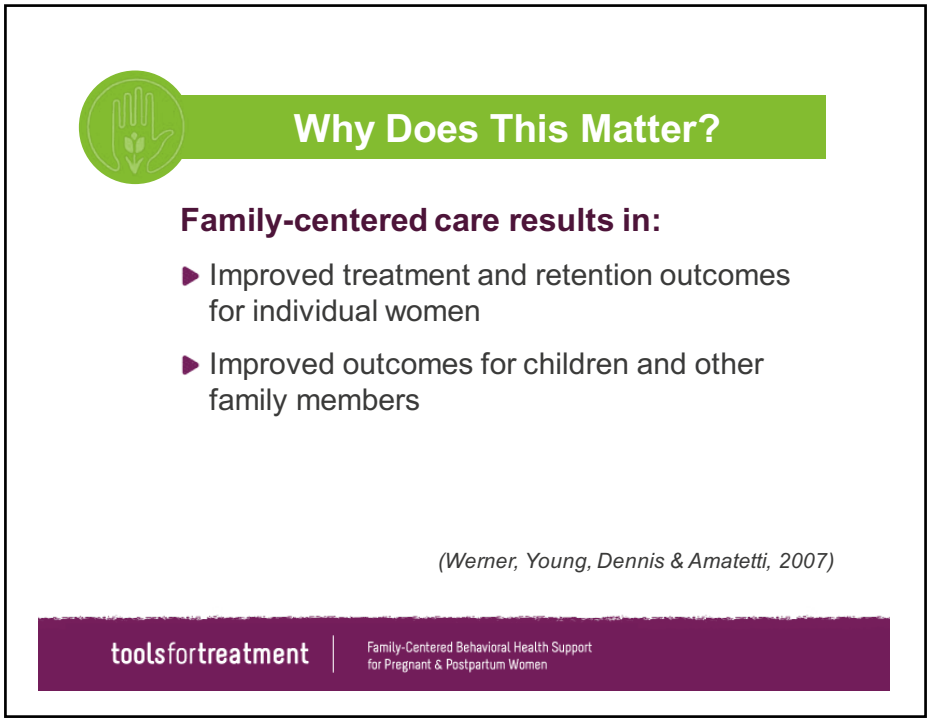


Slide 13

Does anyone know what percentage of U.S. treatment facilities offer residential beds for clients' children?

Answer: b – 3%

Not letting women bring their children to treatment is a huge barrier. Again, a lot of us think family-centered care is widespread and what we've always been doing. However, the data tells a different story. This approach is actually very uncommon.



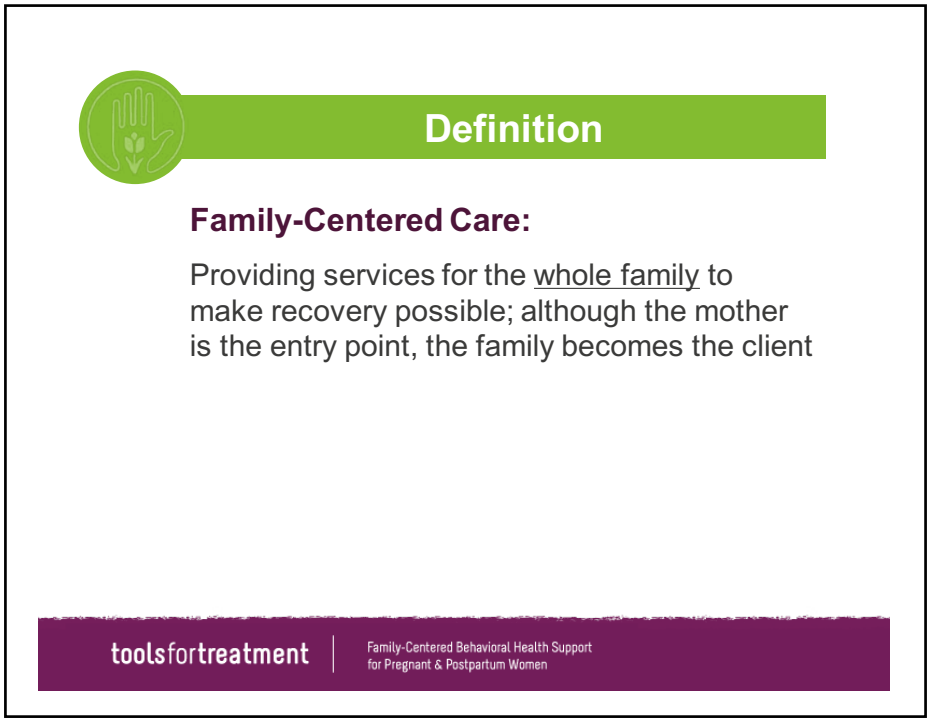
Slide 14

Family-centered care has impressive outcomes. Current data has shown:

- It results in improved treatment and retention outcomes for individual women.
- Children and other family members also have improved outcomes.

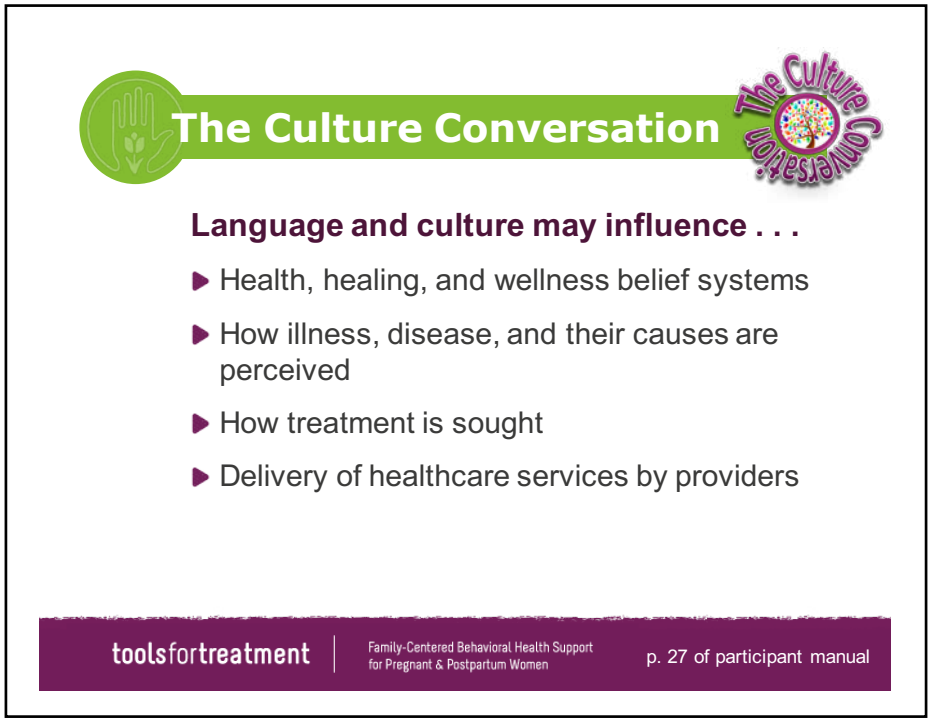
Slide 15

So let's discuss what family-centered care is all about and where this concept came from.



Slide 16

There are many definitions and philosophies about family-centered care as it applies to different fields. In the context of pregnant and postpartum women's addiction treatment, it is providing services for the whole family to make recovery possible. Although the mother is the entry point, the family becomes the client. This includes the father and/or partner, children of all ages, and other extended family members or friends who are an integral part of the woman's family.



Slide 17

As part of family-centered care, we have to consider the culture of the families we serve and our own cultural competence as professionals. Understanding the importance of language and culture is key in eliminating health disparities:

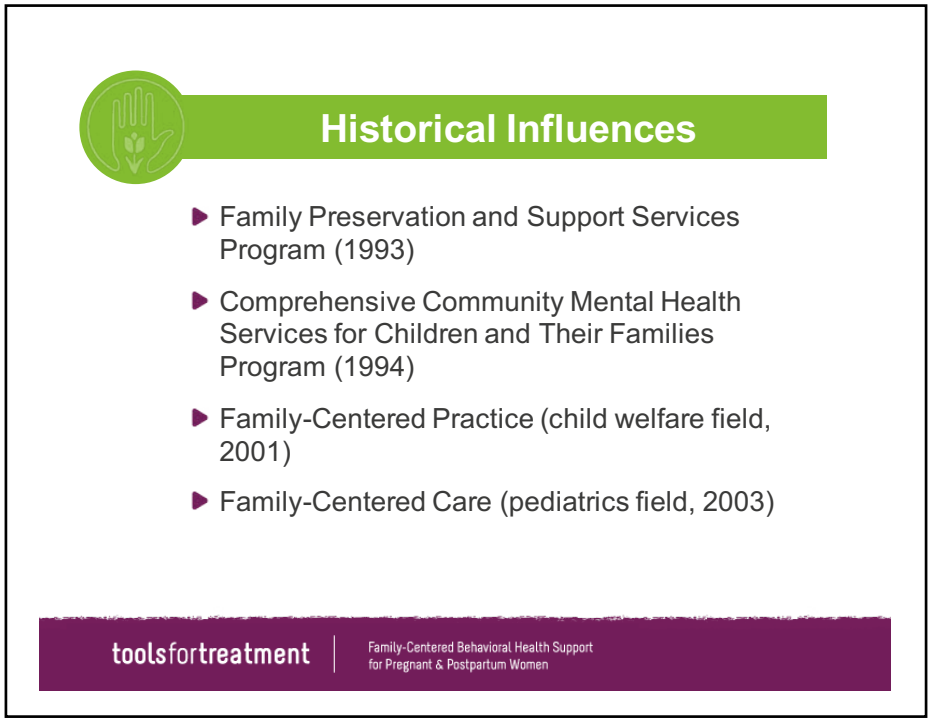
- Health, healing, and wellness belief systems; *how health services are delivered and created for the populations they serve.*
- How illness, disease, and their causes are perceived; *both by the individual and the healthcare system.*
- How treatment is sought; *the behaviors of individuals seeking 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.*

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.

Note to trainer: *For more on culture, see the handout on page 27 of your participant manual. Reference: http://minorityhealth.hhs.gov/templates/*

Slide 18

Family-centered care is not a new idea. It has evolved across many disciplines, including mental health, child welfare, and pediatrics. Let's review its historical influences.



Slide 19

Our definition of family-centered care builds on all of these perspectives. These are some programs and fields that have contributed to the development of family-centered care. You'll notice that different fields are based on the perspectives of different family members. While pregnant/postpartum women's addiction treatment focuses on the perspective of the mother, many of these fields have focused on the child's perspective.

Family Preservation and Support Services Program (1993)

- This program officially recognized the practice of family preservation.
- It expanded the scope from children's services to include family support services.
- Communities were encouraged to build a system of family support services to "assist vulnerable children and families in an effort to prevent child maltreatment."
  [McGowan, B. G. (2010). An historical perspective on child welfare: An international perspective on knowledge in the service of policy.]

Comprehensive Community Mental Health Services for Children and Their Families Program (1994)

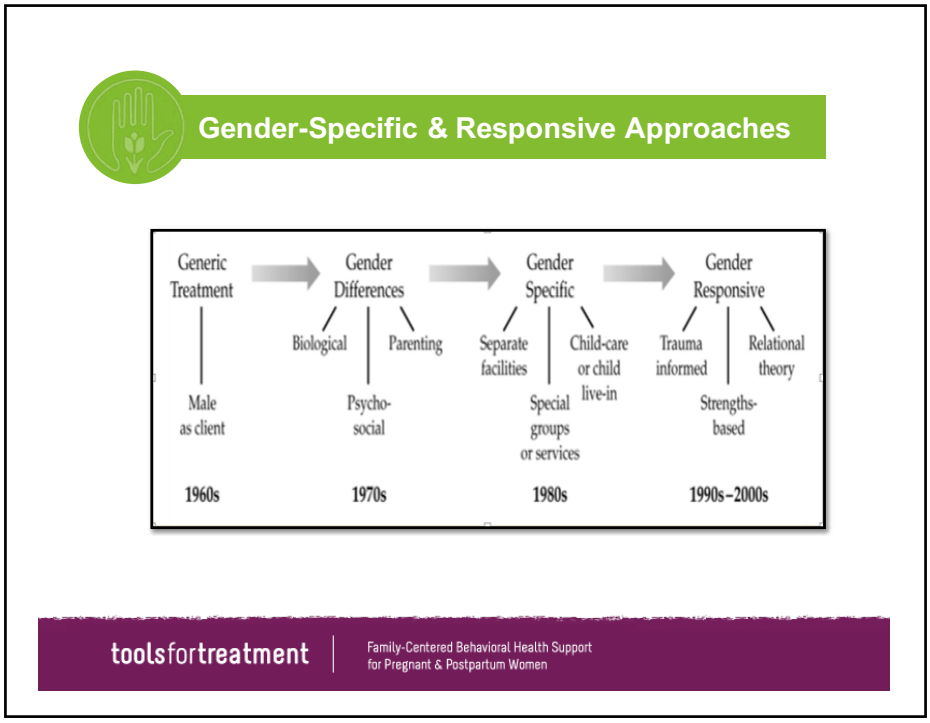
- This framework also emerged from emphasis at the federal level on family-centered and family-focused approaches to providing care for children with severe emotional disturbances and their families. Established in 1994, the Comprehensive Community Mental Health Services for Children and Their Families Program was administered by the Center for Mental Health Services (CMHS) of SAMHSA. Child welfare and U.S. Child Health Policy has incorporated and funded it.

Family-Centered Practice (child welfare, 2001)

- The child welfare field defines family-centered practice as "A way of working with families, both formally and informally, across service systems to enhance their capacity to care for and protect their children. Family-centered practice includes a range of strategies, including advocating for improved conditions for families, supporting them, stabilizing those in crisis, reunifying those who are separated, building new families, and connecting families to resources that will sustain them in the future."
  [https://www.childwelfare.gov/aboutus/faq/famcentered/]

Family-Centered Care (pediatrics, 2003)

- Family-centered care is a term used in the pediatrics field. It is an innovative approach to the planning, delivery, and evaluation of health care that is grounded in a mutually beneficial partnership among patients, families, and providers that recognizes the importance of the family in the patient's life.
  [American Academy of Pediatrics, Institute for Family-Centered Care, PEDIATRICS Vol. 112 No.3 Sep 2003]

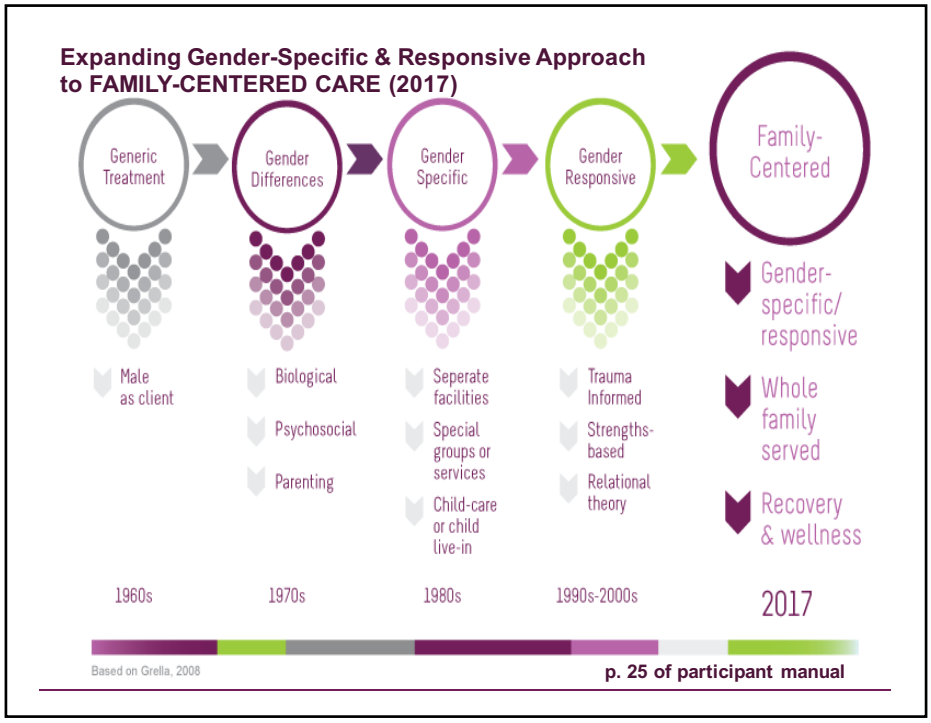


Slide 20

Family-centered care in the context of pregnant and postpartum women's addiction treatment is also heavily rooted in gender-specific and responsive approaches. Up until the 1960s, treatment was designed for male clients. However:

- **Women's specific services** began emerging in the 1970s as research documented the differences between men's and women's substance use.
- In the 1980s, **gender-specific services** were developed to reflect these gender differences. Examples include creating separate facilities for men and women, offering childcare, and having groups focused on women's issues.
- **Gender-responsive approaches** were developed in the 1990s to early 2000s. These approaches integrated trauma-informed care, relational theory, and a strengths-based perspective.
- I want to note that when we're saying "gender" in this context, we mean women/females.

Graphic source: Grella, C. E. (2008). From generic to gender-responsive treatment: Changes in social policies, treatment services, and outcomes of women in substance abuse treatment. *Journal of Psychoactive Drugs, SARC Supplement 5*, 327-343.

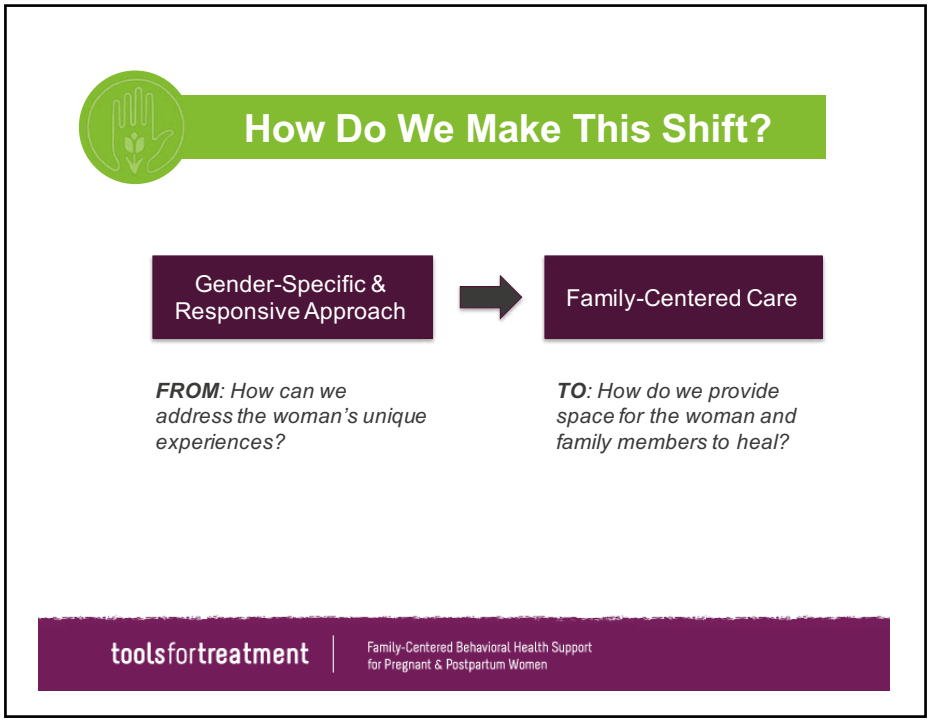


Slide 21

Family-centered care in the context of pregnant/postpartum women's addiction treatment is a natural expansion from gender-specific and responsive approaches. It builds on those principles by providing wraparound services for the entire family and uses a recovery approach to support long-term wellness.

Graphic based on: Grella, C. E. (2008). From generic to gender-responsive treatment: Changes in social policies, treatment services, and outcomes of women in substance abuse treatment. *Journal of Psychoactive Drugs, SARC Supplement 5*, 327-343.

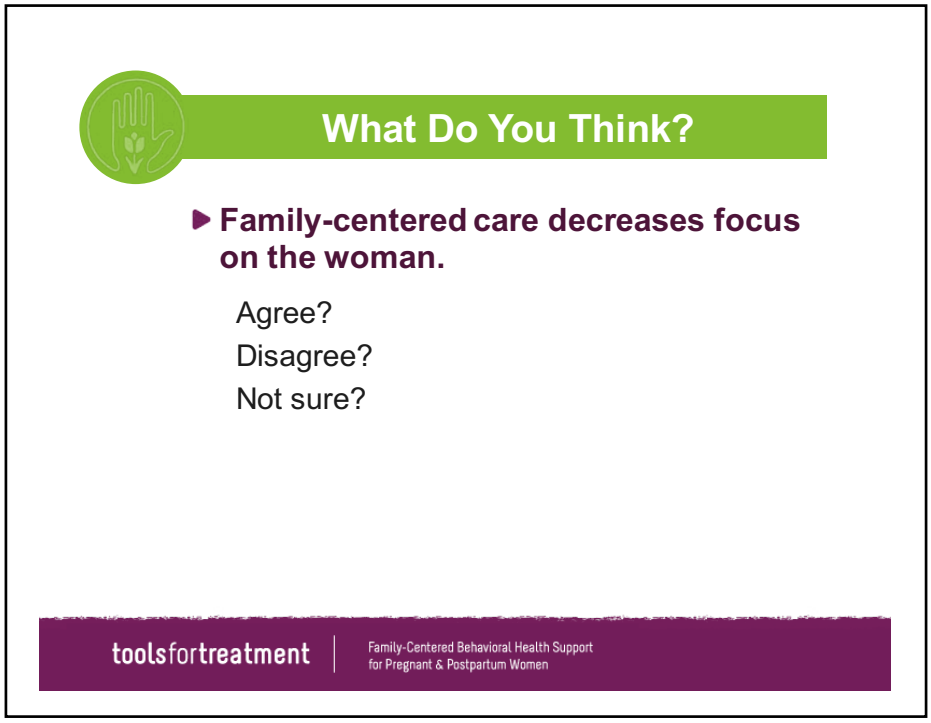
Note to trainer: *This handout is available on page 25 of the participant manual.*



Slide 22

So how do we make this shift?

- In a gender-specific and responsive approach, we address women's unique experiences and multiple needs; provide a healing, safe, and healthy environment; and use relational approaches to provide gender-specific treatment.
- However, for pregnant and postpartum women and mothers in general, it is integral to also consider the needs of family members, including fathers/partners and children.
- In family-centered care, we consider how we can provide a space for the woman AND family members to heal, how we can actively involve family members, how we can recognize the importance of family in the woman's life, and how we can support the woman in negotiating her relationships.
- Family-centered care is a natural and necessary extension of a gender-specific and responsive approach that benefits the mother and family as a whole.
- The "Easier Together" curriculum will provide some practical ideas on how we can make this shift.



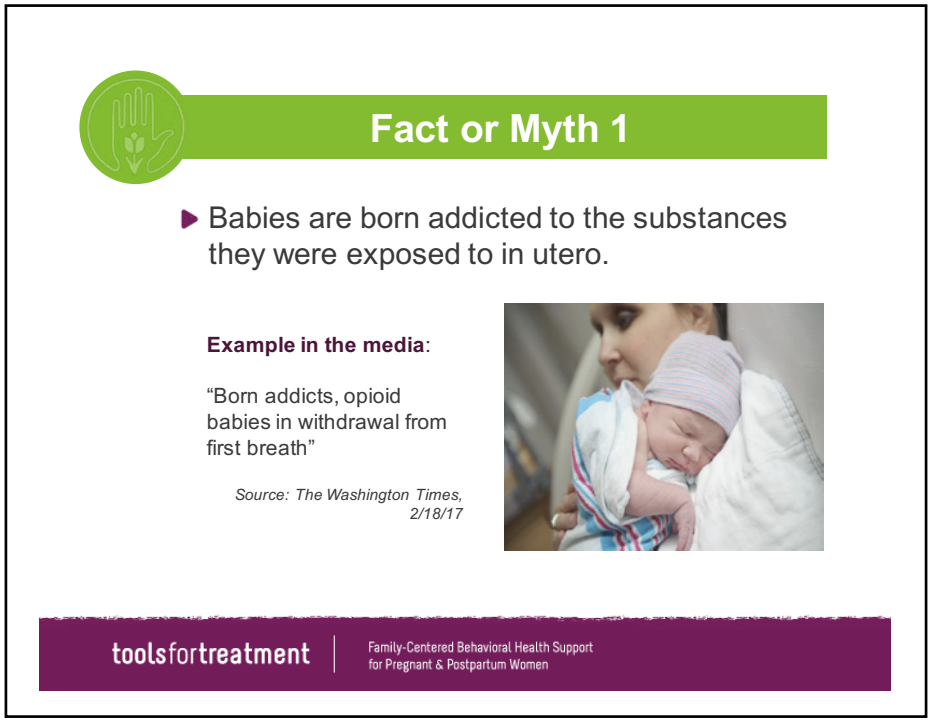
Slide 23

- I want to stop and get your thoughts on making this shift. What do you think? Does family-centered care decrease focus on the woman?
- Raise your hand if you agree
- Raise your hand if you disagree
- Raise your hand if you're not sure
- Those of you who agree, would you talk about some of your concerns?
  ***Note to trainer:** Ask, "Those of you with your hands up, would you be willing to tell us why you responded this way?"*
- Those of you who are unsure, would you describe why?
  ***Note to trainer:** Ask, "Those of you with your hands up, would you be willing to tell us why you responded this way?"*
- Those of you who disagree, would you share your thoughts?
  ***Note to trainer:** Ask, "Those of you with your hands up, would you be willing to tell us why you responded this way?"*
- I appreciate the group for responding to this question. There aren't clear answers to this statement. We hope you get some clarity as we further explore family-centered care throughout this training.

Slide 24

- There are a lot of myths, stigmatizing language, and obstacles relating to family-centered care and pregnant/postpartum women with substance use disorders in general. We have a long history of emotional reactions to substance use issues. Media portrayals influence our perceptions with emotionally charged language that is often without sufficient evidence or data. The resulting attitudes and the impact of these attitudes are often long lasting. Providers are not immune. Media misrepresentation and stigmatizing characterizations are barriers to treatment and long-term recovery.
- Now let's unpack some of these issues by deciding whether statements are facts or myths.
- While we do this, here are some questions to consider: What effects do these attitudes and perceptions have on providers? On pregnant and postpartum women? On their families?

Note to trainer: *See handout, "Open Letter to the Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opioid Use by Pregnant Women," on pages 28-35 of participant manual for discussion on the implications of inaccurate and emotionally charged language.*



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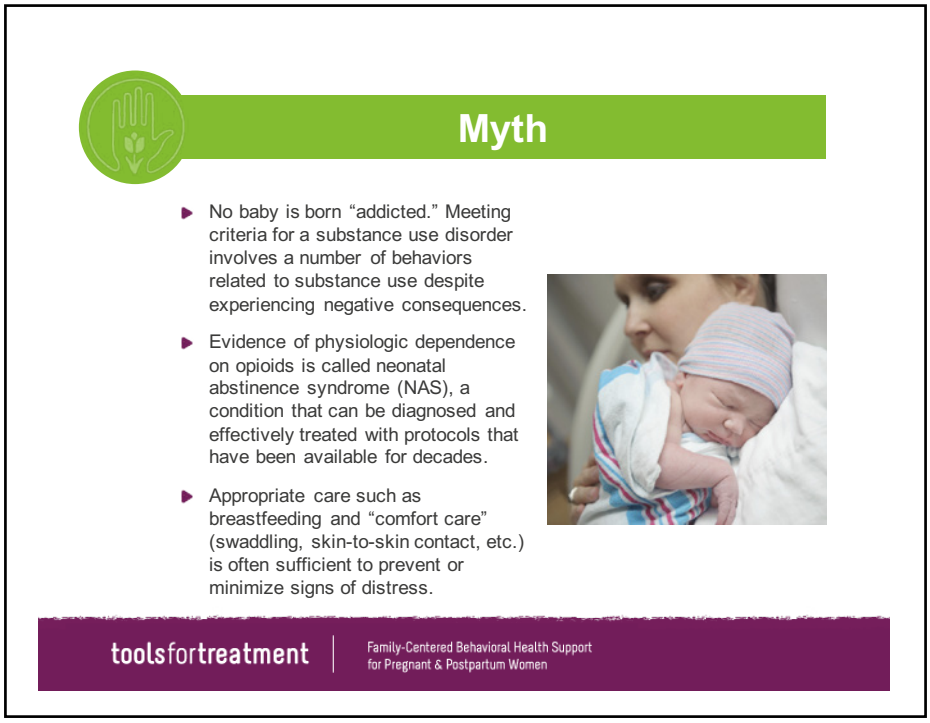
- Is this a fact or myth?
- Babies are born addicted to the substances they were exposed to in utero. This statement is used frequently in the media, such as in this headline: "Born addicts, opioid babies in withdrawal from first breath."
- Example in the media:
  - "Born addicts, opioid babies in withdrawal from first breath."
  - Source: The Washington Times, 2/18/17, http://www.washingtontimes.com/news/2017/feb/18/born-addicts-opioid-babies-in-withdrawal-from-firs/
- Thumbs up if you think this is a fact. Thumbs down if you think this is a myth.



Slide 26

- This is a myth.
- No baby is born "addicted." Meeting the criteria for a substance use disorder involves a number of compulsive behaviors related to substance use despite experiencing negative consequences. For example, babies are not drug-seeking.
- 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 in the baby.
- What effects do these attitudes and perceptions have on providers? On pregnant/postpartum women with SUDs? On their families?

Slide 27

- Is this a fact or myth?
- 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, http://wfpl.org/pregnant-women-addicted-opioids-choosing-treatment-plan-comes-access/
- Thumbs up if you think this is a fact. Thumbs down if you think this is a myth.

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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Slide 28

- This is a 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. (https://www.drugabuse.gov/news-events/nida-notes/2012/07/buprenorphine-during-pregnancy-reduces-neonate-distress)
- 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. (https://www.drugabuse.gov/news-events/nida-notes/2012/07/buprenorphine-during-pregnancy-reduces-neonate-distress)
- Despite this evidence, some media portrayals have been misleading and stigmatizing. This is particularly true with the media portrayals of babies with NAS.
- What effects do these attitudes and perceptions have on providers? On pregnant/postpartum women with SUDs? On their families?

Slide 29

- Is this a fact or myth?
- 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, https://www.theatlantic.com/politics/archive/2017/07/what-the-crack-baby-panic-reveals-about-the-opioid-epidemic/533763/
- Thumbs up if you think this is a fact. Thumbs down if you think this is a myth.

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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Slide 30

- This is a fact.
- These labels put the child at risk for all three: stigma and discrimination in school starting in pre-school, medical misdiagnosis, and separation from supportive families as a result of inappropriate child welfare interventions.
- What effects do these attitudes and perceptions have on providers? On pregnant/postpartum women with SUDs? On their families?

p. 26 of participant manual

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]

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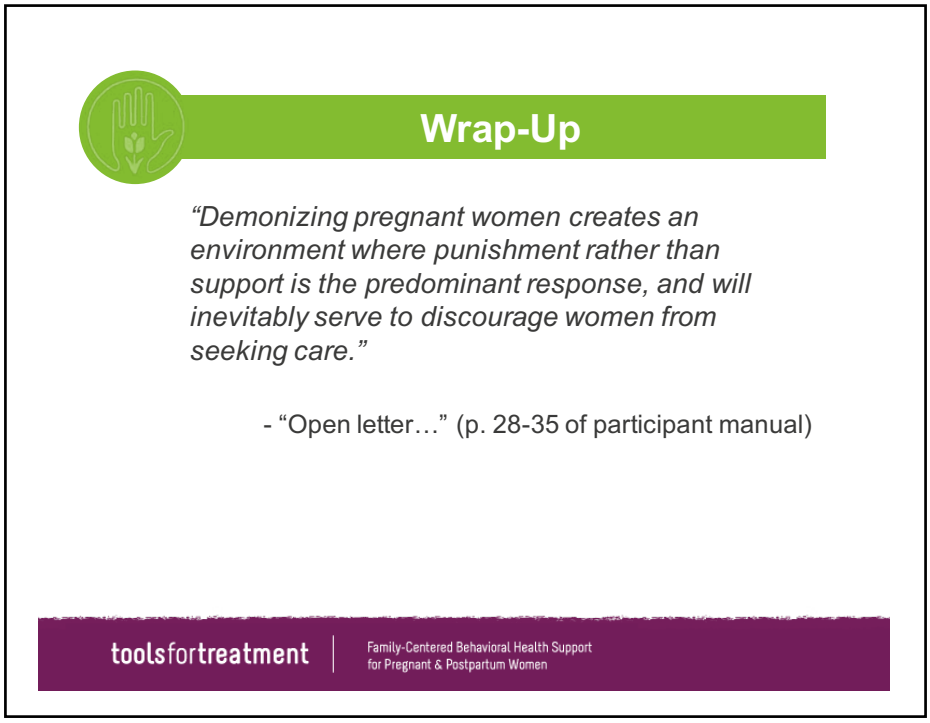
- A lot of these facts versus myths have demonstrated how language matters. Using affirmative language inspires hope and advances family recovery. Our words have power and we should use person-first language when describing these complex issues.
- This table summarizes commonly used stigmatizing language and how we can shift these terms to preferred language. It is adapted from a publication produced by the Office of National Drug Control Policy in 2015.
- If you want to learn more about language and addiction, www.recoveryanswers.org/addiction-ary/ is a great resource.
- Do any of these stand out to you?

Note to trainer: *This is a handout in the participant manual on page 26.*



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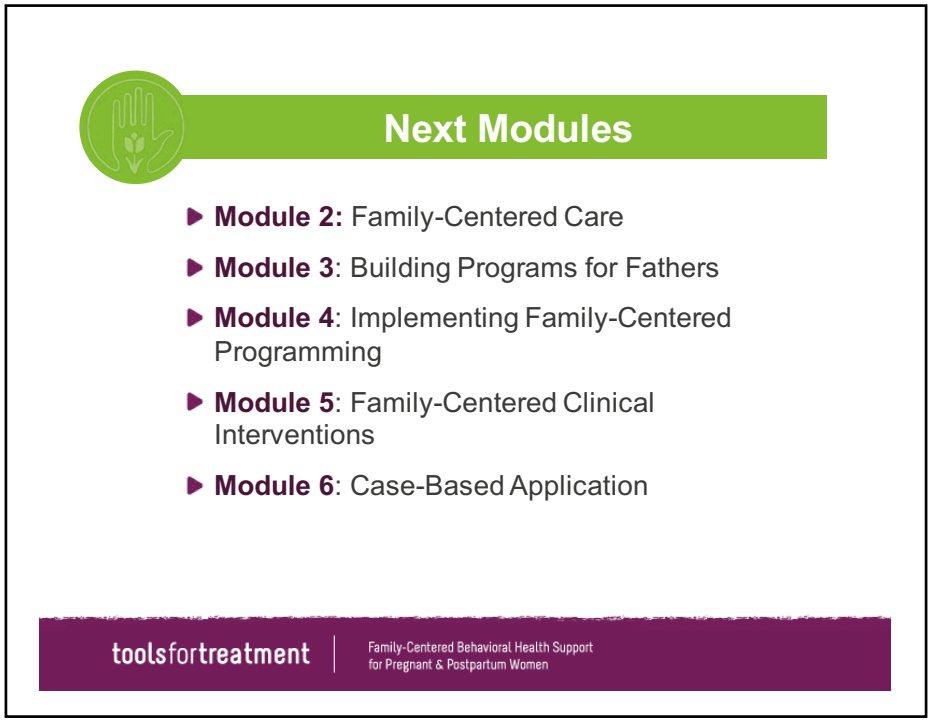
- As we close this module, I'd like to end with a powerful quote from the open letter we talked about earlier. A full copy is available on page 28-35 of your participant manual.
- The quote says: "Demonizing pregnant women creates an environment where punishment rather than support is the predominant response, and will inevitably serve to discourage women from seeking care."
- As advocates for women and their families dealing with addiction, it is important to remember the power of language. Not only can we ensure the language we use is affirming and evidence-based, but we can also advocate to others about the importance of using person-first language and challenge non-scientific portrayals of these issues.
- What closing comments do you have before we talk about next steps?



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These are the next modules in this training series. Make sure to check your participant manual for more information and resources.

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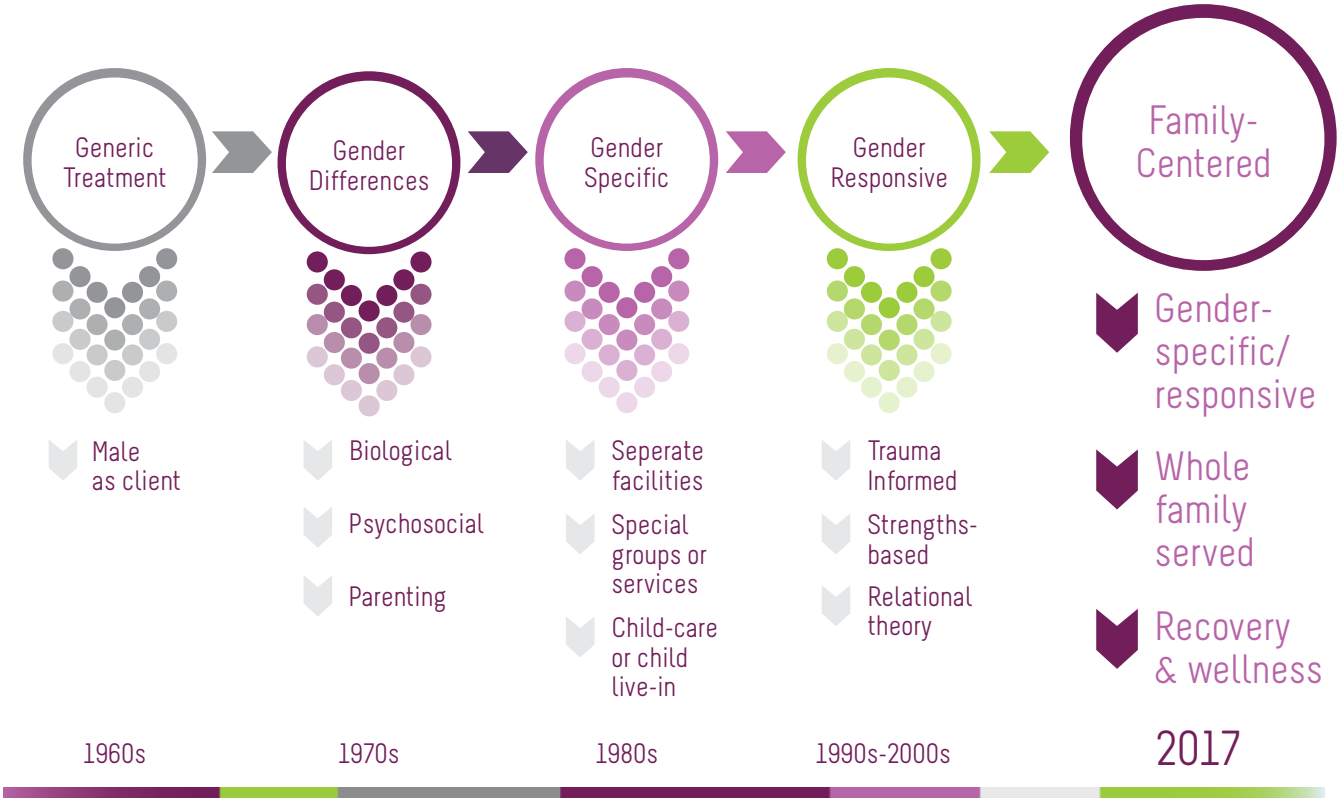
Module 1

Resources

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



Based on Grella, 2008

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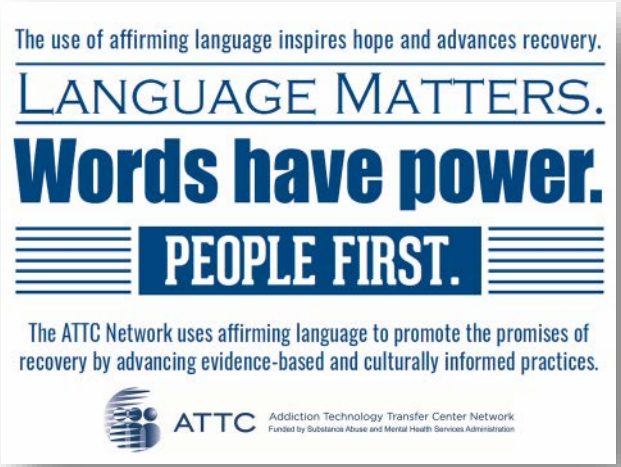
www.attcppwtools.org

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.

Sincerely,

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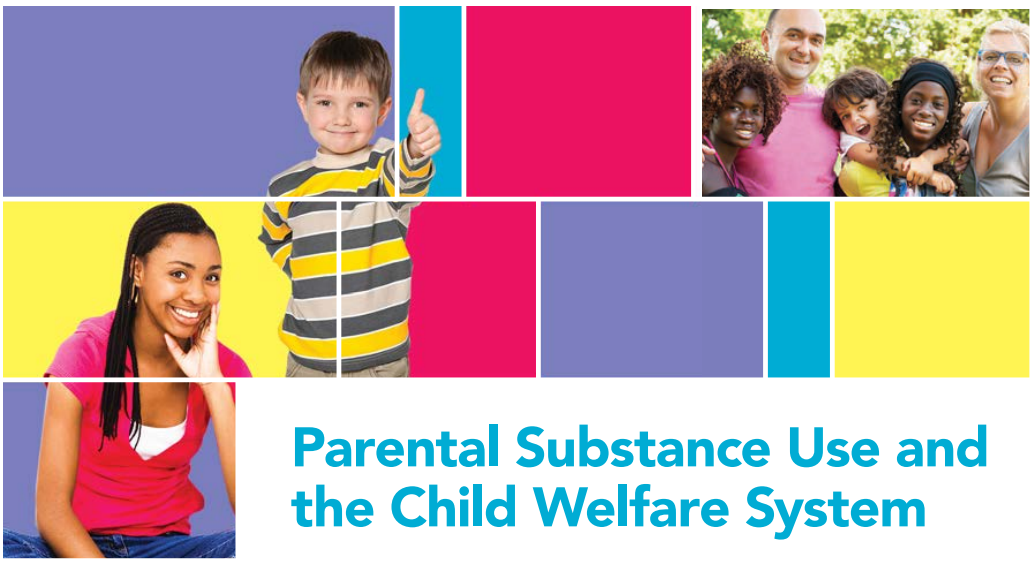

BULLETIN FOR PROFESSIONALS

October 2014

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.

WHAT'S INSIDE

Child Welfare Information Gateway

Children's Bureau/ACYF/ACF/HHS
800.394.3366 | Email: info@childwelfare.gov | https://www.childwelfare.gov

Children's Bureau

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, 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

[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.

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 "siloed" 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 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)

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.

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 grants[4] 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 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 collocated substance abuse counselors within child welfare agencies. (For information on child welfare

[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.

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:

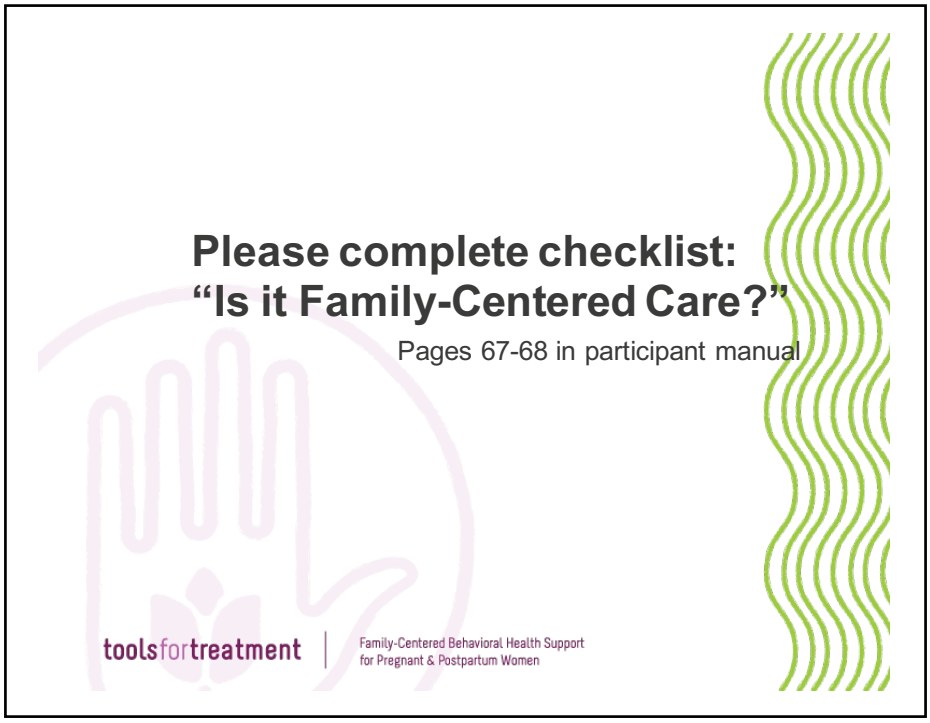
1. Demonstrate understanding of family-centered, recovery and wellness principles.
2. Identify family and staff outcomes of family-centered care.
3. Analyze how the principles of the family-centered, recovery and wellness approach were applied to a program in California.
4. Examine application of family-centered,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

Design and Time

Section	Description	Components	Time
"Is it Family-Centered Care?" checklist	As participants arrive, ask to complete "Is it Family-Centered Care?" checklist.	•See checklist on pages 67-68 of participant manual	5 minutes (pre-training)
Introduction to module	Overview of this module.	•Title & acknowledgements •Participant introductions •Review of Module 2 in participant manual and PPW website •Goals & objectives	5 minutes
Family-centered care and culture	Listen to audio clip on family-centered care and culture. Introduce family-centered, recovery and wellness principles graphic. Review family-centered care outcomes for family and staff.	•3-minute audio clip about culture •Family-centered, recovery and wellness principles •Family and staff outcomes of family-centered care	7 minutes
"Bring Them All" documentary	Watch 17-minute documentary on the family-centered approach in the context of SHIELDS for Families, a treatment program in Compton, CA.	•17-minute online video	17 minutes
Tying it all together discussion	Helps connect the family-centered, recovery and wellness principles to real life examples from the documentary. Gives participants the opportunity to apply these concepts to their work. Listen to "Tales from the Field" audio clip.	•Discussion questions regarding documentary and application of family-centered care principles •"Tales from the Field" audio clip about innovative strategies in family-centered care	15 minutes
Wrap up	Concluding remarks for module.		1 minute

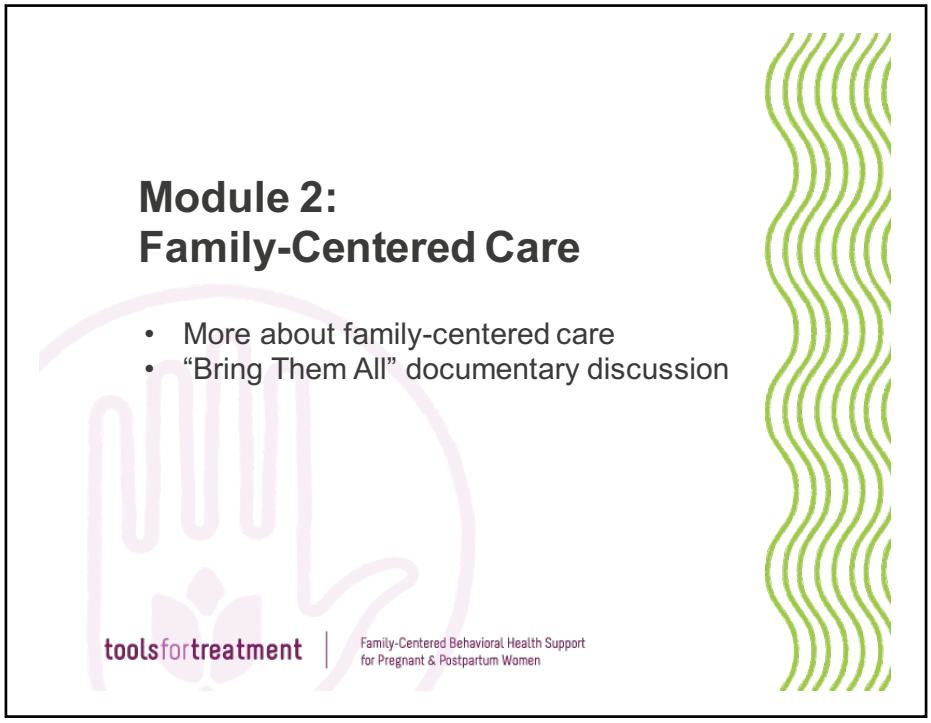
Slide 1

Welcome to module 2 of "Easier Together: Partnering with Families to Make Recovery Possible."



Slide 2

While we are waiting for everyone to join us, please complete the checklist, "Is it Family-Centered Care?" on pages 67-68 of the participant manual. We will review the results of this checklist later in the module.

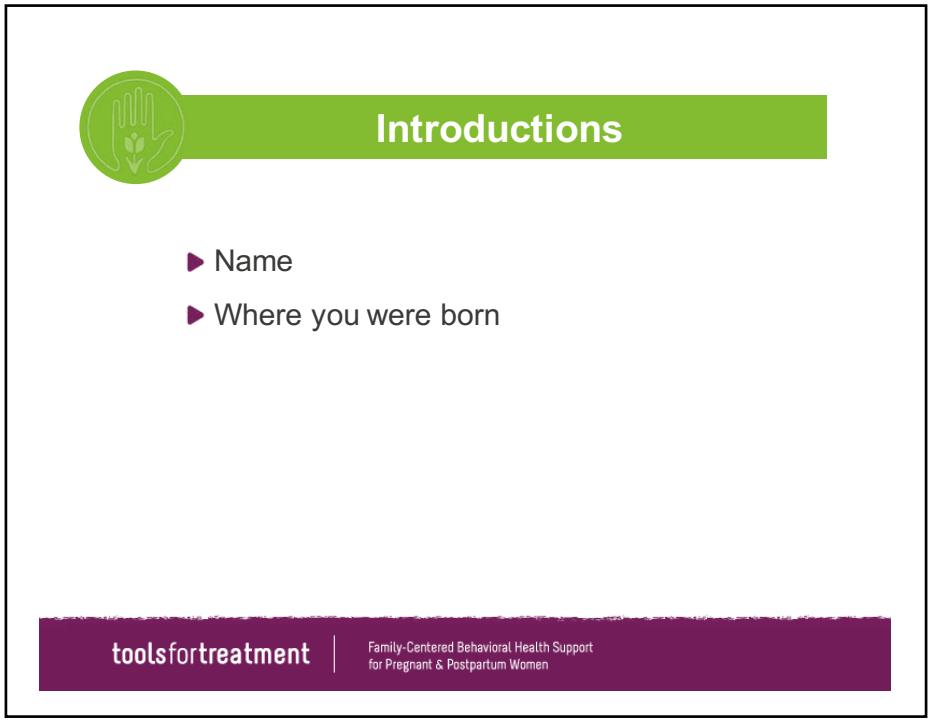


Slide 3

- During Module 2, we are going to take a more in-depth look at family-centered care by exploring some of its key principles and outcomes.
- Then we will watch a brief documentary produced for this curriculum that tells the story of family-centered care through the perspectives of clients and staff at a treatment program in Compton, CA.
- Afterwards, we will go through a series of discussion questions to explore the central principles of family-centered care and see how they might apply to your work.

Slide 4

Our thanks to Kathryn Icenhower, PhD, CEO and Co-founder of SHIELDS for Families, for her expertise and many contributions in the development of this module. Dr. Kathryn Icenhower is the Co-founder and Chief Executive Officer of SHIELDS for Families, a private non-profit organization with 340 staff, a $30 million dollar budget and 38 programs that serve over 10,000 families annually in South Los Angeles. She received her BSSW from Ohio State University and her MSW and PhD from the University of Southern California. Dr. Icenhower sits on numerous local, state, and federal coalitions and advisory boards, including the California State Child Welfare Council and SAMHSA'S Advisory Council for Women's Services. She has been recognized by numerous entities for her piloting work in the substance use and child welfare fields including an Innovator Award from CSAT for her work in Family Centered Treatment, the James Irvine Foundation Leadership Award, the Visionary Award from the National Association of Minority Contractors, and named as one of the 50 most influential women in Los Angeles by Los Angeles Magazine.



Slide 5

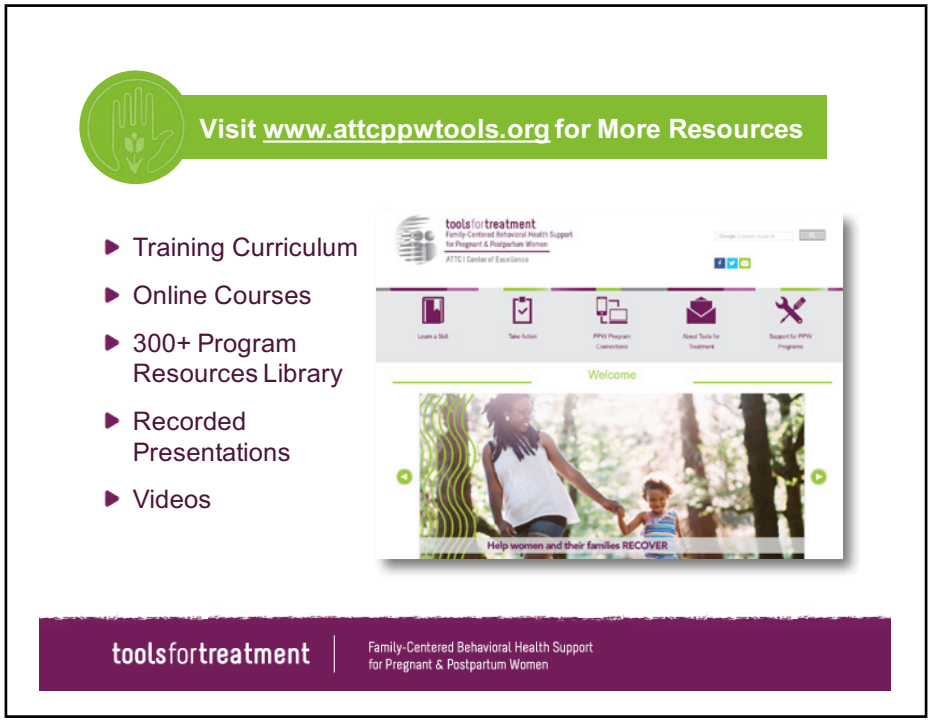
Before we get started, I'd like to do some brief introductions.
• Trainer: introduce yourself
• Now I'd like everyone to introduce themselves. Please say your name and where you were born.

Note to trainer: *You can modify this activity based on your audience.*

Slide 6

As part of this curriculum, you all have a participant manual. I'd like us to do a hands-on review of this module's content so you are familiar:

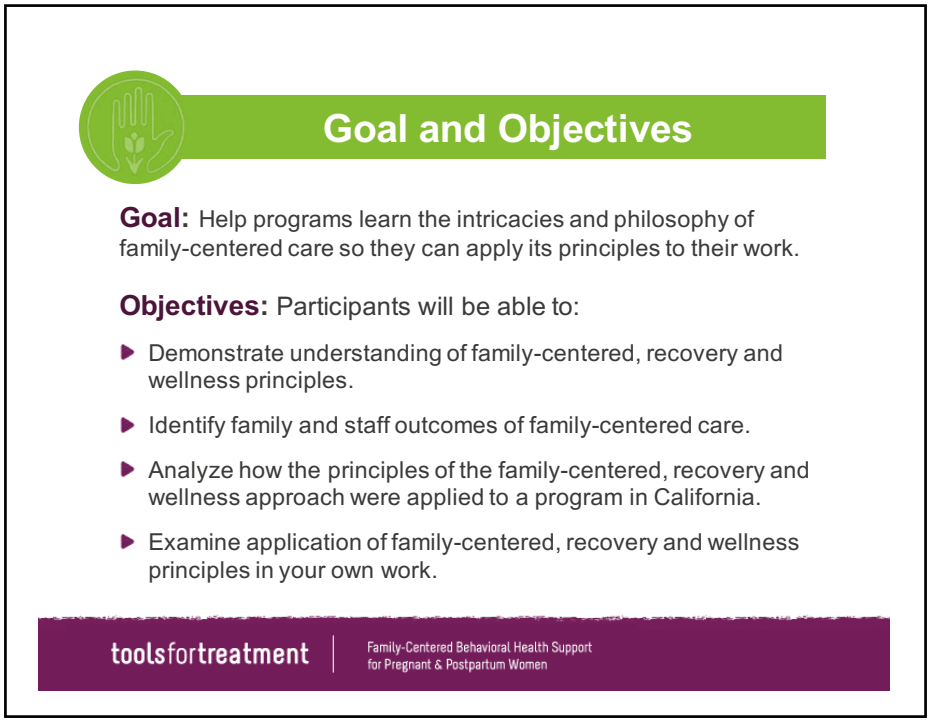
- On page 52, the module begins with the training goals and objectives.
- Next on page 53 you will find all of the presentation slides with room for taking notes.
- Then on page 66 you will find the resources section, which contains a collection of handouts, worksheets, activities, assessments, recommended reading, and a reference list for that module.



Slide 7

For additional resources, visit www.attcppwtools.org. Here you can download the "Easier Together" curriculum and access other resources such as:

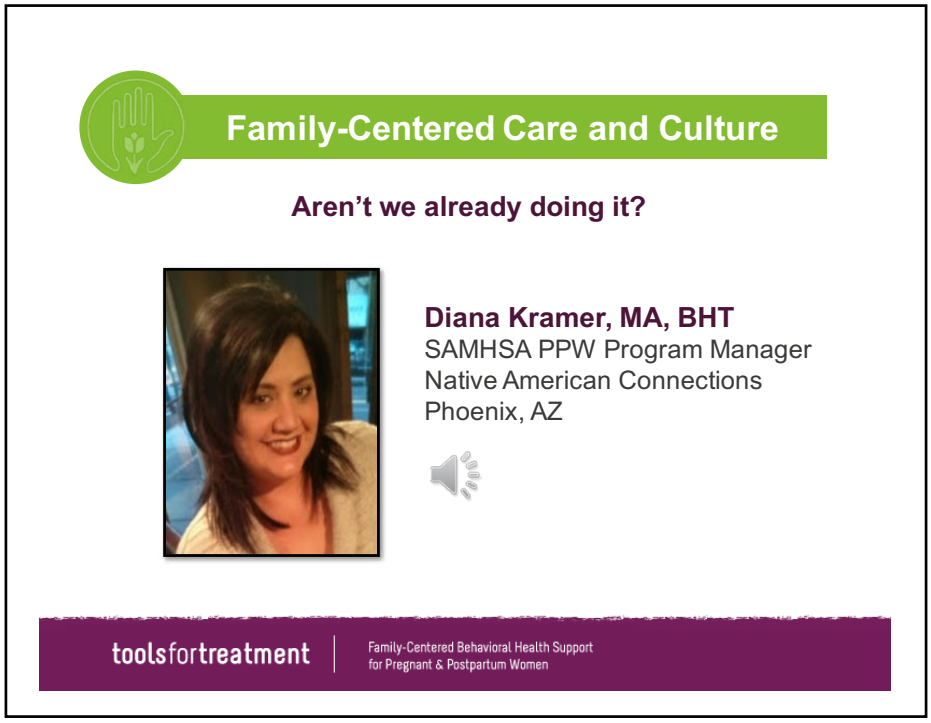
- Training curriculum
- Online courses
- 300+ resources in the Program Resources library
- Recorded presentations
- Videos



Slide 8

The goal of this module is to help programs learn the intricacies and philosophy of family-centered care so they can apply its principles to their work.

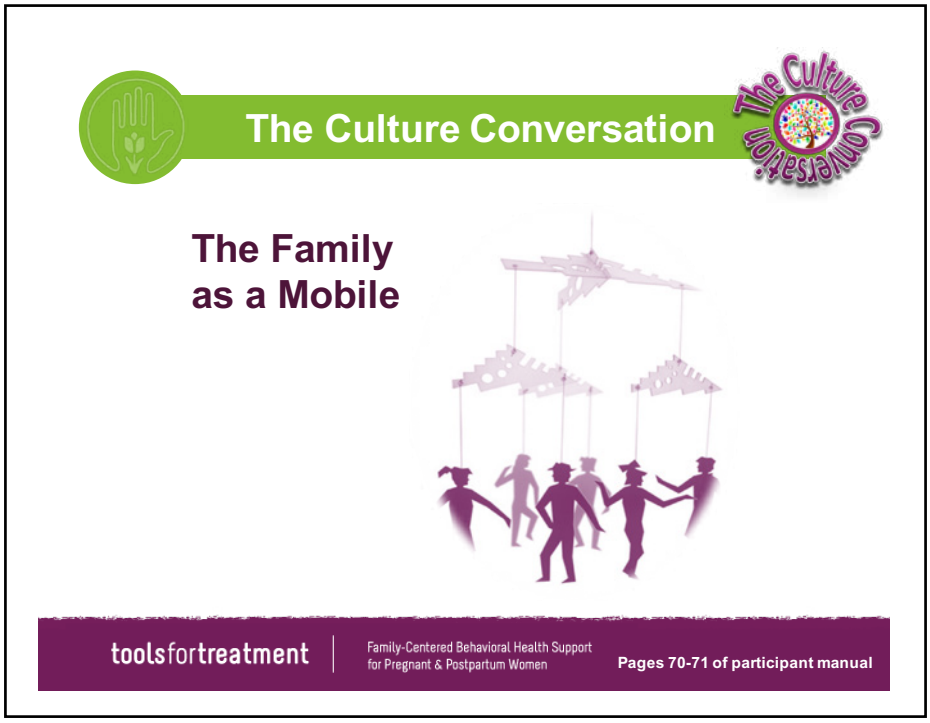
These are our learning objectives for Module 2.



Slide 9

- As we talk about family-centered care, a lot of us think our agencies are already doing it. And we might be to some extent. Many of the client cultural groups we serve value family and our communities already feel family-centered. However, working with clients from family-centered cultural groups is not the same as having family-centered services in our agencies. This hasn't always translated into the treatment system.
- We are going to listen to a 3-minute audio clip from Diana Kramer. She is a cultural competency expert and SAMHSA PPW Program Manager at Native American Connections in Phoenix, AZ. She shares her thoughts on this distinction between cultures that value family and agencies that implement family-centered services.
- Do you have any thoughts about what Diana shared?

Note to trainer: *Hover over the audio icon and press the play button to play the audio clip.*

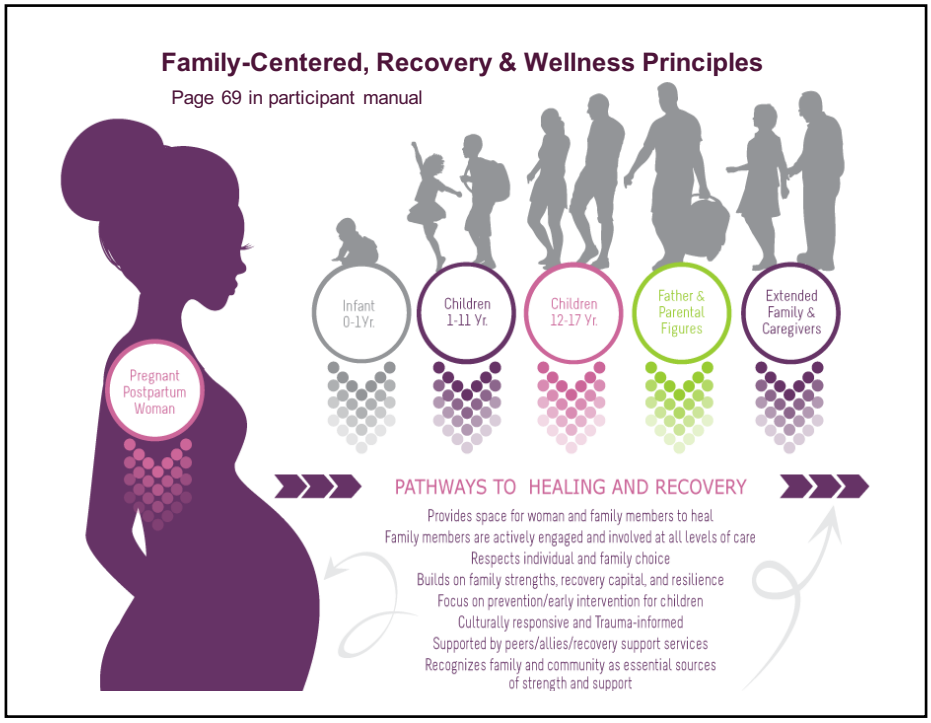


Slide 10

Continuing our discussion about culture, we know that across cultures, the family unit is recognized as the cornerstone of society. In *"What Is a Family?," Edith Schaeffer (2001) compares the family with a mobile: "What is a family? A family is a mobile. A family is the most versatile, ever-changing mobile that exists"(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.

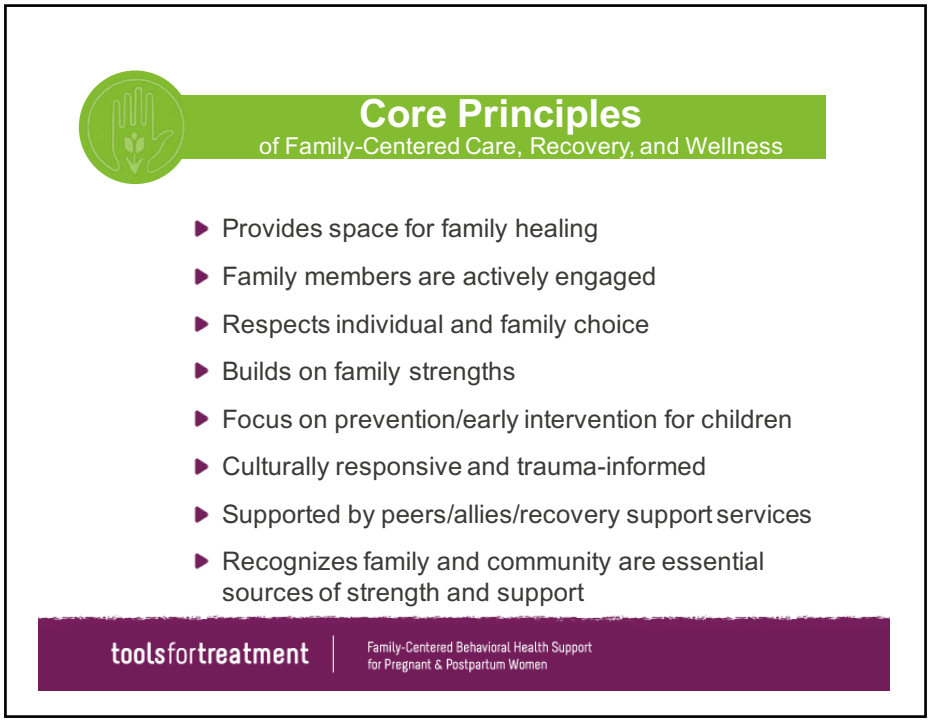
Note to trainer: *For more on culture, see the handout on pages 70-71of your participant manual. Reference: https://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf*



Slide 11

- This is a graphic that was developed to embody family-centered care in pregnant/postpartum women's treatment. In this graphic, you can see that the woman is the vehicle of entry for all family members. She is the initial client that comes into the program to receive services, but through her, our view expands to include all family members. The family becomes the client and we wrap services around all family members to support family strengthening and healing.
- Additionally, this graphic outlines "family-centered, recovery and wellness principles." It is imperative to view family-centered care through the lens of recovery and wellness, not just as a treatment episode. Family-centered care sets families up for sustainable recovery and wellness long after treatment ends.

Note to trainer: *This is available as a handout on page 69 of the participant manual.*

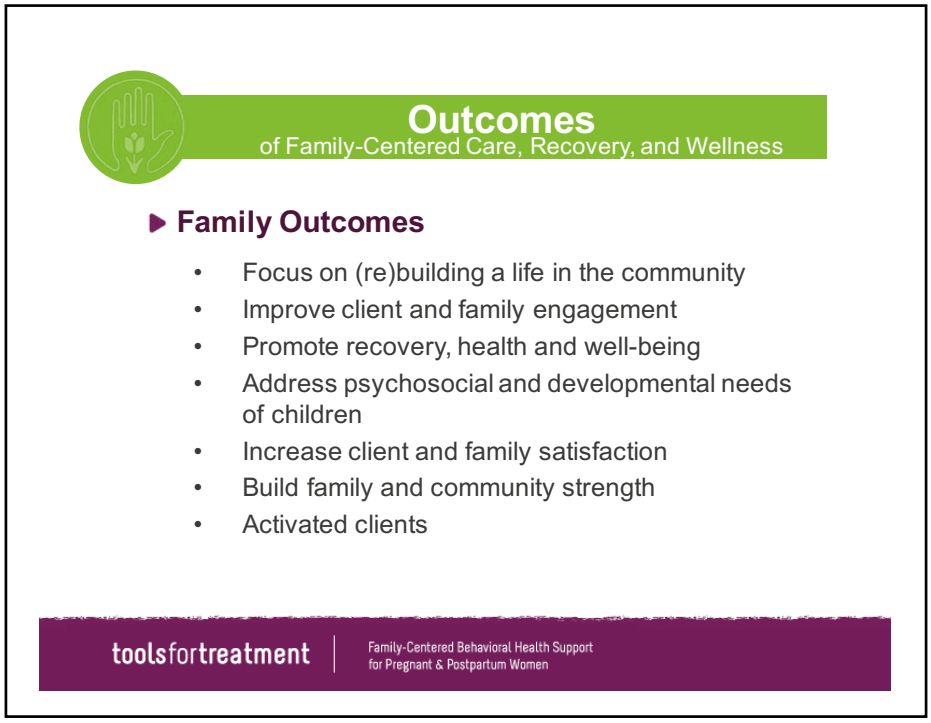


Slide 12

Let's dive deeper into the principles of a family-centered, recovery and wellness approach:

- Provides space for the woman and her family members to heal
- Family members are actively engaged and involved at all levels of care
- Respects individual and family choice
- Builds on family strengths, recovery capital, and resilience
- Focus on prevention/early intervention for children
- Culturally responsive and trauma-informed
- Supported by peers/allies/recovery support services (e.g., housing, employment, medical care)
- Recognizes family and community are essential sources of strength and support

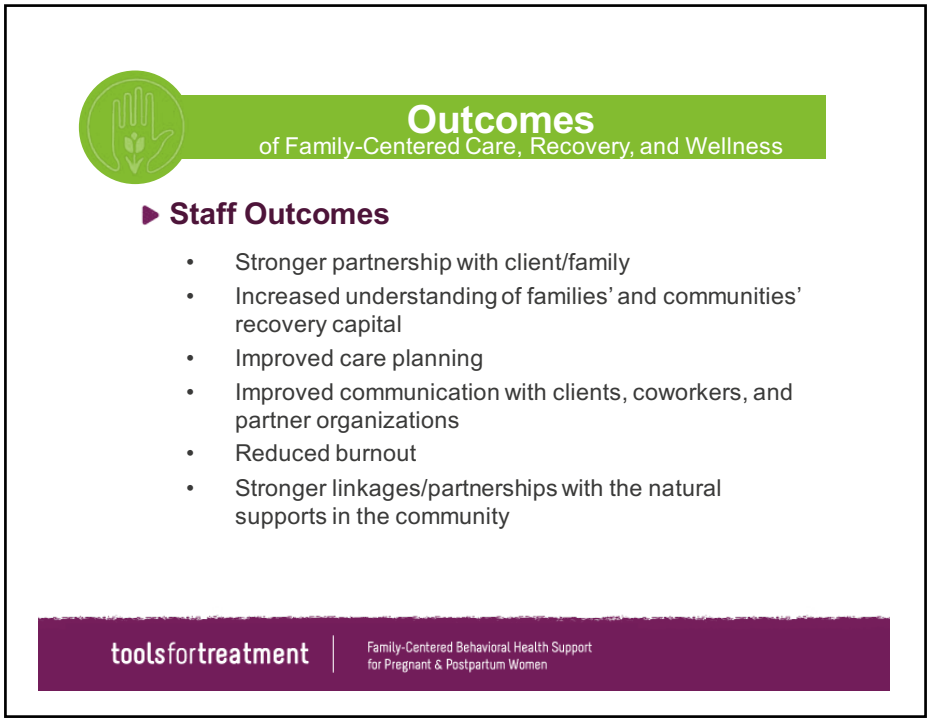
Do any of these resonate with you?



Slide 13

A family-centered, recovery and wellness approach to addiction treatment can result in:

- Focus on (re) building a life in the community
- Improve client and family engagement (partnership with program staff)
- Promote recovery, health and well-being of all family members
- Address psychosocial and developmental needs of infant/children
- Increase client and family satisfaction
- Build family and community strengths (recovery capital)
- Activated clients (clients are empowered to take responsibility for and guide their recovery)



Slide 14

This approach also produces a number of benefits for staff:

- Stronger partnership with client and commitment to the client and family choice.
- Increased understanding of families' and communities' recovery capital.
  - Uses a strengths-based approach and supports sustainable recovery after treatment episode.
- Improved care planning when developed in collaboration with family/peer support (team is expanded to include family).
- Improved communication with families, coworkers, and partner organizations.
  - Family-centered approach requires multidisciplinary team to work together to wrap services around family members and meet their different needs (e.g., early childhood, fathering/parenting programs, etc.).
- Increased professional self-efficacy; reduced burnout.
  - Reduced burden on staff when families are experts in their own lives.
- Stronger linkages/partnerships with the natural supports in the community.
  - Build good relationships with community partners so your program doesn't have to do everything itself. Partnerships allow you to provide families with all the different services they need. Also, building strong partnerships with child welfare, justice system, education system, and others allows you to help families navigate potential challenges.

Slide 15

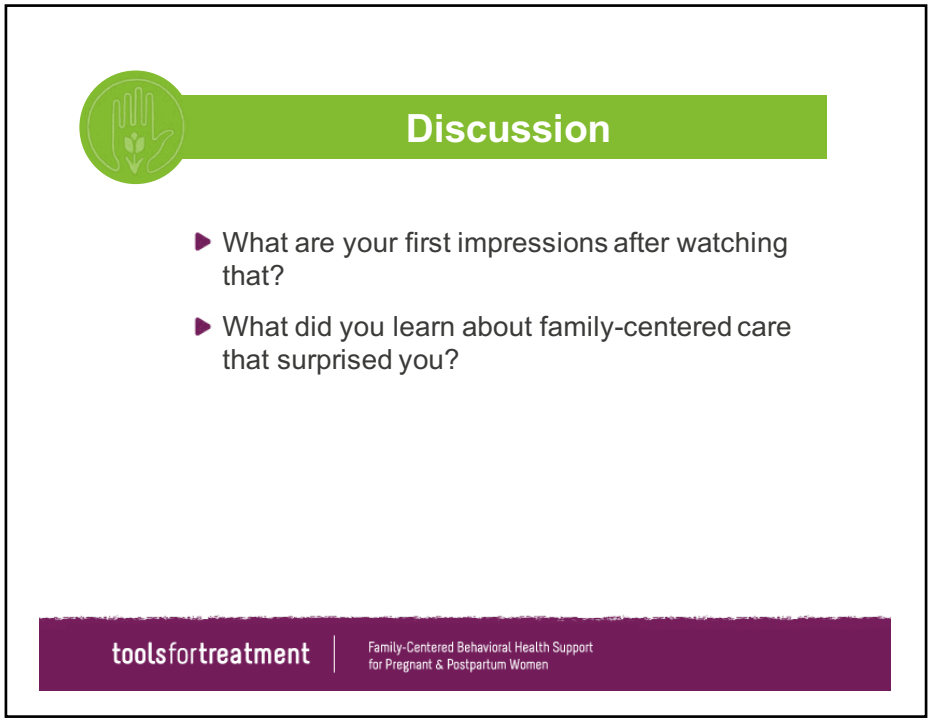
Sometimes the best way to learn about something is to see it in action. This brief documentary shows what family-centered care is like from the perspectives of clients and staff at SHIELDS for Families in Compton, CA. Let's watch this 17-minute documentary, then afterwards we'll discuss its content.

Link to documentary: https://vimeo.com/233560293/bc3c8dd057

Slide 16

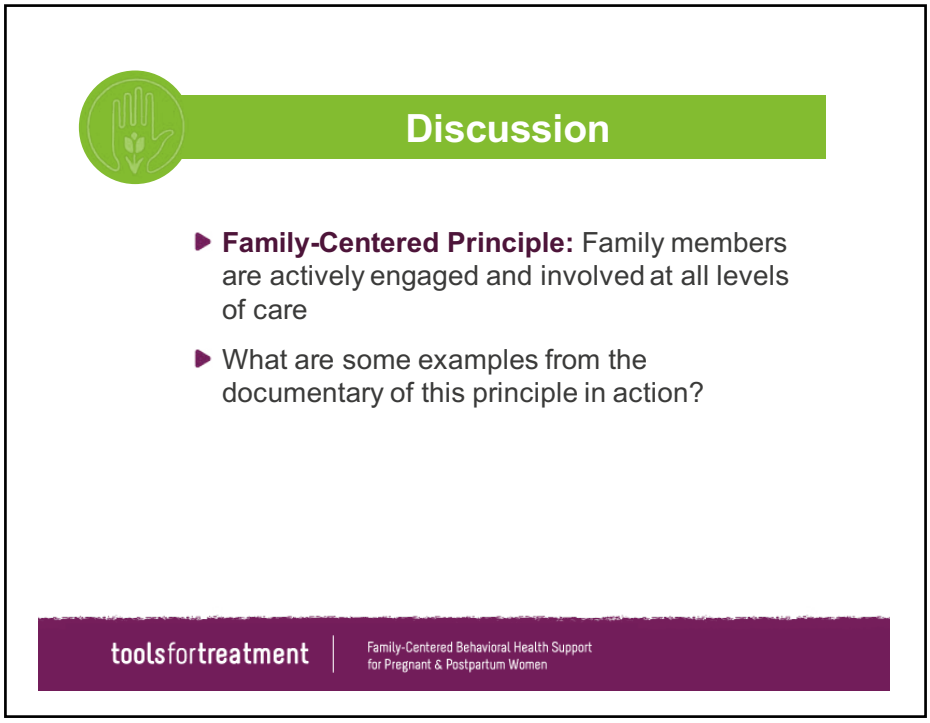
Let's debrief about what we just watched, keeping in mind the family-centered care principles we discussed earlier.

Note to trainer: *Questions may arise about SHIELDS for Families, the program featured in the documentary. Here is a description of the agency: Established in 1991, the organization has grown to serve more than 10,000 families each year, employing more than 350 full-time staff, with an annual budget of more than $30 million from federal, state, and local funding sources. SHIELDS operates 38 programs and serves as the lead agency with four collaborative networks. Programs are collaborative and comprehensive, spanning across three main divisions including community and family, behavioral health, and supportive services. More information is available on their website at www.shieldsforfamilies.org. Additionally, a brief vignette on "How They Did It" is available at www.BringThemAll.org.*



Slide 17

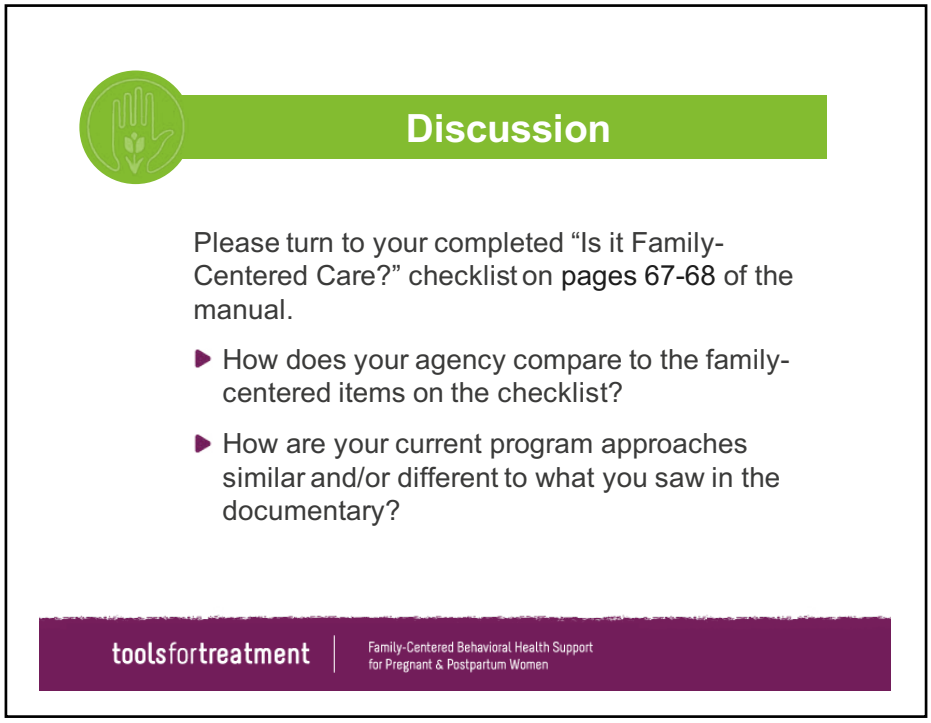
- What are your first impressions after watching that? What did you learn about family-centered care that surprised you?



Slide 18

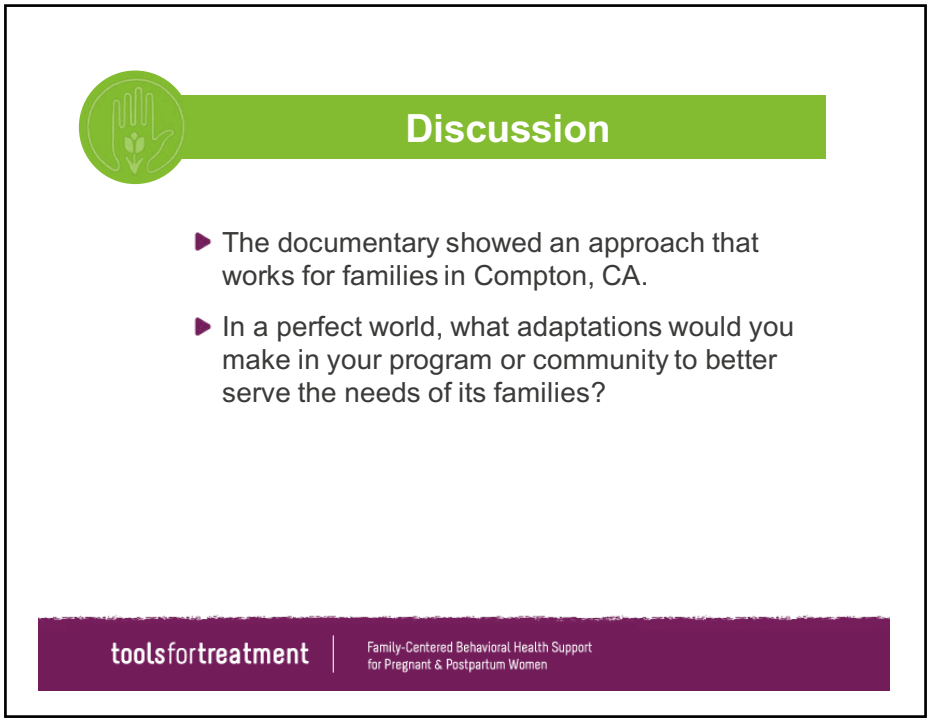
- Let's revisit one of the most important family-centered principles: family members are actively engaged and involved at all levels of care.
- What are some examples from the documentary of this principle in action?

- ***Note to trainer:*** *These are some points you can reference if needed:*
- *CEO Kathryn Icenhower discussed the Exodus program, where a mother can bring her whole family to live and receive services on-site.*
- *Staff member Colette talked about how it is different working with all family members, not just one client. It was an adjustment for her at first since she had previously worked with individual clients. Now she works as part of a multidisciplinary team to serve all the different needs of families.*
- *Staff member Danielle talked about how staff value the opinions of the families because the program is for them.*
- *Staff member Danielle talked about how staff are "on demand" for families.*
- *Male client talks about how much it means to have staff care about him and his kids.*
- *Client talks about what it was like to find a program that let her bring her kids.*
- *CEO Kathryn Icenhower talks about how "it's much easier to let people in than keep people out" in reference to accepting families where they're at.*
- *CEO Kathryn Icenhower talks about the importance of designing a program that meets the needs of the families in your community.*



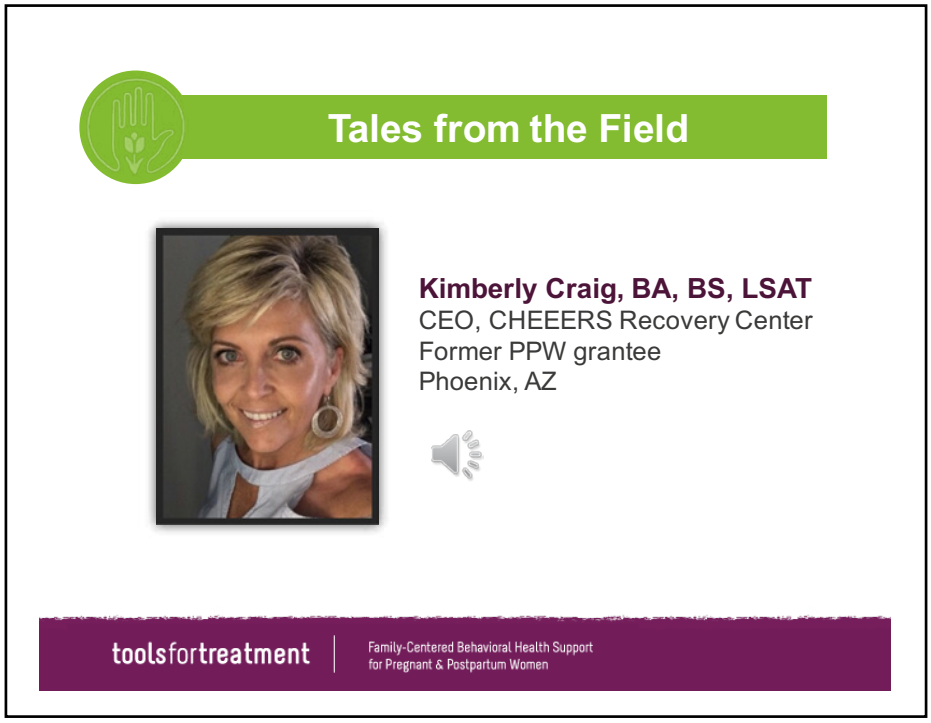
Slide 19

- 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?



Slide 20

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



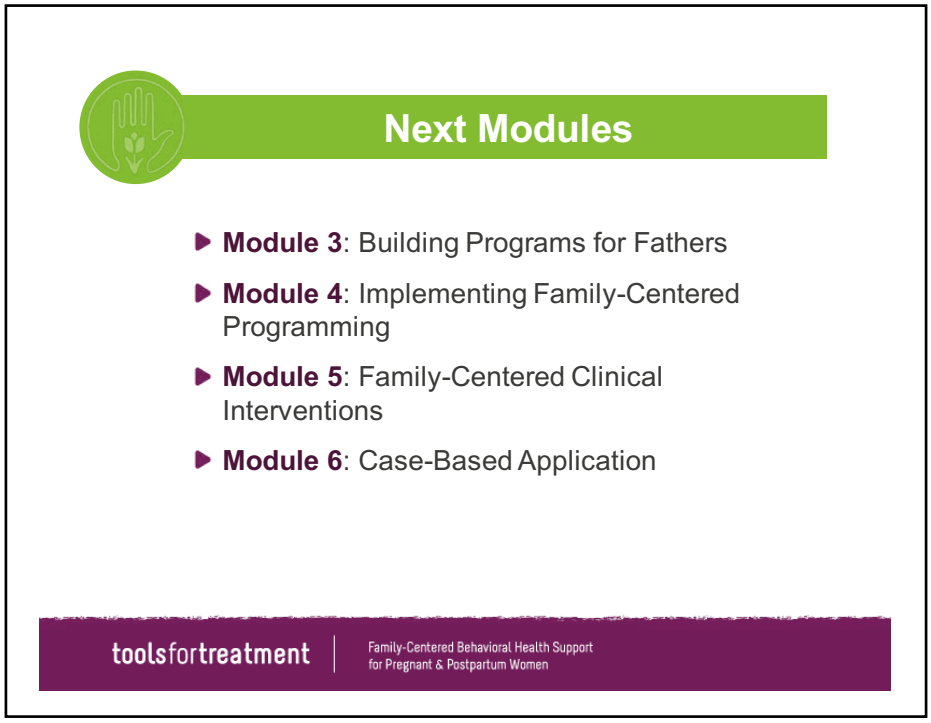
Slide 21

- In addition to SHIELDS for Families, many other programs have used innovative strategies to develop and fund family-centered services.
- We are going to listen to a 2-minute audio clip from Kimberly Craig. She is CEO of CHEEERS Recovery Center, a former PPW grantee, in Phoenix, AZ. She shares a creative way that her agency has developed family housing in collaboration with the police department and city.
- Do you have any thoughts about what Kimberly shared?

Note to trainer: *Hover over the audio icon and press the play button to play the audio clip.*

Slide 22

- After processing all of this information, how has your impression of family-centered care changed?
- That concludes the second module in this training series. We took a deeper exploration of what family-centered care really means and saw it in action at one treatment program.



Slide 23

These are the next modules in this training series. Make sure to check your participant manual for more information and resources.

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?

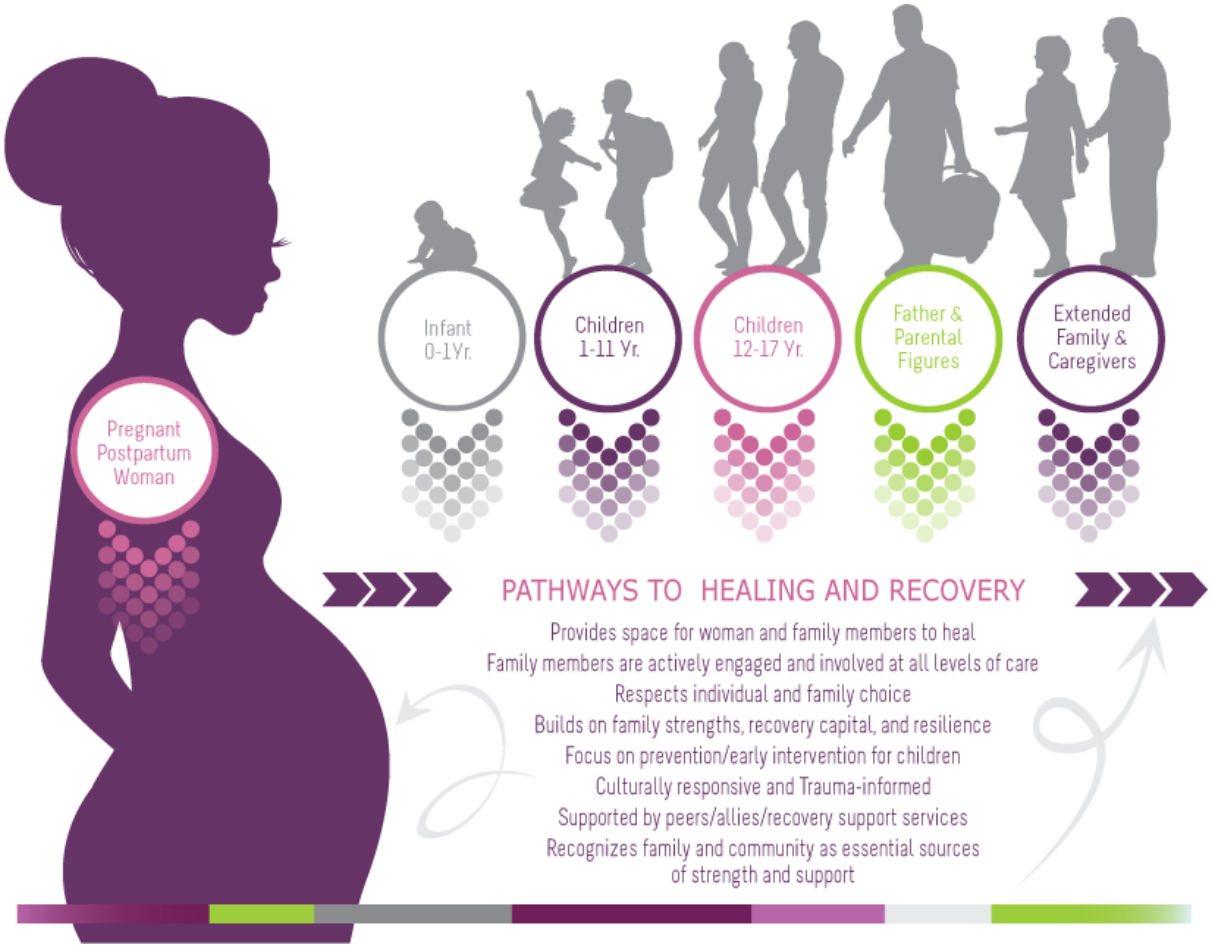
- ☐ Strong community partnerships with child welfare, school districts, social services, local attorneys, educational institutions, and business (potential employers)?

- ☐ Opportunities to develop client leadership through structures such as Client Councils that formulate some of the program polices 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

BRING them all

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

toolsfortreatment
Family-Centered Behavioral Health Support for Pregnant & Postpartum Women
ATTC | Center of Excellence

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:

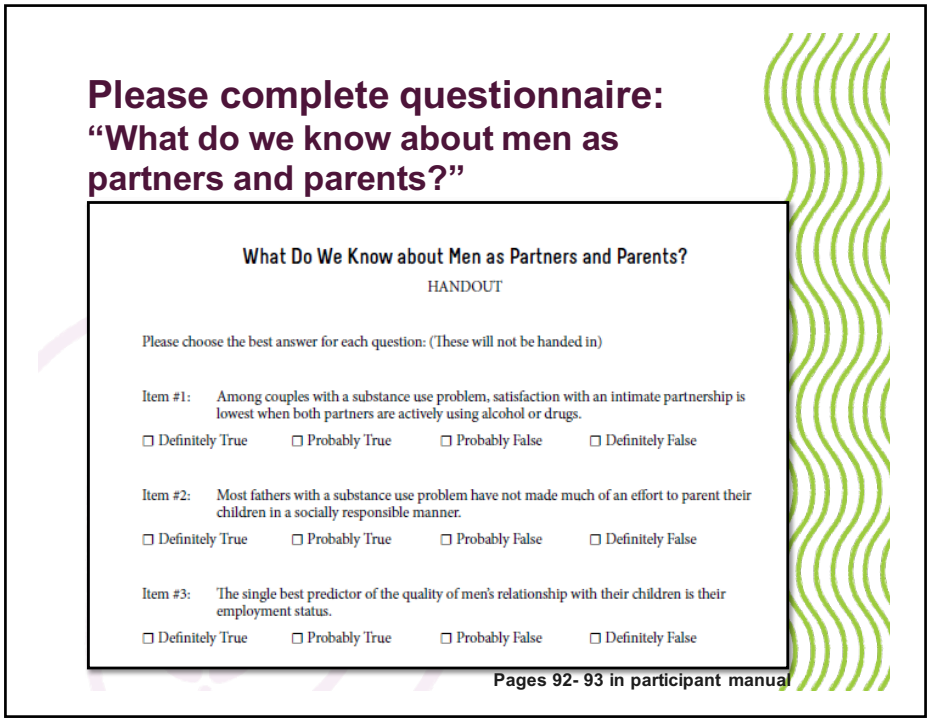
1. Explain why engaging fathers is important.
2. Describe the evidence base for involving fathers, male co-parents, and male partners.
3. List considerations and cautions when developing programming.

Design and Time

Section	Description	Components	Time
Questionnaire completion	As participants arrive, ask to complete "What Do We Know About Men as Partners and Parents?" questionnaire. ***Trainers need to familiarize themselves well with the questionnaire and answers in order to facilitate discussion and highlight elements relevant to participants.**	•See questionnaire on pages 92-93 of participant manual	5 minutes
Introduction to module	Overview of module. Sets training in context of family-centered care and new grant requirements.	•Title & acknowledgements •Participant introductions •Review of Module 3 in participant manual and PPW website •Goals & objectives •Participant introductions •Family-centered care graphic •New PPW goals	3 minutes
Why engage fathers?	Describes systemic negative attitudes and growing recognition of the value of involving fathers.	•Why engage fathers? •Stereotypes and stigma •"Tales from the Field"	15 minutes
What do we know about fathers that has implications for treatment?	Reviews research on fathers as parents and partners both in the slides and during the discussion of questionnaire answers. ***Trainers need to familiarize themselves well with the questionnaire and answers in order to facilitate discussion and highlight elements relevant to participants.** In 3-minute video, experienced clinicians explain the practical value, based on their experience, of programming and interventions that include fathers. Discussion regarding what resonated for participants from video.	•About fathers •About fathers continued •Activity – review of questionnaire answers •"Tales from the Field" •Video clip – Services for Fathers & Partners •Discussion questions	15 minutes
Considerations and cautions	Examines practical considerations when developing programming for fathers regarding intervention and materials.	•General considerations •General considerations continued •Consider prior to implementation •Culture conversation	5 minutes
Wrap up	Concluding remarks for module.		2 minutes

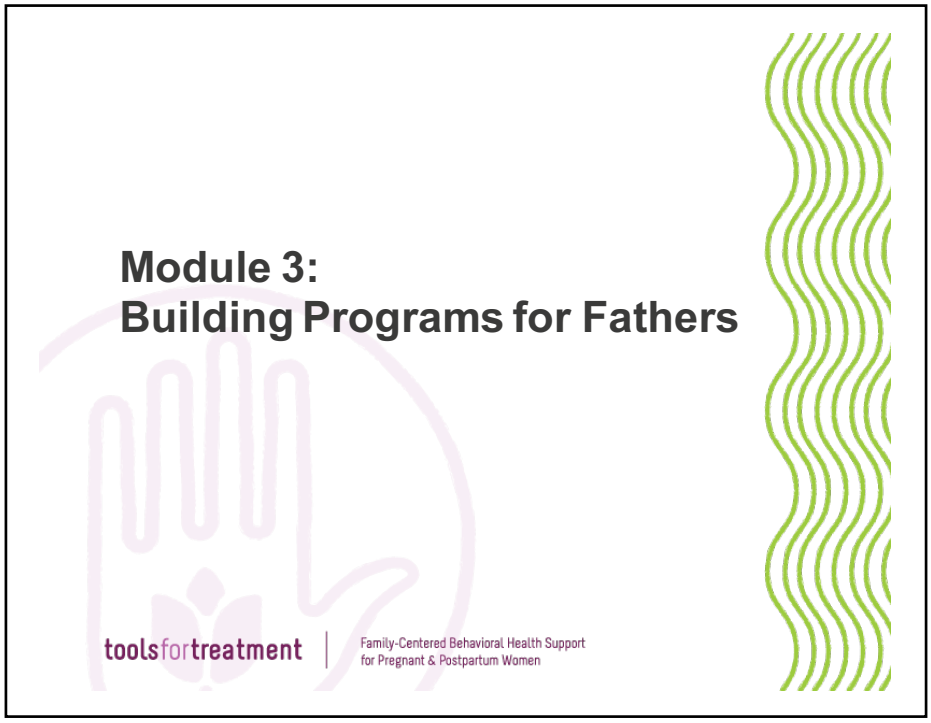
Slide 1

Welcome to Module 3 of "Easier Together: Partnering with Families to Make Recovery Possible."



Slide 2

While we are waiting for everyone to join us, please complete the checklist, "What do we know about men as partners and parents?" on pages 92-93 of the participant manual. We will review the results of this checklist later in the module.

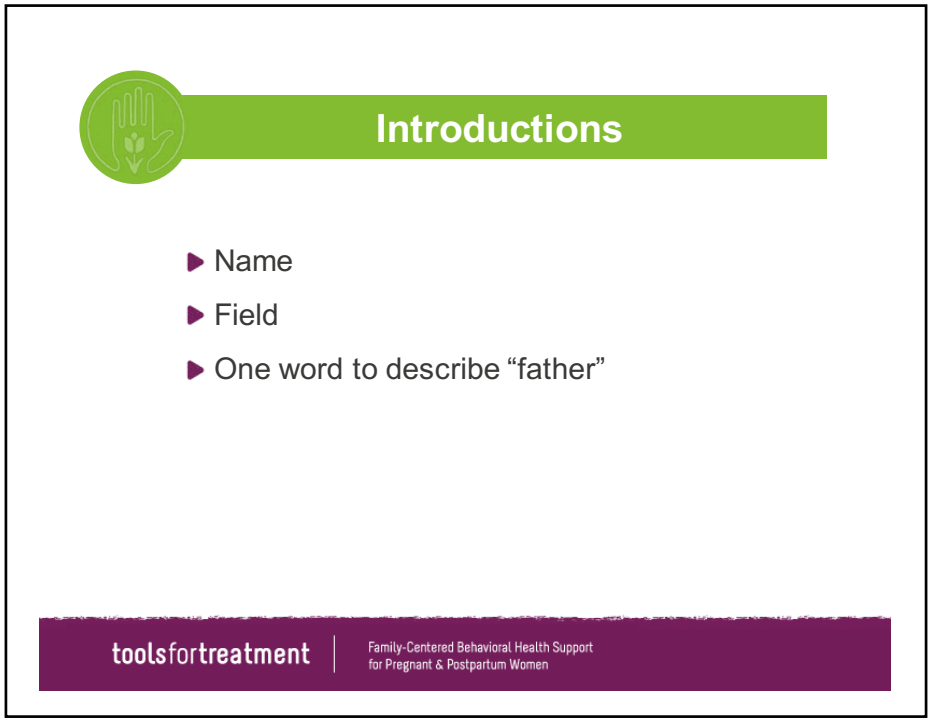


Slide 3

During Module 3, we are going to discuss why it is important to engage fathers, review the evidence base for involving them, and identify considerations and cautions when developing programming for fathers.

Slide 4

Our thanks to Thomas McMahon, PhD for his expertise, guidance, and many contributions in the development of this module. Dr. McMahon is a Professor in Psychiatry and the Child Study Center at the Yale University School of Medicine. Dr. McMahon is interested in ways in which the principles of developmental psychopathology can be used to expand understanding of the impact that parental addiction has on family process and child development. He has worked on the development of gender-specific parent interventions for men enrolled in addiction treatment. Dr. McMahon is also interested in the psychological assessment and treatment of children, adolescents, and young adults who have been abused or neglected in the context of parental addiction, as well as clinical and research training on the roles that genetic liability and family process play in the intergenerational transmission of developmental psychopathology. Dr. McMahon completed his doctoral training in clinical child and school psychology at New York University in 1994. Since 1998, he has been the recipient of several grants from the National Institute on Drug Abuse. With his colleagues, he has published more than 75 peer-reviewed papers and book chapters.

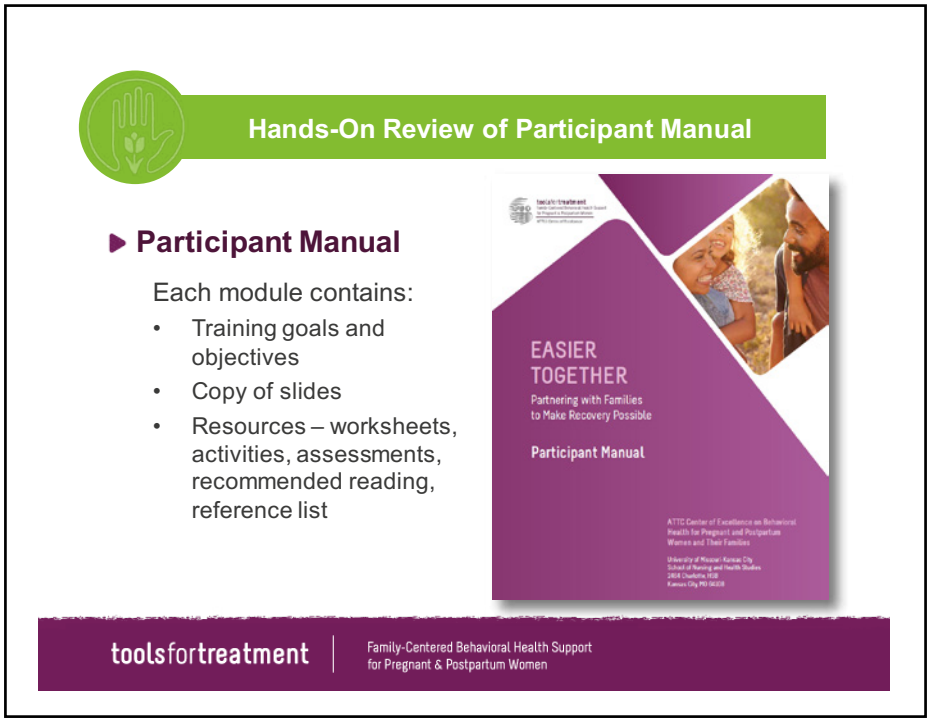


Slide 5

Before we get started, I'd like to do some brief introductions.

- Trainer: introduce yourself
- Now I'd like everyone to introduce yourself and share the first word you think of to describe the word "father."
- Have everyone say their name and one word to describe a "father."

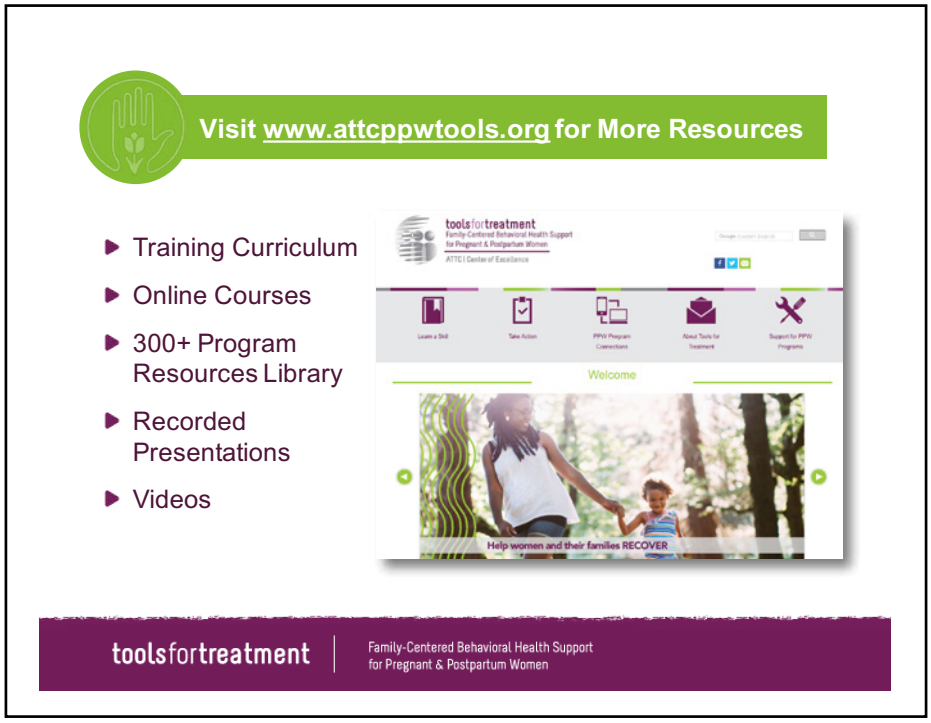
Note to trainer: *based on the group, you're welcome to modify this introduction activity.*



Slide 6

As part of this curriculum, you all have a participant manual. I'd like us to do a hands-on review of this module's content so you are familiar:

- On page 74, the module begins with the training goals and objectives.
- Next on page 75 you will find all of the presentation slides with room for taking notes.
- Then on page 90 you will find the resources section, which contains a collection of handouts, worksheets, activities, assessments, recommended reading, and a reference list for that module.



Slide 7

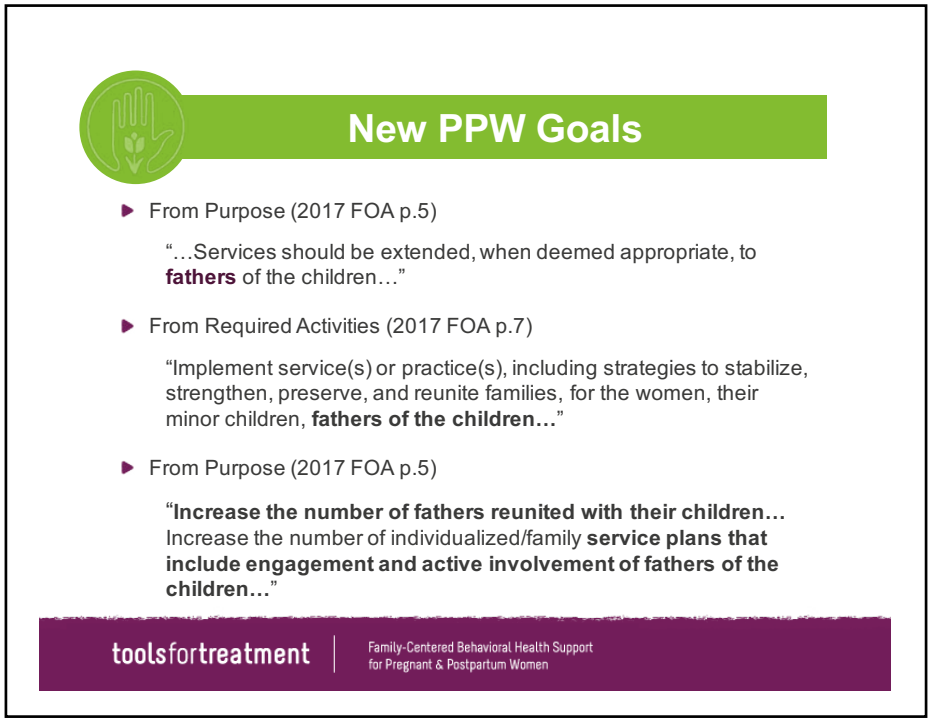
For additional resources, visit www.attcppwtools.org. Here you can download the "Easier Together" curriculum and access other resources such as:

- Training curriculum
- Online courses
- 300+ resources in the Program Resources library
- Recorded presentations
- Videos

Slide 8

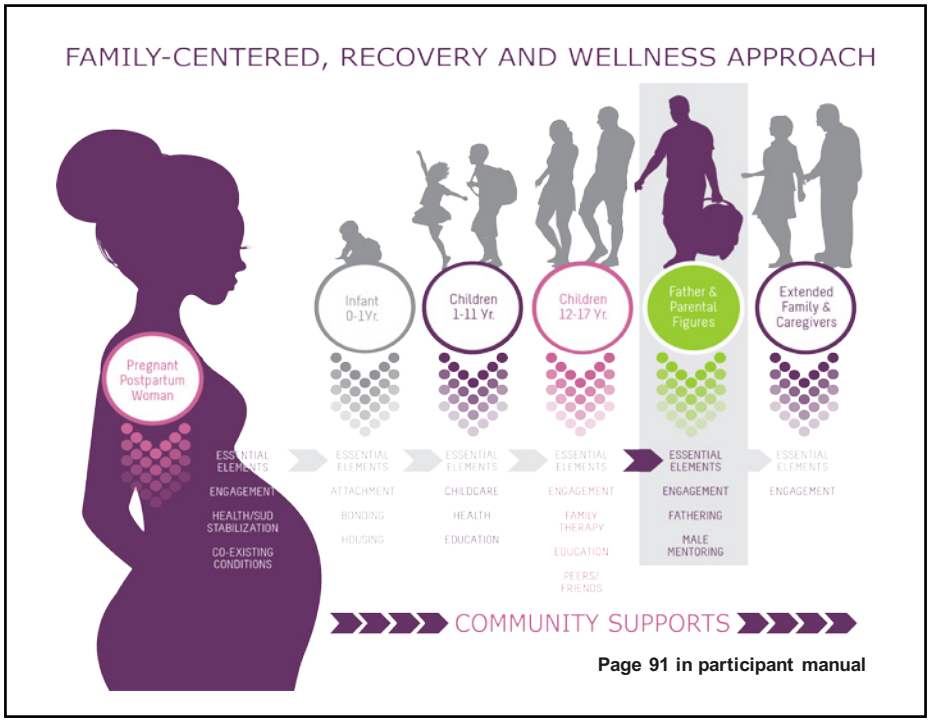
The goal of this module is to help programs begin to meet expectations for PPW programming that addresses the needs of fathers/male partners and co-parents.

These are our learning objectives for Module 3.



Slide 9

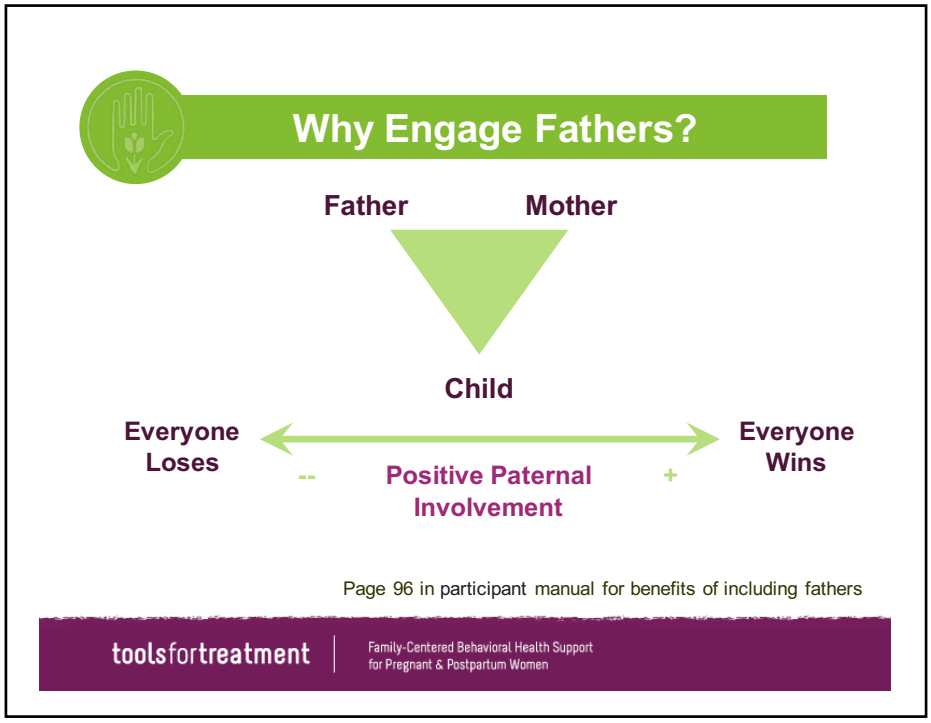
Given the changes in the field, PPW funding and programming now includes a focus on reaching the whole family. Particular emphasis is being placed on the development of ways to more effectively involve the fathers of the clients' children. This emphasis is evident throughout the most recent funding opportunity announcement (FOA) issued by SAMHSA for continued funding of the PPW program.



Slide 10

A version of this family-centered care graphic was introduced during module 2. As you can see, our focus today is on fathers and parental figures.
While it is clear that not all partners and co-parents of the women in PPW programs are men, this module was designed in response to the recent focus on fathers.
This graphic also shows how the Recovery-Oriented System of Care is transforming the vision of programs from a focus on treatment to a focus on stable, long-term recovery. It's all about partnering, not only with the woman, but with all the relationships in her life that are going to impact her ability to address her addiction, prevent relapse, and promote stable recovery.

Note to trainer: *This is available as a handout on page 91 of the participant manual.*



Slide 11

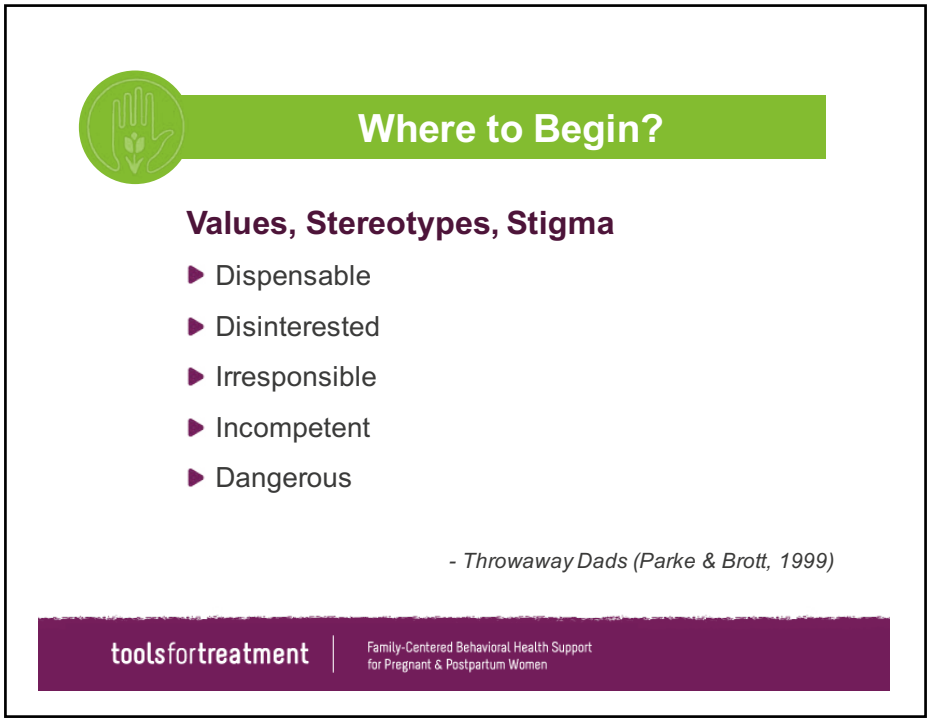
What is the justification for developing programing to more effectively engage men in programs for women?

Research shows that when men are absent or involved in a negative way, the mother, father, and child all lose socially, psychologically, and economically.

Research indicates that there are social, psychological, and economic benefits for the mother, father, and child when men can be involved in a positive way. Please look on page 96 **of the participant manual** for a list of some of these potential benefits. There are also other documents in the manual that describe this research in more detail.

So, programs need to consider:

- What can be done to minimize the absence or negative involvement by the men in the families in your program?
- What can be done to promote family involvement by the men that can benefit everyone in the family?



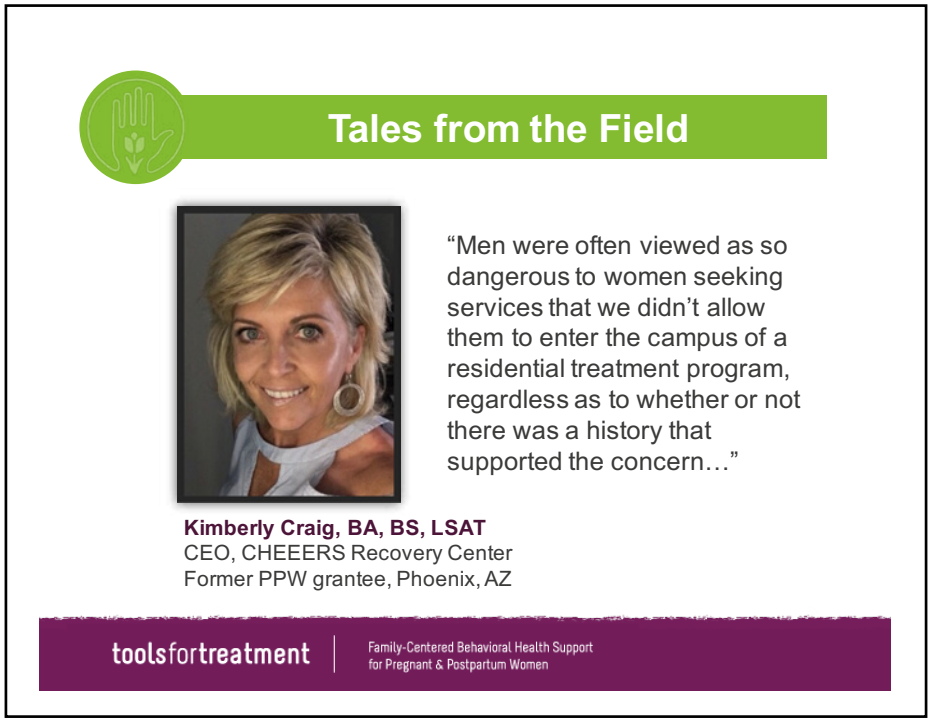
Slide 12

In our culture, men who need help as parents are often considered dispensable, disinterested, irresponsible, incompetent, and dangerous. These attitudes have influenced how fathers are treated in our systems of care.

Since the early 1970s, there has been a concerted effort to do everything possible to support women experiencing substance use and psychiatric difficulty in their role as parents. Until recently, however, there has been very little interest in supporting men experiencing social and psychological difficulty in their role as parents.

While policymakers, researchers, and providers expressed concern about absent fathers, they tended to only talk about absent fathers as a risk factor for children. Writing about the issue almost 20 years ago, Ross Parke and Armin Brott referred to these men as "throw-away dads." They argued that, as a culture, we have been more interested in blaming these men and labeling these men than we have been in actually helping them.

Most systems of care in this culture are oriented toward helping mothers be more effective parents. People like Ross Parke and Armin Brott have highlighted that these systems, including our criminal justice, child protection, child guidance, educational, social service, primary care, mental health, and substance use disorder treatment systems rarely acknowledge that many of the men involved in those systems are fathers.



Slide 13

- Many of the pioneers in the field such as Kimberly Craig, CEO of CHEEERS Recovery Center, and a former PPW grantee, in Phoenix, AZ, have become part of the change in how men are viewed. She recalls that: **(READ QUOTE BELOW)**

- "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. Not many of us would tolerate a policy such as that for the women we serve. As providers many of us believed that engaging men in services or allowing them to have contact with the woman in the program increased her likelihood of leaving treatment before she completed it. Our policy was really driven by fear around her leaving treatment. Somehow we thought if we could just keep him away we could break the spell…I think most of us that have worked in the field for many years know that was flawed thinking."

- Do you have any thoughts about what Kimberly shared?

Slide 14

So what do we know about fathers that has implications for treatment?

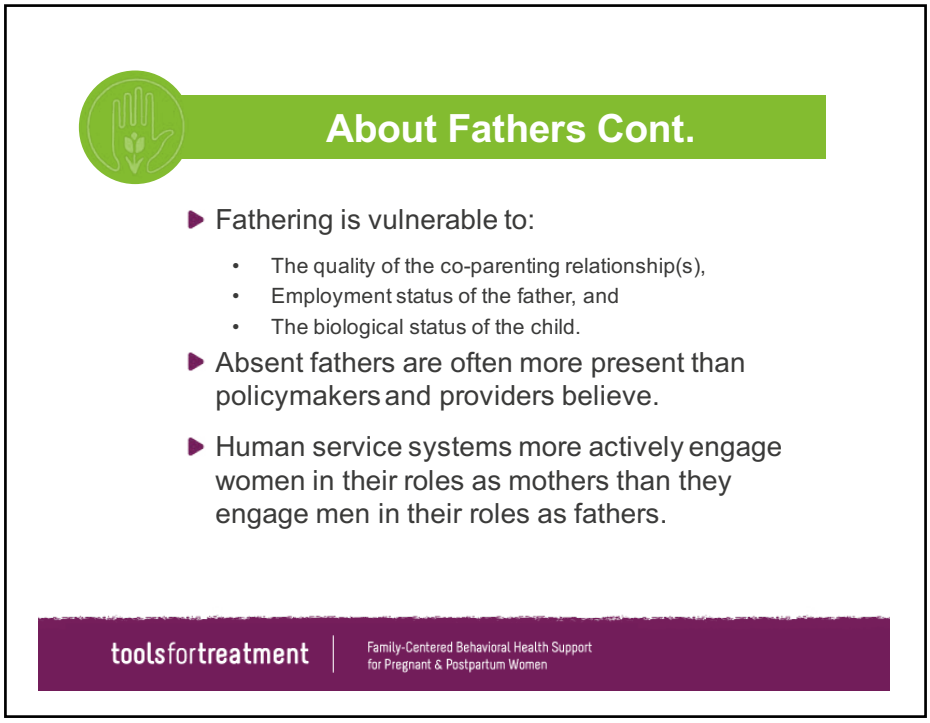
Slide 15

What do we know about men as parents that has implications for assessment and treatment?

1. Fathering is a developmental concern for men. Even as boys, young men think about partnerships and parenting as a developmental concern for them as men.

2. Fathering affects the behavioral health of men and the behavioral health of men affects their capacity to be an effective parent. Research suggests that the mental/behavioral health of men deteriorates following separation from their children. For example, men become more depressed and are more likely to use substances after being separated from their children because of a marital separation. We also know that, like women, men with mental/behavioral health problems have difficulty functioning effectively as a parent. One implication is the possibility of creating cycles of improvement for men, such that improvements in the mental/behavioral health of men lead to improvements in their parenting which lead to further improvements in their mental/behavioral health over time.

3. Men have less social support for fathering than women do for mothering. Partially because of the way women are socialized, women have greater support from grandmothers, aunts, sisters, friends etc. around parenting than men do. Generally parenting is not an issue that men talk about when they are out socially as a group. There has been increasing call for finding ways to get men social supports in a formal or informal way.



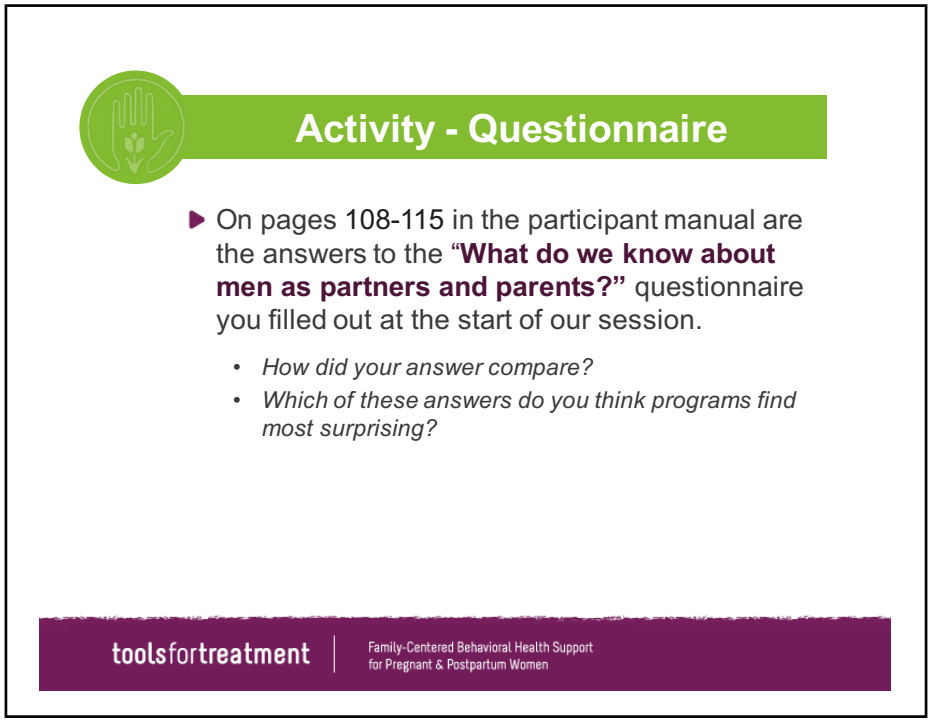
Slide 16

4. Fathering is vulnerable to:

a) *Quality of relationship with co-parent* – When men are involved in conflictual relationships with their partner, they tend to withdraw from their role with their children. Particularly when a couple ends their sexual partnership, the single best predictor of whether men will remain involved with their children in a positive manner is the quality of his relationship with the mother of his children. If the parents can somehow get along as parents, men are more likely to remain involved. If they cannot, men are more likely to stay away to avoid conflict with the mothers of their children.
b) *Employment status of the father* – If men are not employed and not able to contribute financially, then they are more likely to withdraw from parenting roles.
c) *Age and biological status of the child* – Men are also generally more likely to be involved with younger children and with children who are their biological children.

5. Absent fathers are more present than policymakers and providers believe they are. Fathers who who we think are "absent" have repeatedly been found to be far more present in the lives of women and children than policy makers and providers believe.

6. Most human service systems more actively engage women in their roles roles as mothers than they engage men in their roles as fathers.



Slide 17

Remind participant about the "What do we know about men as partners and parents?" questionnaire they filled out at the start of the session.

Have them turn to pages 108-115 in participant manual to view the correct responses and explanations. Give participants a few minutes to read over the responses.

- Ask if anyone got them all correct? All but one correct? Reward with small candy or treat.
- Ask, "Which of these answers do you think programs find most surprising?" Have them work in dyads or table groups for 1 minute or less.
- Elicit quick sharing of results with larger group from a couple of dyads or tables and ask for show of hands of others with similar answers. Reward those who share with small candy or treat.
- Note and elicit from group any patterns in the answers that emerge.

Note to trainer: *Modify this activity based on the audience and time constraints.*

Slide 18

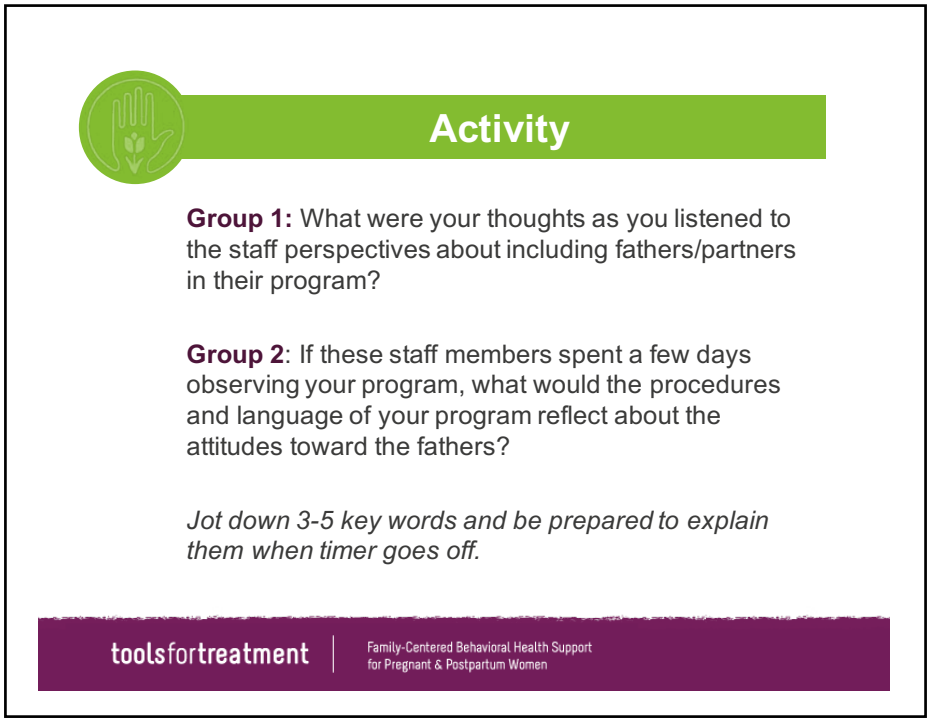
Kimberly Craig, CEO of CHEEERS Recovery Center, and a former PPW grantee, has some thoughts on changing how we regard men and fathers in our programs:

- When we look at what is "real" about fathering and male involvement, it may be useful to make comparisons to what we as providers know or believe to be true about the women we serve in our programs. For example, we know that sometimes women decide not to parent, and not all women are born with maternal desire or instinct. Could we say the same about men?
- As women's service providers we are too savvy to make statements, assumptions, or stereotype that all women want to parent. So, it seems fair to say not all men want to parent.
- We also know that often women who chose to not parent their children, or who are struggling with the devastation and consequences of a substance use disorder which has resulted in separation from their children, are often judged harshly by society. Do we agree on that? Perhaps we do, and now let's consider if we believe men are judged as harshly for not fulfilling paternal roles and responsibly? Perhaps men receive a different form of stereotyping and judgment from society?
- As women's service providers many of us are highly aware of the societal pressures and stigma that women face around parenting and we would not tolerate or allow anyone to make assumptions about a woman's maternal instinct or ability to parent her children when she is active with her illness of substance use disorder or mental health issues. What if we extended that belief and position to men and fathers? 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?"

Slide 19

So, what is a PPW program that actively includes fathers like? What perspectives can they offer about including fathers? This video features senior staff at Shields for Families, a program that has been delivering family-centered care to pregnant and postpartum women for 25 years. (Provide a little background on Shields if group has not seen "Bring Them All" documentary or completed the Family-Centered Care Modules). Let's listen.

Note to trainer: *This video is 3:07 minutes long and also available online at https://vimeopro.com/attcnetwork/bring-them-all/video/236123916.*



Slide 20

ACTIVITY:
Quickly divide participants in two large groups (eg. left side and right side of room, every other table, etc.).
Assign each group one of two questions (see below).
In dyads or at their table, have participants discuss the question for 2-3 minutes and then report out.

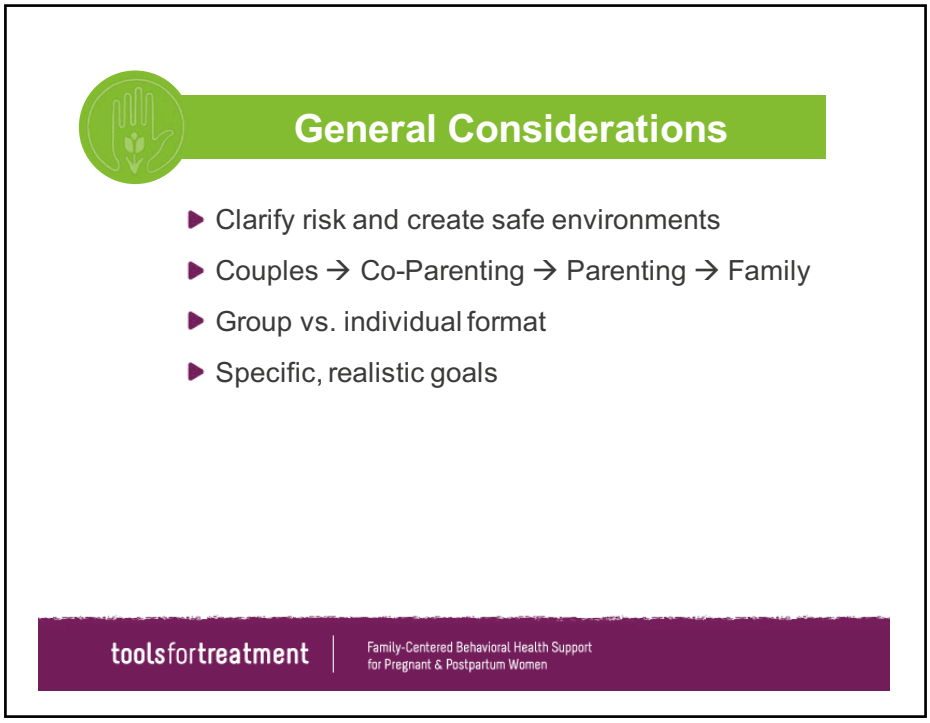
- *Group 1: What were your thoughts as you listened to the staff perspectives about including men in their program?*
- *Group 2: If these staff members spent a few days observing your program, what would the procedures and language of your program reflect about the attitudes toward the fathers?*
- *Ask them to jot down 3-5 key words and be prepared to explain them when timer goes off.*

Elicit sharing with larger group after 3 minutes.
Probe, if needed, regarding:

- Differences between the video's program and participants' programs regarding attitudes, values, and integration of fathers into programming
- Patterns in the participant responses

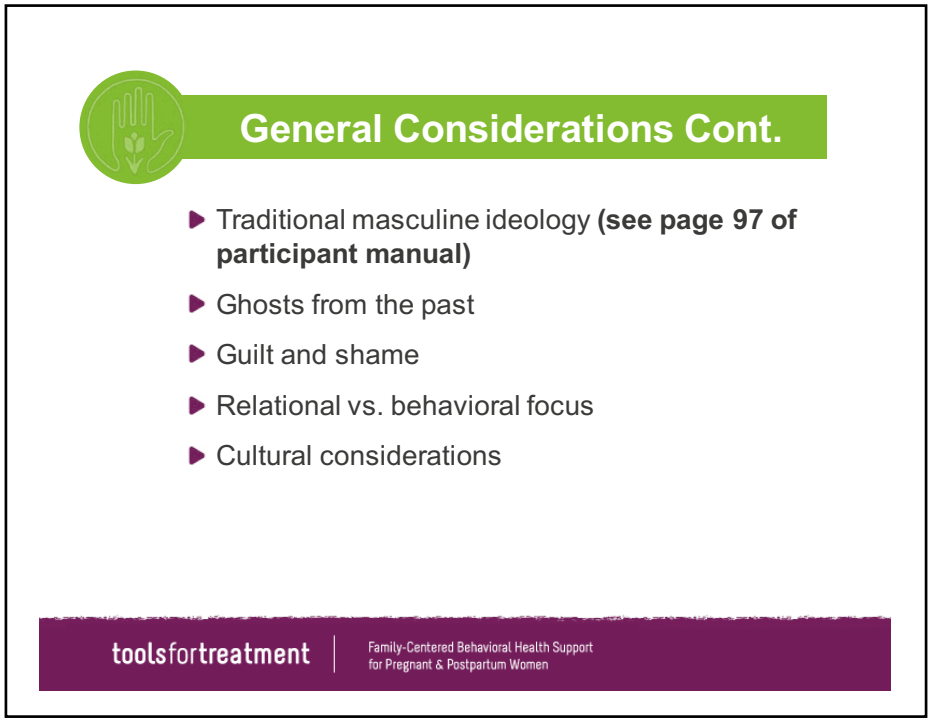
Slide 21

As you develop programming for fathers, there are several considerations and lessons learned by other programs you may want to keep in mind.



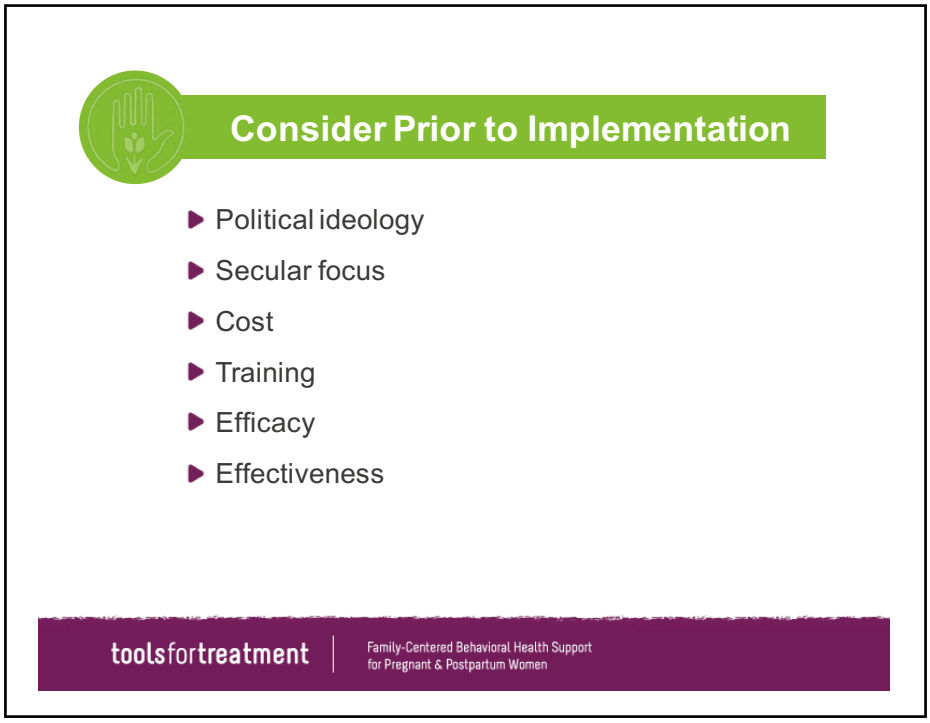
Slide 22

1. Clarify risk and create safe environments – Safety assessment and safety management are necessities. These need to considered from the perspective of the mothers, fathers, and children. As noted previously, the first goal of any family-centered intervention has to be the creation of physically and psychologically safe, supportive environments for everyone involved.
2. Many programs consider offering parenting intervention to men first or exclusively. When engaging fathers, it may be more effective to consider a progression of interventions that address couples' issues when the couple is together, co-parenting issues whether or not the couple is together, parenting issues, and then family issues in that order. Depending on the need of an individual client and her family, it may be possible to pursue some interventions simultaneously.
3. A group versus individual format – As programs develop a continuum of family-centered intervention, it is important to note that there are advantages and disadvantages to using both a group and individual format. For example, group interventions can be more economical in terms of cost and time, and there can be advantages in terms of providing empathy for common experiences. Sometimes, however, it can be difficult to fully address the specific needs of an individual client within a group intervention.
4. Because many women come to treatment with a complex array of family problems, it can feel overwhelming to think about how to address all of them. Programs have found it is helpful instead to set very specific, realistic goals that can be addressed in a specific time period. It can be helpful to make a list of goals to be pursued over time, order them in terms of urgency, and then decide which goals can be realized while the client is in her current level of care, and which goals may have to be deferred to later phases of treatment.



Slide 23

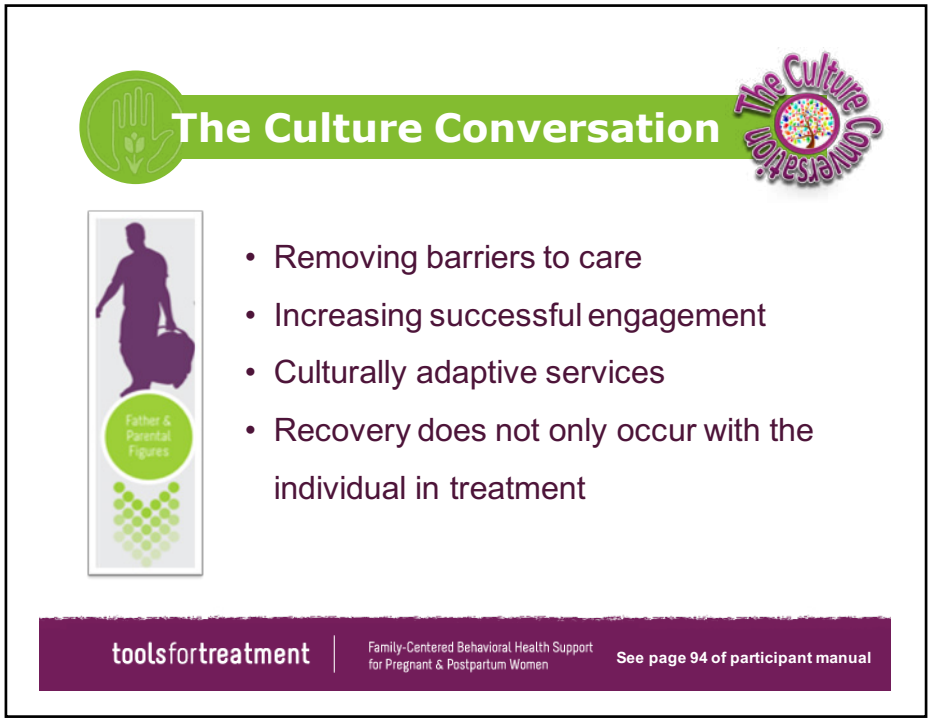
5. There is growing literature, primarily in counseling psychology, about how men and women's ideas about what it means to be a man influences what men do as partners and parents. A list of some of these overvalued ideas about men and masculinity is on page 97 of the participant manual. When working with men, it is important that clinicians have a good basic understanding of these ideas and an awareness how they influence our thinking about men in systems of care.
6. Another consideration is when and how to address the "ghosts in the nursery" that may be influencing the partnerships and parenting of men and women across generations. There are differences of opinion regarding the extent to which counselors and clinicians should focus on the impact of the past on the present in different types of family-centered intervention. Some people suggest that when childhood experiences seem to be clearly interfering with current functioning, the counselor or clinician may have to address the link between the past and the present. Similarly, counselors and clinicians should be aware that even when someone says, "I want to be a better father to my child than my father was to me," that father may, because of his experience as a child, not clearly understand how to do that.
7. Guilt and shame are ever-present issues for programs to consider. Generally, some guilt can be a positive influence in the lives of men and women because guilt is often associated with a message that I have done something wrong and I need to repair a relationship. Shame on the other hand can be problematic because it is often associated with a message that there is something wrong with me. It often motivates people to flee, externalize blame, blame others, and aggressively defend themselves.
8. Issues related to having a relational focus versus a behavioral focus also need to be considered, particularly within parent interventions for men. Men and women with substance use disorders may need very basic parenting skills. For example, before learning to give a child a time out, men may need to learn very basic relationship skills, like being consistent with visitation with children, learning how to talk with children, how to spend time, and play with children. Without some positive parent-child relationship, the use of time out is not likely to be effective. Other more basic skills need to come first.
9. Again, any family-centered assessment and intervention will be pursued in a cultural context. Counselors and clinicians must be competent to deliver culturally and linguistically sensitive services to clients entering the program.



Slide 24

Several structured group programs are available for delivery to couples and fathers. Organizations may make these materials available to programs like yours. When choosing a program and materials for use with clients, consider:

1. *Political ideology* – Examine carefully the values that underlie any program. What are the implications for use of these with the people you serve? Some popular programs have been criticized because they are grounded in very traditional political ideology about the nature of family and family life.
2. *Secular focus* – Do these ideologies represent a clear religious belief system that may not be acceptable within your agency or to your clients?
3. *Cost* – Most of these curricula have a cost attached.
4. *Training* – Some programs require that a staff person or group of staff be trained in the use of the program before the materials can be released to you.
5. *Efficacy* – Although several of these programs have become quite popular, they are relatively new, so there is often little known regarding their efficacy and effectiveness. Efficacy addresses how well the program or intervention delivers the expected positive outcomes under "ideal" conditions, i.e. how the program was evaluated. Make sure to examine the conditions under which these outcomes were obtained, such as characteristics of the target audience, the skill level and expertise of those implementing the program, the length of time, additional staff, and incentives or supports used. How closely can your agency duplicate these?
6. *Effectiveness* – Effectiveness addresses how well the program or intervention delivers the expected outcomes under every-day or "real world" conditions. Is the program likely to produce the desired outcomes under the "real world" clinical conditions at your agency? For the populations you serve?



Slide 25

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

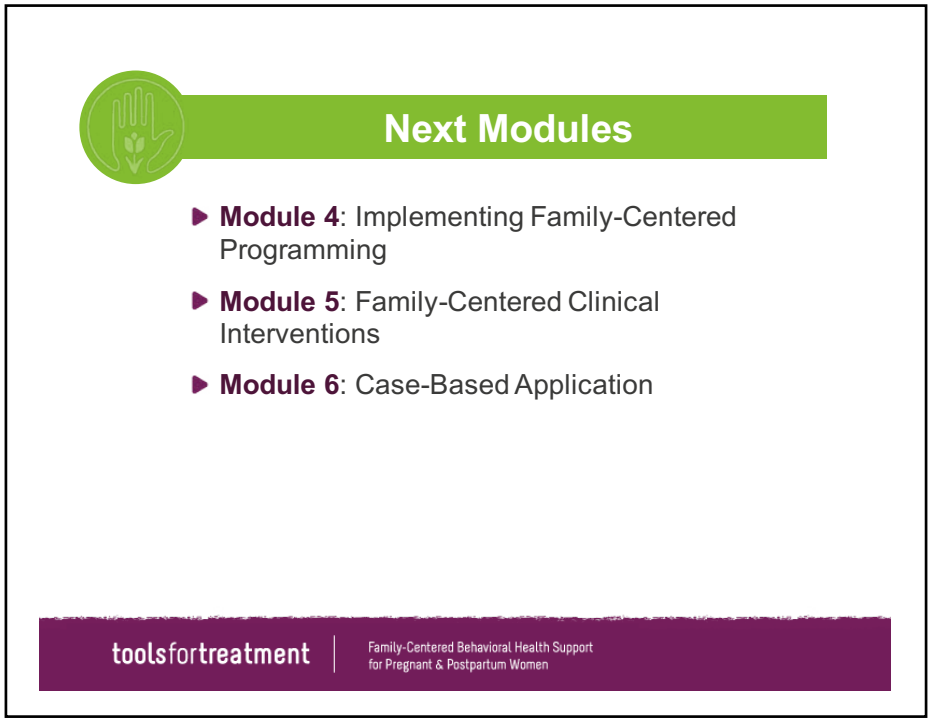
We know recovery is not just about the individual in treatment—it also is about the family/parents/fathers. As the individuals in treatment heal, they must establish new ways of communicating for their family and partnerships.

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.

The focus is on successful engagement and inclusion of culturally responsive/adaptive services for individuals, families, and fathers. The role of the parent/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 to family, parent/father inclusive services.

Slide 26

- We've spent time discussing some of the whys and hows of building programming for fathers.
- How has your impression of family-centered programming for fathers changed?



Slide 27

These are the next modules in this training series. Make sure to check your participant manual for more information and resources.

References

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

toolsfortreatment | Family-Centered Behavioral Health Support for Pregnant & Postpartum Women

Slide 28

Module 3

Module 3

Resources

FAMILY-CENTERED, RECOVERY AND WELLNESS APPROACH

Module 3

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)
• Avoidance of Femininity • Negativity Toward Sexual Minorities • Self-Reliance • Toughness • Dominance • Importance of Sex • Restrictive Emotionality	• 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. J*ournal 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.

Module 3

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

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

References

See page 244-247 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.

Design and Time

Section	Description	Components	Time
Questionnaire completion	As participants arrive, ask to complete "Is Your Organization Family Friendly?" questionnaire.	•"Is Your Organization Family Friendly?" questionnaire on pages 133-138 in manual	8 minutes
Introduction to module	Overview of the module and project.	•Title & acknowledgements •Participant introductions •Review of module 4 in participant manual and PPW website •Goals & objectives	5 minutes
Discussion	Encourage participants to assess their workplace through the eyes of the families they serve. Allows participants to imagine and verbalize desired changes to better serve families.	•Completed questionnaire •Discussion questions	5 minutes
The 7 steps	Reviews the 7-step cycle that can guide programs when developing family centered programming. Includes "Tales from the Field" slide with script to be read of a seasoned peer's recollections of past practices. Also includes a brief "Culture Conversation" slide.	•Mission & values •Needs assessment •"Tales from the Field" •Agency policy •Risk management •Family assessment •Culture conversation •Clinical intervention •Types of clinical intervention •Program evaluation	20 minutes
Discussion	Concludes 7-step presentation by encouraging participants to examine their work place in terms of the 7 steps for developing family-centered programming. Which elements are already in place, should they wish to develop more family-centered programming, and which are still needed?	•Discussion slide	5 minutes
Wrap up	Concluding remarks for module.		2 minutes

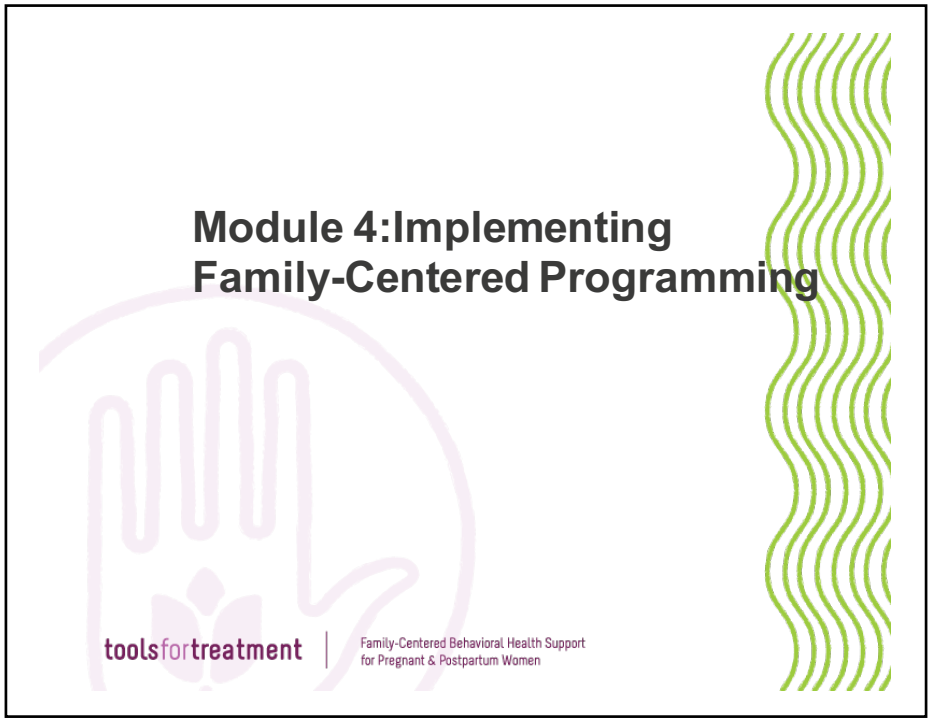

Easier Together:
Partnering with Families to Make Recovery Possible
toolsfortreatment
Family-Centered Behavioral Health Support for Pregnant & Postpartum Women
ATTC | Center of Excellence

Slide 1

Slide 2

Before we begin, please take a few minutes to complete the checklist, *Is Your Organization Family Friendly?*, on pages 133-138 of your participant manual.

Module 4

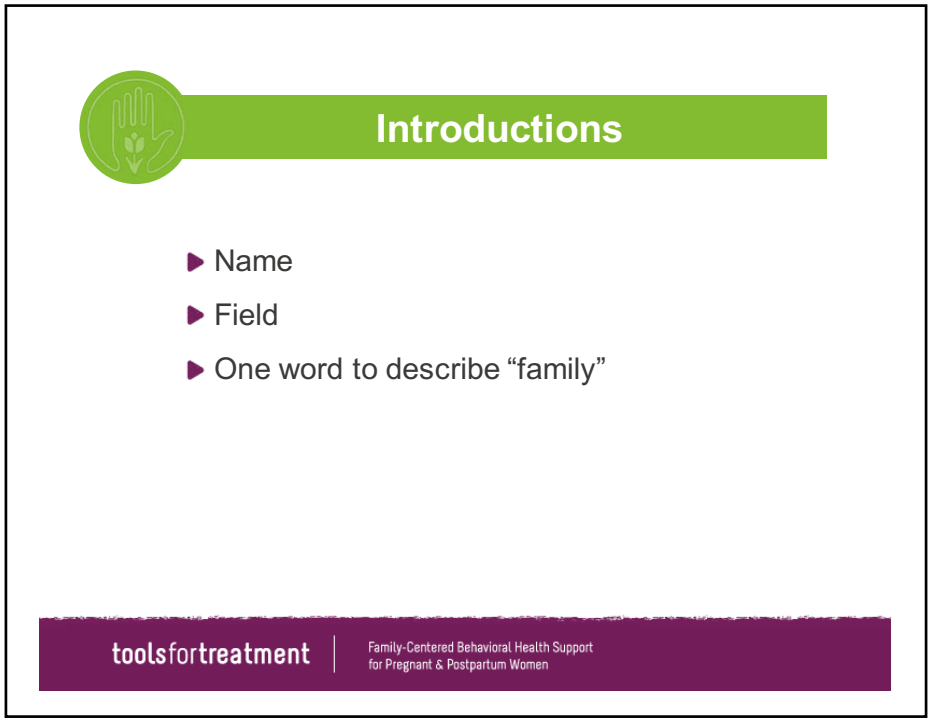


Slide 3

Welcome to Module 4: *Implementing Family-Centered Programming*. During Module 4, we will take a program-level view and review the steps agencies can take when developing programming that includes fathers and other family members.

Slide 4

Our thanks to Thomas McMahon, PhD for his expertise, guidance, and many contributions in the development of this module. Dr. McMahon is a Professor in Psychiatry and the Child Study Center at the Yale University School of Medicine. Dr. McMahon is interested in ways in which the principles of developmental psychopathology can be used to expand understanding of the impact that parental addiction has on family process and child development. He has worked on the development of gender-specific parent interventions for men enrolled in addiction treatment. Dr. McMahon is also interested in the psychological assessment and treatment of children, adolescents, and young adults who have been abused or neglected in the context of parental addiction, as well as clinical and research training on the roles that genetic liability and family process play in the intergenerational transmission of developmental psychopathology. Dr. McMahon completed his doctoral training in clinical child and school psychology at New York University in 1994. Since 1998, he has been the recipient of several grants from the National Institute on Drug Abuse. With his colleagues, he has published more than 75 peer-reviewed papers and book chapters.



Slide 5

Before we get started, I'd like to do some brief introductions.

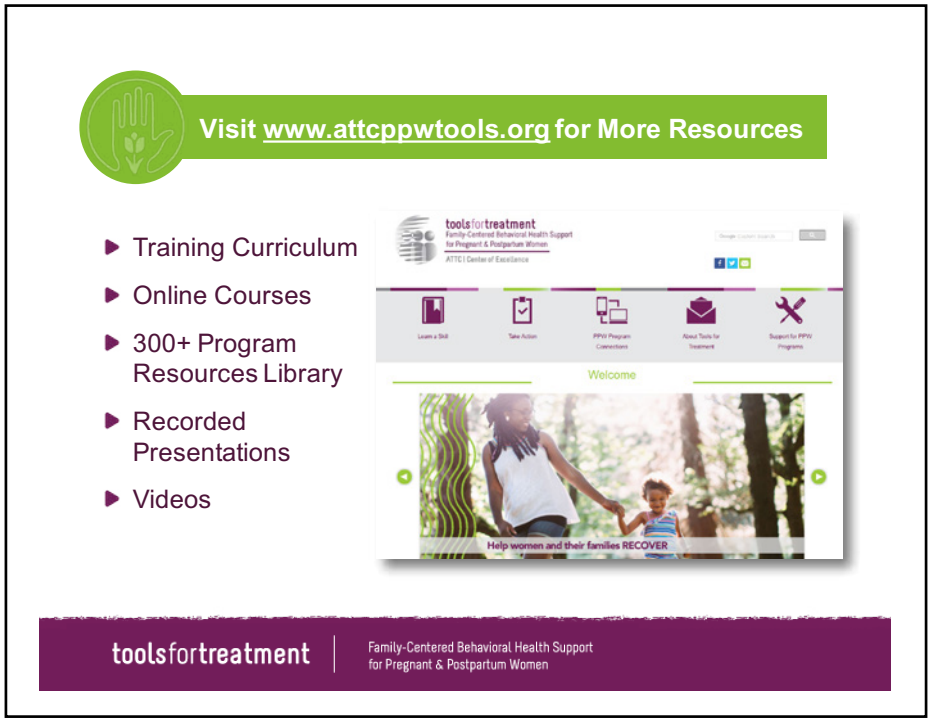
- Trainer: introduce yourself
- Now I'd like everyone to introduce yourself and share the first word you think of to describe the word "family."
- Have everyone say their name one word to describe a "family."

Note to trainer: *You can modify this activity based on your audience.*

Slide 6

As part of this curriculum, you all have a participant manual. I'd like us to do a hands-on review of this module's content so you are familiar:

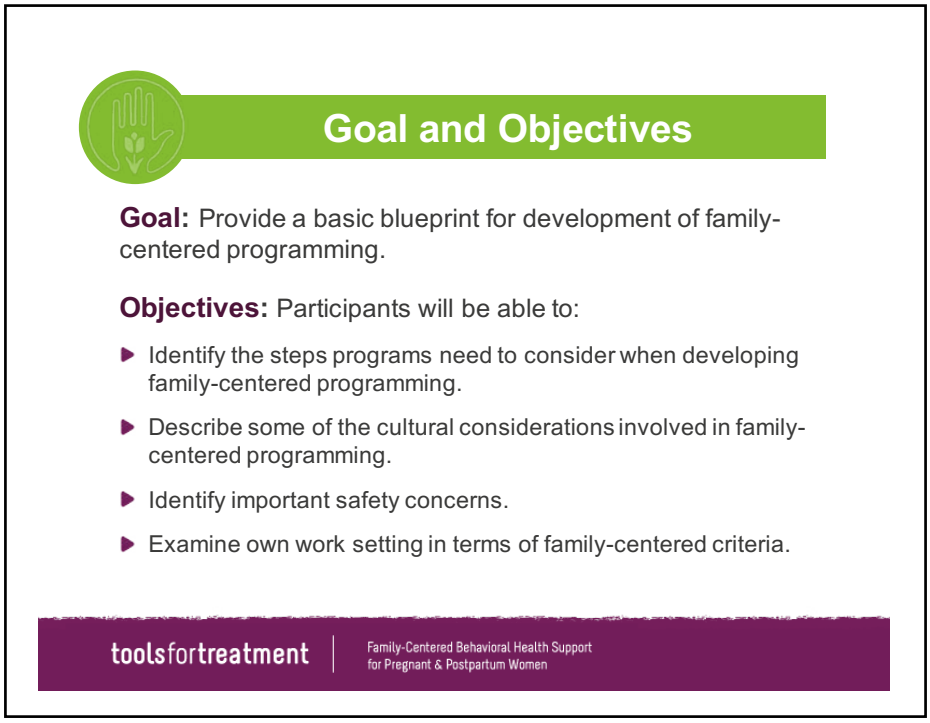
- On page 116, the module begins with the training goals and objectives.
- Next on page 117 you will find all of the presentation slides with room for taking notes.
- Then on page 132 you will find the resources section, which contains a collection of handouts, worksheets, activities, assessments, recommended reading, and a reference list for that module.



Slide 7

For additional resources, visit www.attcppwtools.org. Here you can download the "Easier Together" curriculum and access other resources such as:

- Training curriculum
- Online courses
- 300+ resources in the Program Resources library
- Recorded presentations
- Videos



Slide 8

The goal of this module is to provide a basic blueprint that agencies can follow when developing family-centered programming.

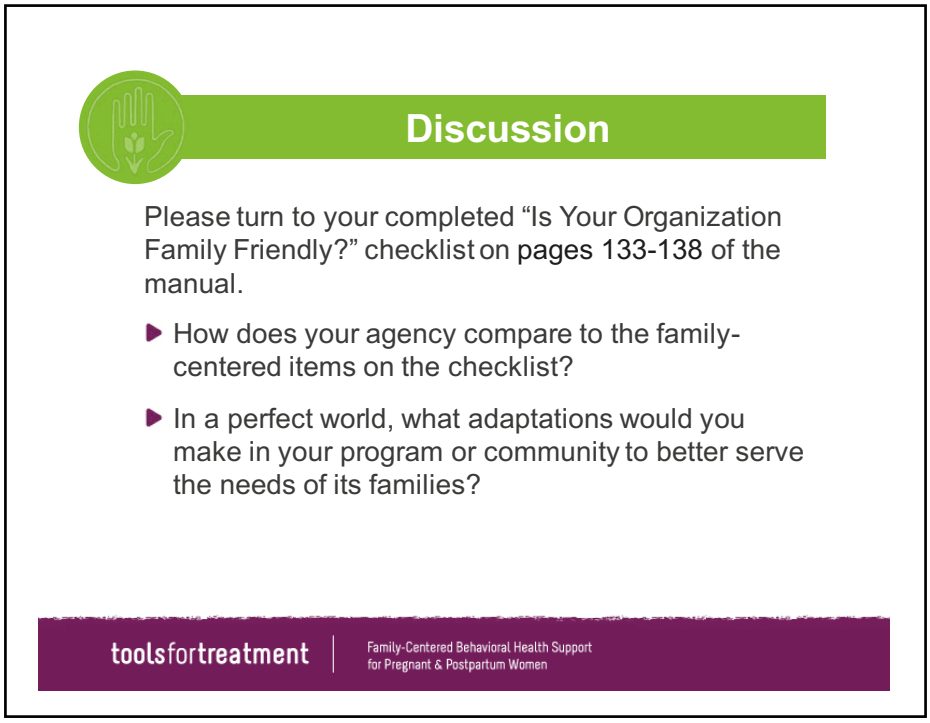
These are our learning objectives for module 4:

- 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.

Slide 9

- This is a graphic that was developed to embody family-centered care and was presented in earlier modules. In this graphic, you can see that the woman is the vehicle of entry for all family members. She is the initial client that comes into the program to receive services, but through her, our view expands to include all family members. The family becomes the client and we wrap services around all family members to support family strengthening and healing.
- Additionally, this graphic outlines "family-centered, recovery and wellness principles." It is imperative to view family-centered care through the lens of recovery and wellness, not just as a treatment episode. Family-centered care sets families up for sustainable recovery and wellness long after treatment ends.

Note to trainer: *This is available as a handout on page 69 of the participant manual.*

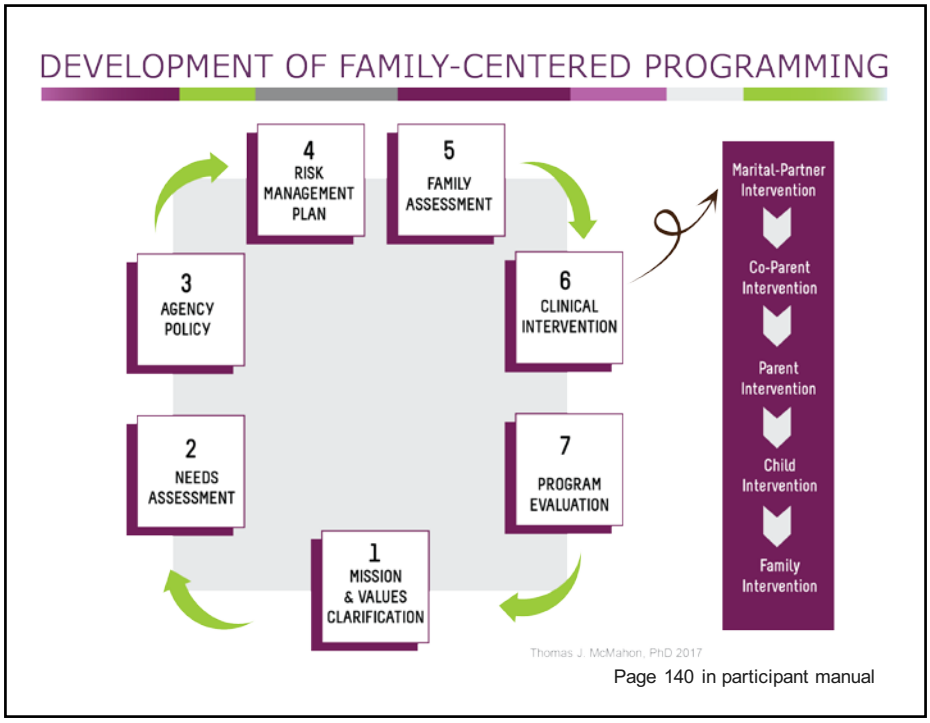


Slide 10

- 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?
- How are your current program approaches similar and/or different?
- In a perfect world, what adaptations would you make in your program or community to better serve the needs of its families?

Slide 11

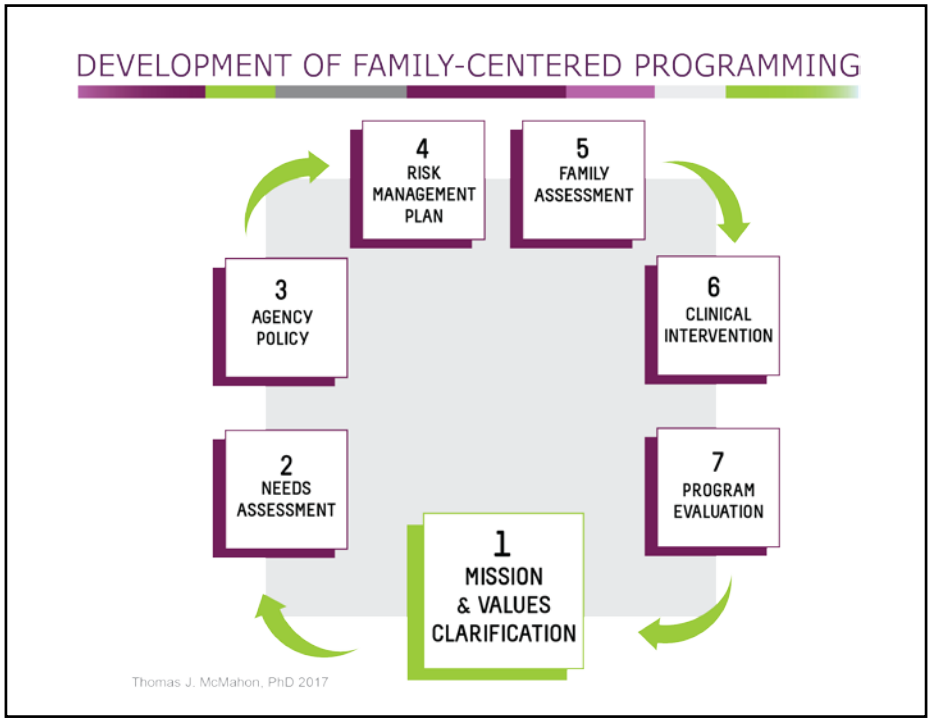
- Regardless of where an agency or institution is in the process of implementing family-centered programming, there are 7 steps that are helpful for an agency to consider.



Slide 12

- This visual provides a basic "How To" blueprint that programs can follow. The steps are listed in their recommended order. We will take a closer look at each step.
- This graphic is available on page 140 of your participant manual.

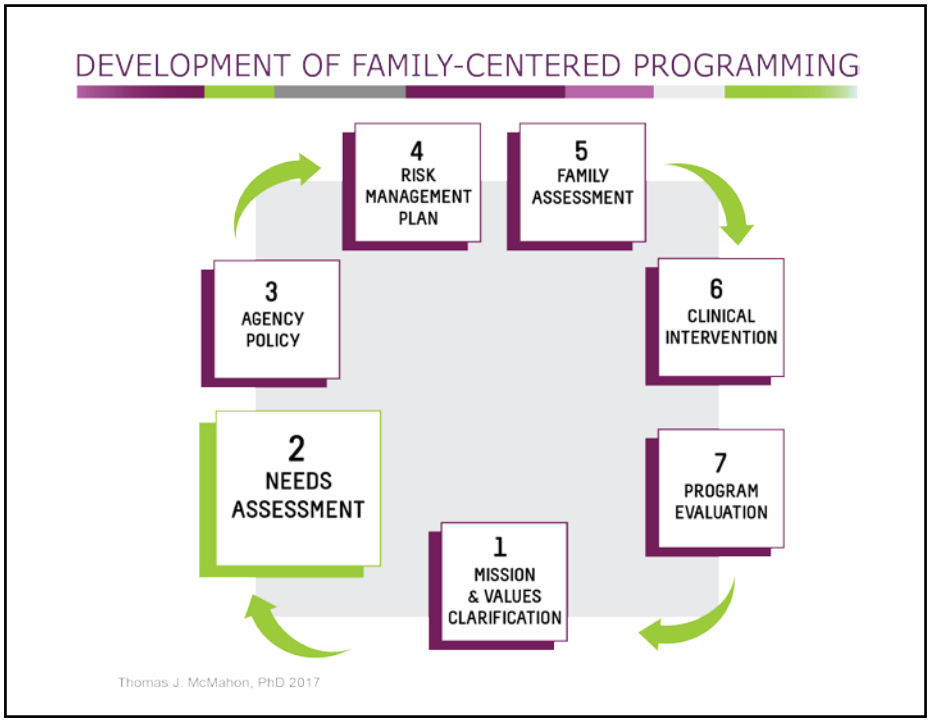
Module 4



Slide 13

Step 1. Clarify mission, values and attitudes -

- Because PPW programs have been historically developed by women for women, it is useful to spend some time exploring and talking about the values and attitudes in your program, especially feelings and concerns regarding beginning or continuing to include men and others in programming.
- Useful tools for this process, such as program "father-friendliness" assessments are included on pages 100-106 in your participant manual as well as in the list of resources.
- It is recommended that staff and administrators sit and actually write down a policy about values, goals, and expectations for a program that intends to better engage men and others considered family.



Slide 14

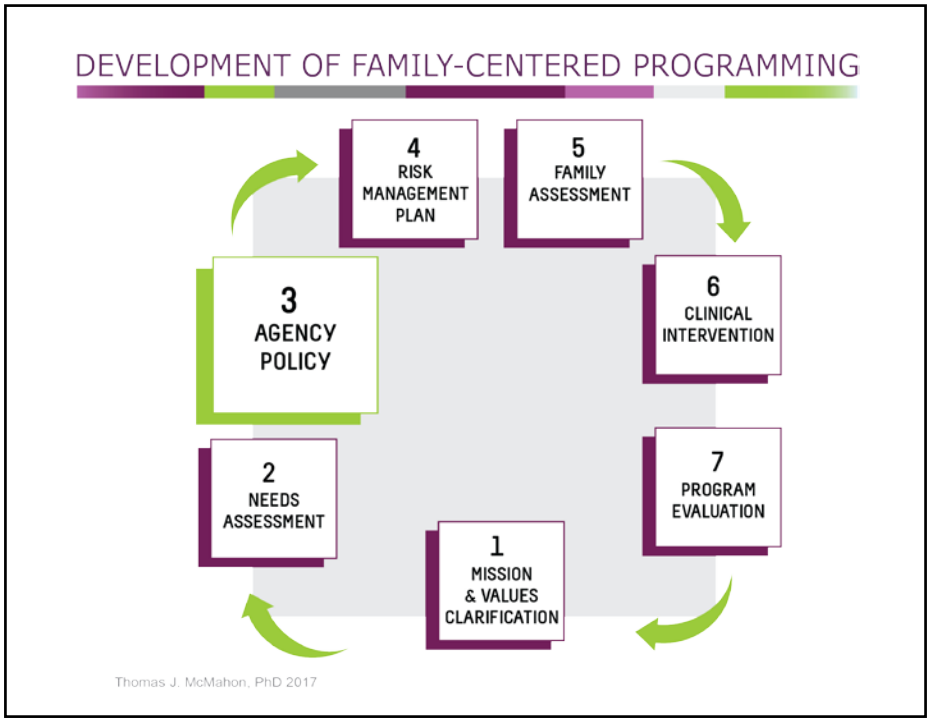
Step 2. Conduct needs assessment

- Look at the needs of the women in terms of the partners and co-parents in their lives.
- Look at needs of your program. What would be helpful for your program to do to develop more programming for men and other family members?
- What information does your program already gather on the fathers and other individuals considered family?
- What additional information would be useful?
- If your agency cannot meet the identified needs, could they be met by current partners or potential partners of your agency?

Slide 15

- Pioneers in the field such as Kimberly Craig, CEO of CHEEERS Recovery Center, and a former PPW grantee, in Phoenix, Arizona, can offer insights on this process.

"A needs assessment can also include the use of some tools provided in your manual about assessing your organization on Father / Family Friendliness or Readiness. After years of running a program for just women and their children, we had to look at every aspect of our program to include our environment, policies and even our language. For example, we used the word "screening" to describe a fathers first face to face interaction with the counseling staff. Men had to complete a "Screening" appointment before they were allowed on the campus for visitation with their children. It was common to use this "screening" as a way for staff to say no, he wasn't allowed to visit. It was always the first question, "has he completed a screening?" Screening definitely did not say, "welcome, we are a father friendly environment". We also had to look at what our environment said about fathering; did we have pictures, magazines and space that was welcoming and inviting for men? Did we have posters or pictures, printed materials that had images of men parenting? As programs looking to implement family centered care and in particular father/male involvement we have to look at everything top to bottom; and through the lens of those we are hoping to engage in services.



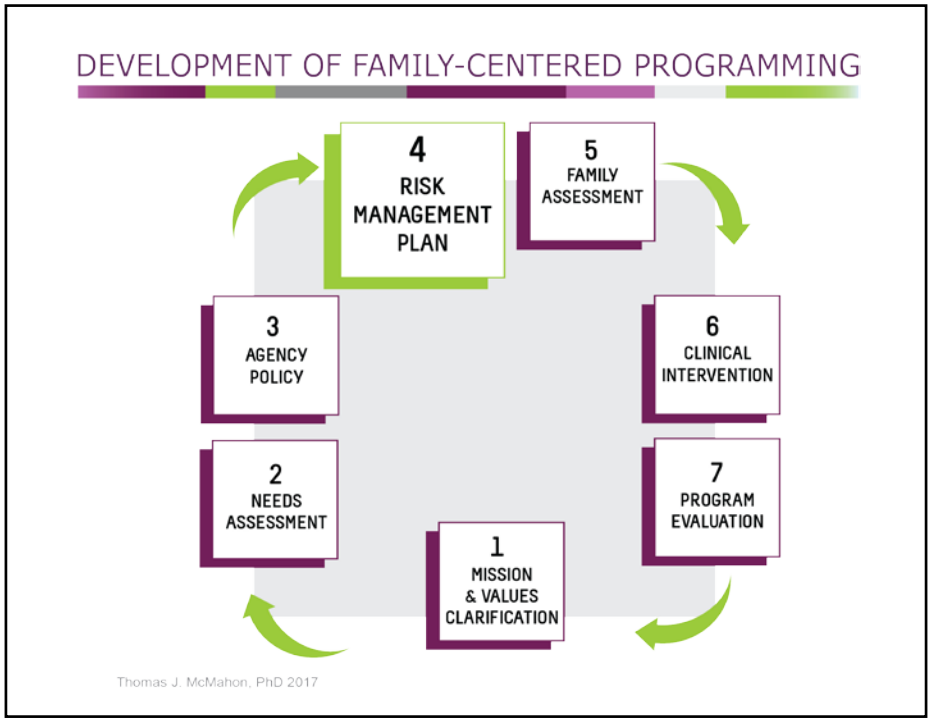
Slide 16

Step 3. Clarify Agency Policy

- Think about legal and ethical issues you are likely to encounter when you engage and include services for fathers, partners or co-parents. How will you deal with these?

Examples include: A father, who is not your patient, comes for a visit intoxicated. A woman in your program reveals her partner has a substance use disorder and asks for help.

- It's recommended that staff and administrators sit and actually create a policy concerning the involvement of fathers, partners, co-parents and other identified family members. Such a policy should outline the values, goals, expectations, and procedures relevant to their involvement. Generally, a good policy statement would indicate why a program believes it is important to involve the fathers, co-parents, partners, or other identified family member, and how they intend to do so. Other programs have found that the process of putting their ideas about how to do this on paper was very useful and helped focus the process.



Slide 17

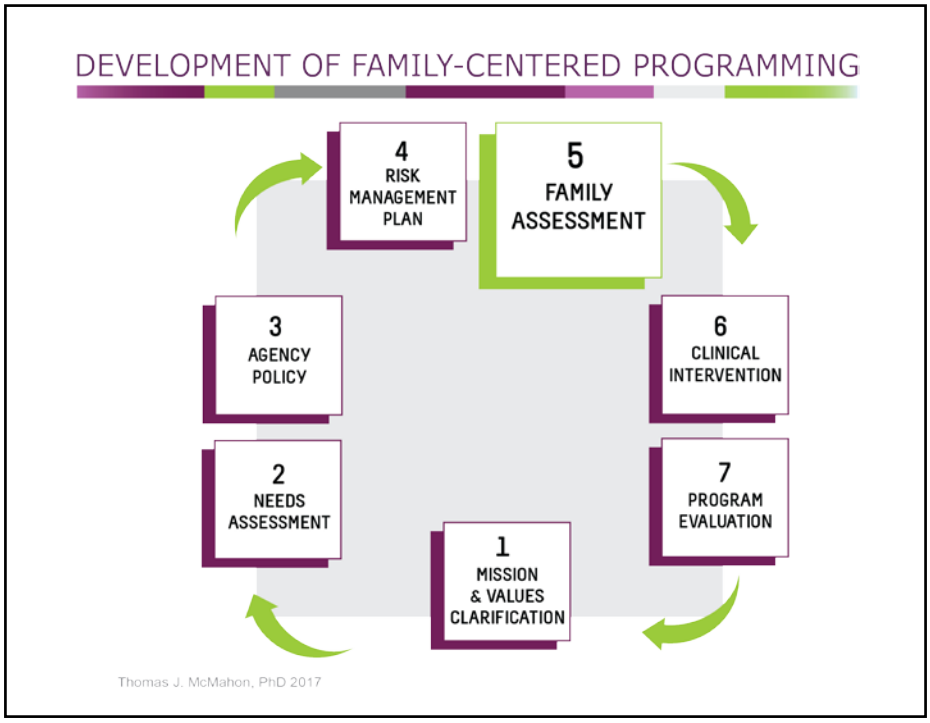
Step 4. Think about procedures for safety and risk management.

- Assessment and treatment of PPW with substance use disorders involves elements of risk. Increasing the involvement of fathers and others identified as family may also involve elements of risk. It is best to be proactive about the development of safety procedures to manage the risks inherent in the work an agency does. As more family-oriented interventions are developed, it may be useful to consider how to minimize the risks known to be associated with substance use for everyone in the family.
- Safety management procedures and policies for inside the program consider how to handle clients as well as those who are considered visitors.

Examples include:

- Will you allow fathers or co-parents to attend a family event before they have had an individual, couple's, or family meeting with a counselor or clinician?
- How will your program respond to couples when there has been a history of intimate partner violence?
- How will your program help a client who wants to end a sexual partnership with the father of her child?
- How would your program respond to a father, partner, or co-parent who is not your patient and presents for a family visit intoxicated?

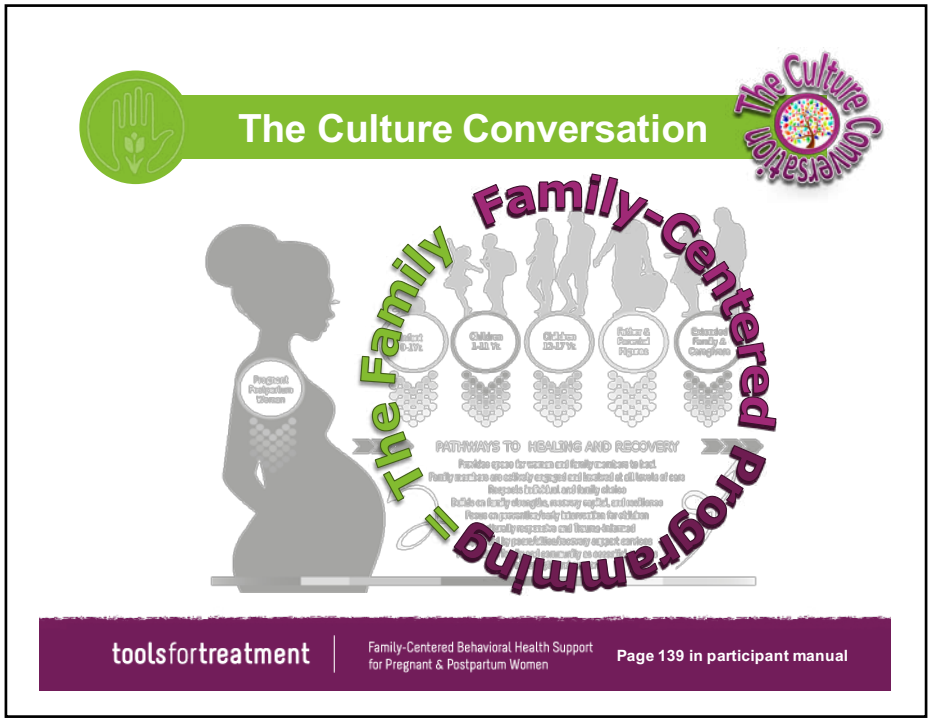
- Safety management must also include procedures and planning as the woman moves back into the community.
- And as programs develop outpatient services (which is where the field appears to be moving), safety management policies and procedures must also be included.



Slide 18

Step 5. Family Assessment

- Who defines who can be considered family?
  - What if the program has an interest in or a requirement to communicate with the father even though mom may not want to include him?
  - What if the definition of family from mom's perspective differs from that of her child or children?
- How will families be assessed?
- Formal initial family assessment typically begins with mom and expands over the rest of mom's time in treatment as more is learned about the family.
- Given the principles of family-centered care, the family assessment focuses not only on the problems but also the strengths of the family.
- The assessment also gathers information on the family's cultural and socioeconomic background so it can place the family in a cultural and socioeconomic context. As mentioned earlier, definition of family may differ considerably for mothers, fathers, and children in response to differences in race, ethnicity, religion, marital status, sexual orientation, socioeconomic status, and other sociocultural influences.



Slide 19

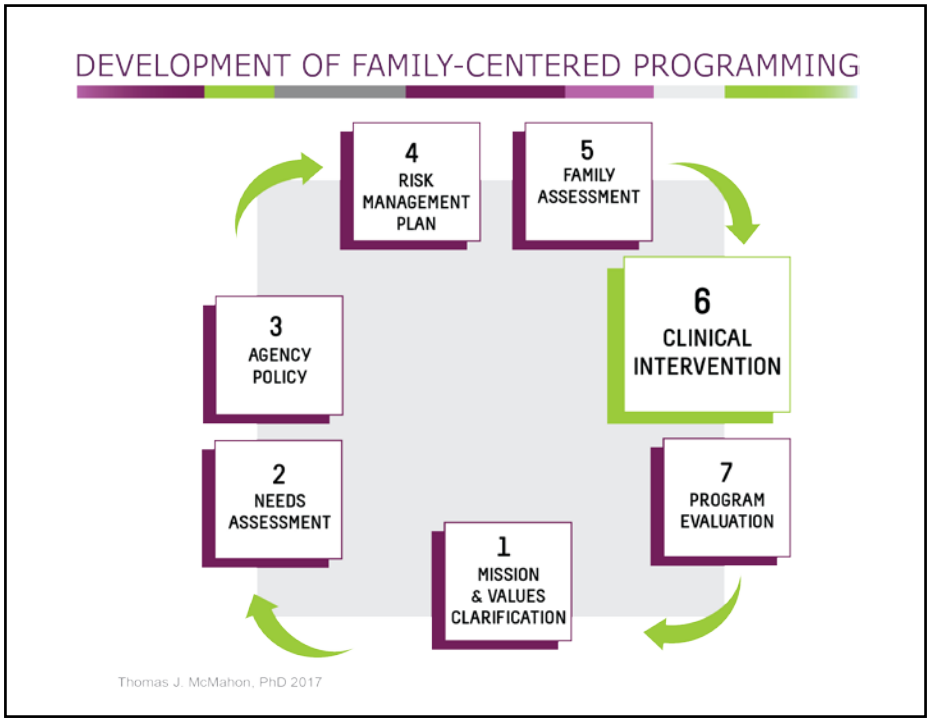
- Although we are reviewing a "blueprint" for family-centered programming, it's important to remember that there is no "blueprint" for families. Families are diverse in landscape, constantly in flux, and dynamic in nature. Culture and the family requires awareness and understanding that "all families are not the same." This concept may be acknowledged, however, it is by looking at the levels within cultural constructs that we can discover 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

- It is defining with the individuals who and what family is and means to them. It is having the conversation from their perspective and working from there.

- Understanding the populations and communities which 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 which 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?"

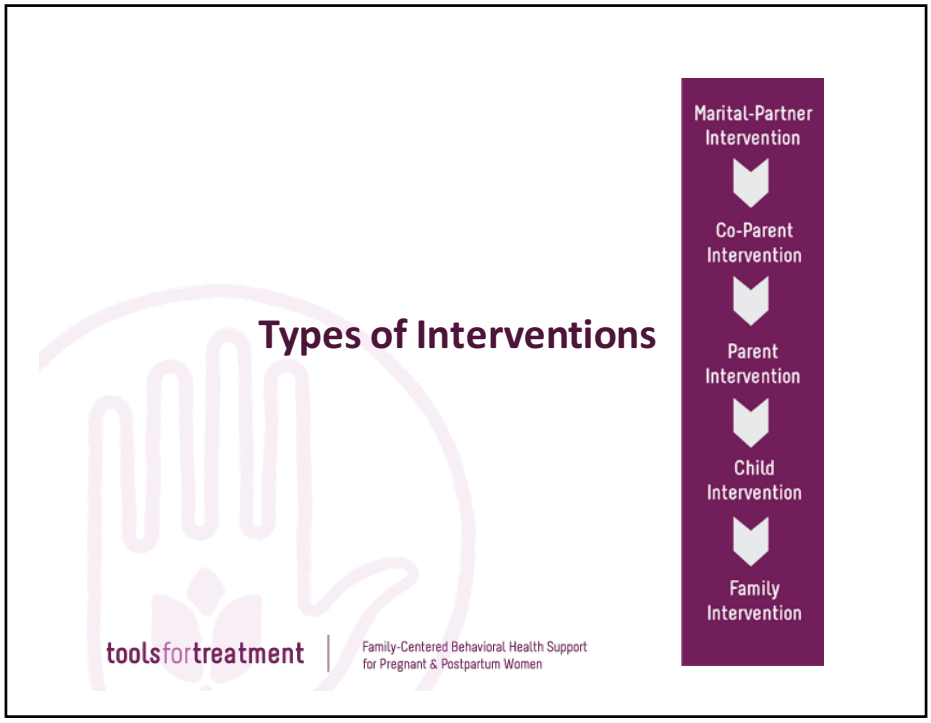


Slide 20

Step 6. Define Clinical Interventions

- What interventions will you offer for families including fathers and other family members?
- Which interventions will you provide in-house? What additional services are needed so that families can easily access services offered by partners and not in-house?

Let's look at the most common types of interventions more closely.



Slide 21

Interventions here are listed in the order that problems typically should be addressed.

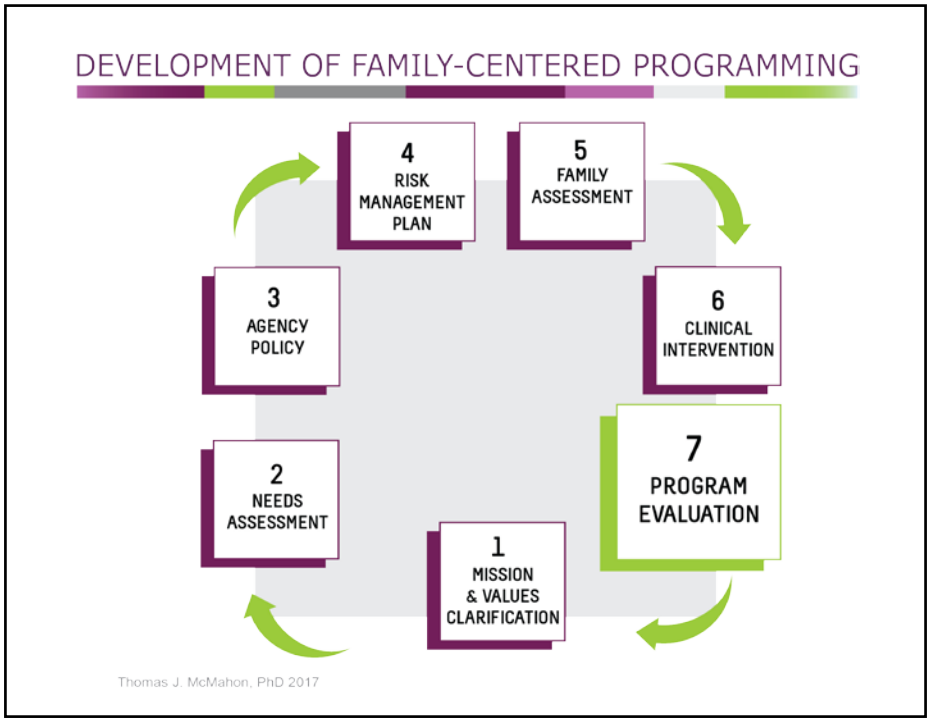
Marital – Partner Interventions – is for couples choosing to remain together and experiencing difficulties other than parenting. E.g. Difficulties with intimate partner violence, continued substance use as a couple, questions about whether to remain together, communication problems, concerns about fidelity.

Co-parenting Interventions - It may be one dimension of a marital-partner intervention or it may be the primary form of intervention for couples who have ended their sexual relationship or partnership.

Parenting Interventions – These would match, for the fathers and co-parents, the parenting interventions being done with the mothers. Links to some of the more popular interventions for use with fathers are in the resources list for this module. There has been work on defining the components of these programs for men, and there is evidence that men like them, but evidence on whether they really work as advertised is evolving.

Child Intervention - Some programs include interventions where children of parents who are in treatment meet without the parents. It is separate from family interventions. Such groups give a child a place to talk about what it has been like to live with a parent with a substance use disorder . It is also an opportunity to educate children in a developmentally appropriate way about the nature of addiction. Some programs also offer summer camps with daylong programming for kids who have a parent with substance use issues.

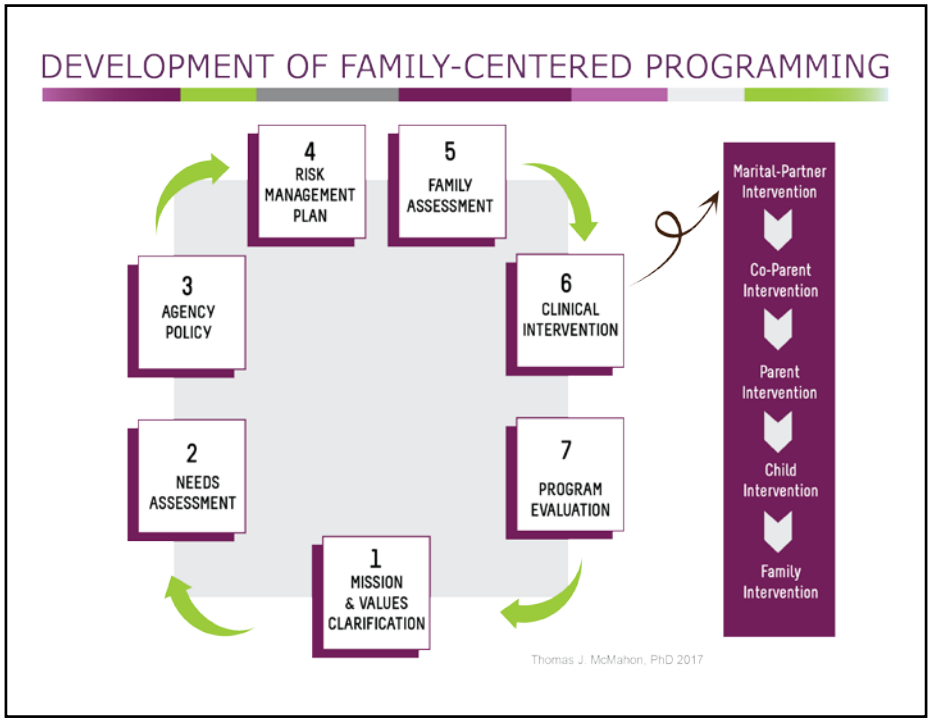
Family Intervention – These are carried out with parent and children in whatever configuration there is – mom and children, dad and children, or mom and dad and children.



Slide 22

Step 7. Evaluation

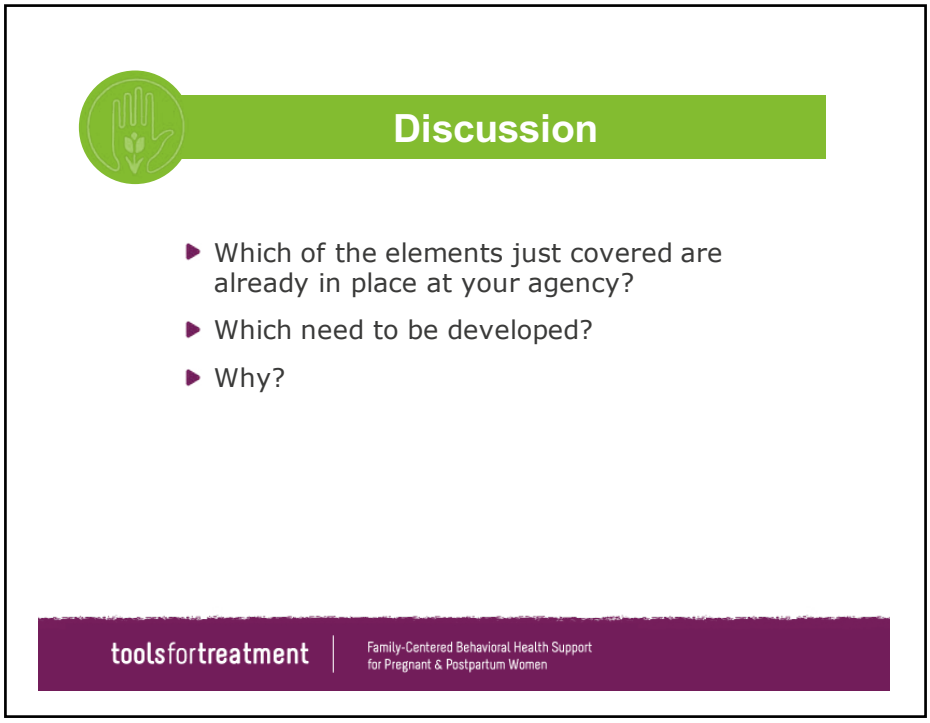
- Any program of assessment and intervention designed to better meet the needs of fathers should include some simple, but formal way to assess what is being done both in terms of:
  - how it is being received by the men and other members identified as family?
  - the extent to which it is promoting change within the families you are working with.
- These outcomes should align with the values, goals and expectations that were set in Step 1, the values clarification step.
  - Results from the evaluation would lead to a re-examination of the values and goals and expectations at the beginning of the cycle. Do these stay the same or do they need to be clarified further?
  - The cycle of steps starts again with a re-examination of the needs assessment, agency policy, and on through the cycle.



Slide 23

Ask participants to keep that page open as they answer the question on the next slide.

Note to trainer: *A full size copy of the complete graphic is included on page 140 of the participant manual.*



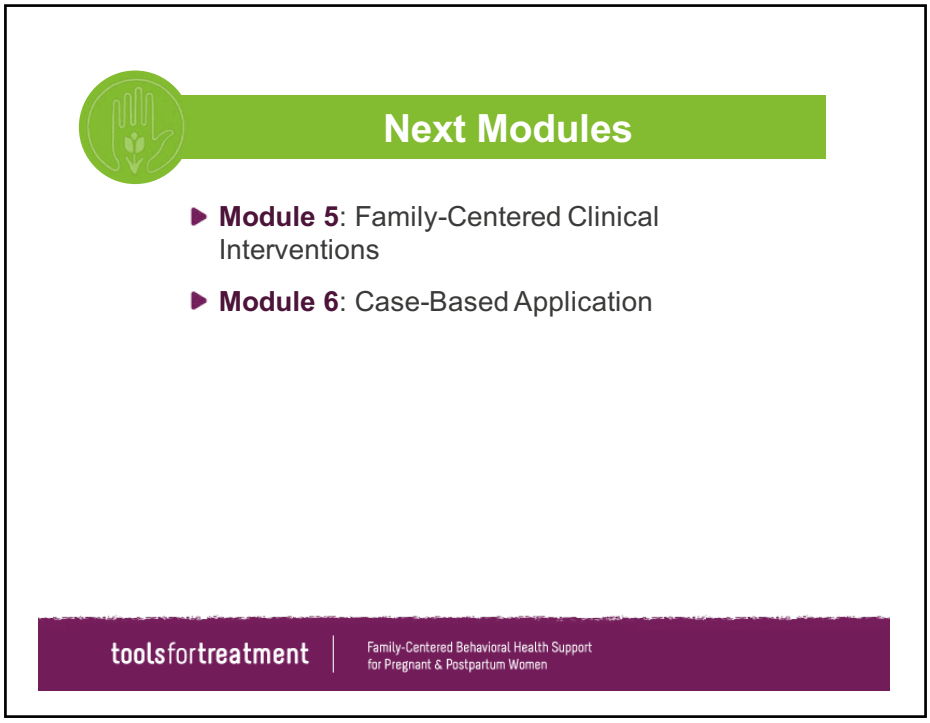
Slide 24

- Think of the 7 steps in terms of the system or program you work in. If your system or program embarked on this process of greater inclusion of fathers and family, which of the elements just covered are already in place?
- Which would need to be developed further?
- Would any of you be willing to tell us why?

Note to trainer: *You can have people respond or you can point to each step on the visual and ask for a show of hands. This activity can be modified based on the audience and time constraints.*

Slide 25

How has your impression of family-centered programming changed?



Slide 26

These are the next modules in this training series. Make sure to check your participant manual for more information and resources.

References

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

toolsfortreatment | Family-Centered Behavioral Health Support for Pregnant & Postpartum Women

Slide 27

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:

- ☐ Developmental Disabilities
- ☐ Behavioral Health
- ☐ Mental Health
- ☐ Physical Health
- ☐ Juvenile Justice
- ☐ Adult Corrections
- ☐ Substance Abuse
- ☐ Child Welfare
- ☐ Other _____
- ☐ Pre-school
- ☐ Elementary School
- ☐ Middle School
- ☐ Higher Education
- ☐ Residential Service Provider
- ☐ Child/Family Advocacy
- ☐ Rehabilitation Services
- ☐ Vocational Services

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?
1	2	3	4	5	Are agency policies and procedures family centered/oriented?
1	2	3	4	5	Does the agency train staff on the value of family input?

Yes	No	N/A	
☐	☐	☐	Are families on the agency's board of directors or advisory committee?
☐	☐	☐	Do families write and/or approve the agency's policies and procedures on an ongoing basis?
☐	☐	☐	Do families orient and train new staff?
☐	☐	☐	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	
☐	☐	☐	Does the agency give families information regularly and whenever asked?
☐	☐	☐	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	
☐	☐	☐	Does the agency have an open door policy for families at any time?
☐	☐	☐	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	No	N/A	
☐	☐	☐	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	
☐	☐	☐	Are families included on all committees and meetings?
☐	☐	☐	Do families receive meeting minutes and agendas?
☐	☐	☐	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	
☐	☐	☐	Does your agency provide changing tables or a family restroom?

Module 4

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:

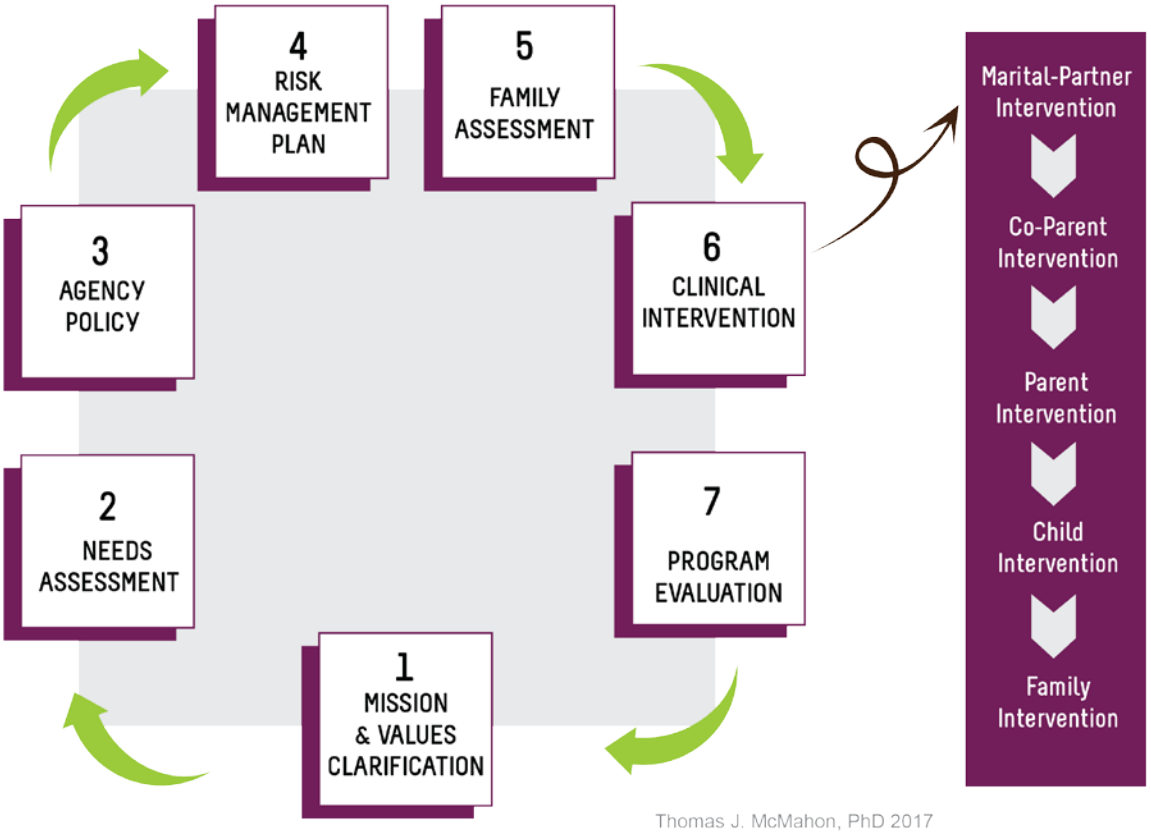
- Were established by parents caring for children and youth with mental/behavioral health needs
- Are led by persons with shared experiences (similar lived experiences)
- Balance passion and business practices in an effort to strengthen the whole

"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 with 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 than 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 page 244-247 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:

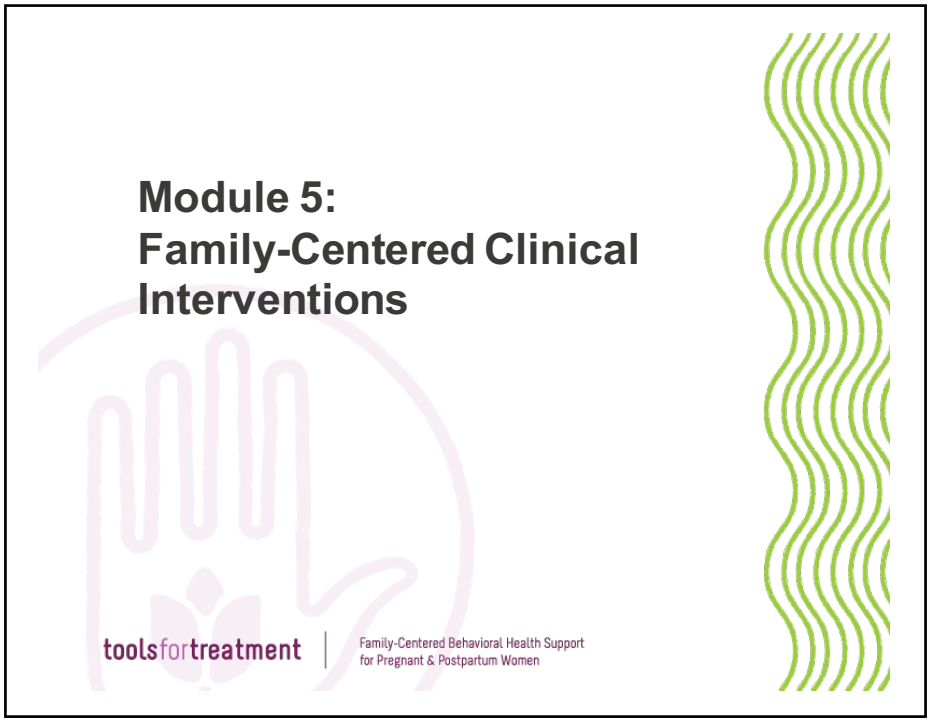
1. Identify the steps for developing family-centered interventions.
2. Describe some of the cultural considerations family-centered interventions involve.
3. Identify important safety concerns.
4. Examine own practice in terms of family-centered criteria.

Design and Time

Section	Description	Components	Time
Introduction to module	Overview of this module.	•Title & acknowledgements •Participant introductions •Review of Module 5 in participant manual and PPW website •Goals & objectives •Culture conversation •Family-centered care graphic	10 minutes
Family-centered clinical interventions: 6 steps to working with men and women as family	Introduce the 6-step sequence that answers: "How can I develop family-centered interventions for an individual family?" Includes a video clip on "Partnering with Child Welfare" (4:12 minutes) and video clip illustrating "Services for Children" (3:17 minutes).	Individual assessment •Definition of family •Family assessment •Risk management plan •"Partnering with Child Welfare" video clip •Clinical intervention •"Services for Children" video clip •Evaluation of clinical outcomes	25 minutes
"Tales from the Field" and discussion	Encourages participants to think about family-centered practice as the most current stage of a continually evolving field, and will also allow them to evaluate if their workplace and their own practice is closer to how things used to be or closer to where the field is heading.	•"Tales from the Field" script •Discussion questions	7 minutes
Wrap up	Concluding remarks for module.		3 minutes

Slide 1

Welcome to module 5 of "Easier Together: Partnering with Families to Make Recovery Possible."

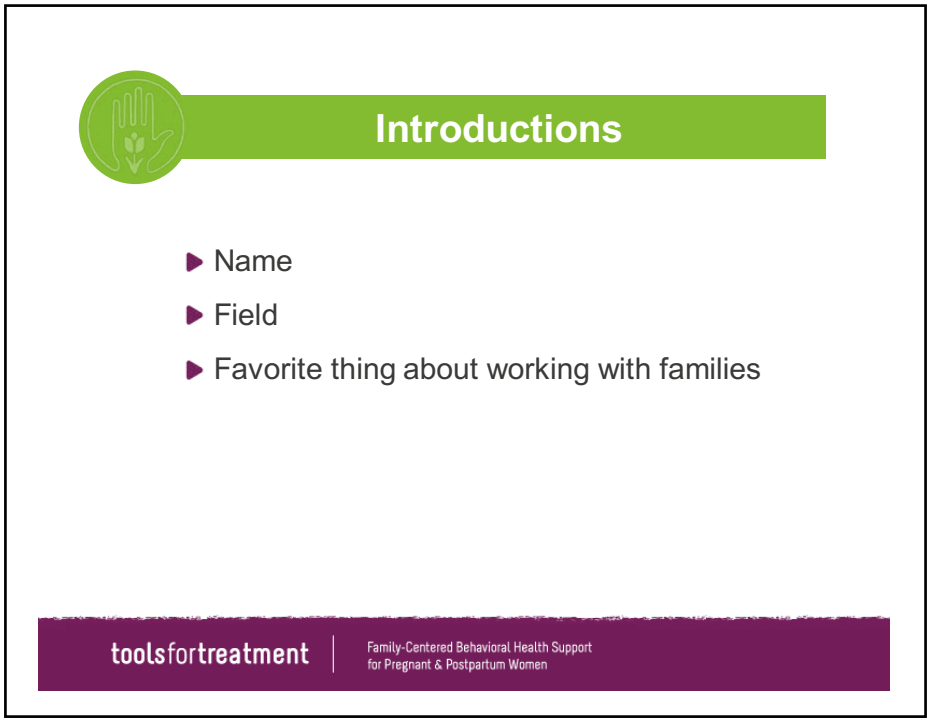


Slide 2

In Module 5, we take a client-level view and concentrate on the steps that can guide development of family-centered interventions for the individual families you serve.

Slide 3

Our thanks to Thomas McMahon, PhD for his expertise, guidance, and many contributions in the development of this module. Dr. McMahon is a Professor in Psychiatry and the Child Study Center at the Yale University School of Medicine. Dr. McMahon is interested in ways in which the principles of developmental psychopathology can be used to expand understanding of the impact that parental addiction has on family process and child development. He has worked on the development of gender-specific parent interventions for men enrolled in addiction treatment. Dr. McMahon is also interested in the psychological assessment and treatment of children, adolescents, and young adults who have been abused or neglected in the context of parental addiction, as well as clinical and research training on the roles that genetic liability and family process play in the intergenerational transmission of developmental psychopathology. Dr. McMahon completed his doctoral training in clinical child and school psychology at New York University in 1994. Since 1998, he has been the recipient of several grants from the National Institute on Drug Abuse. With his colleagues, he has published more than 75 peer-reviewed papers and book chapters.



Slide 4

Before we get started, I'd like to do some brief introductions.

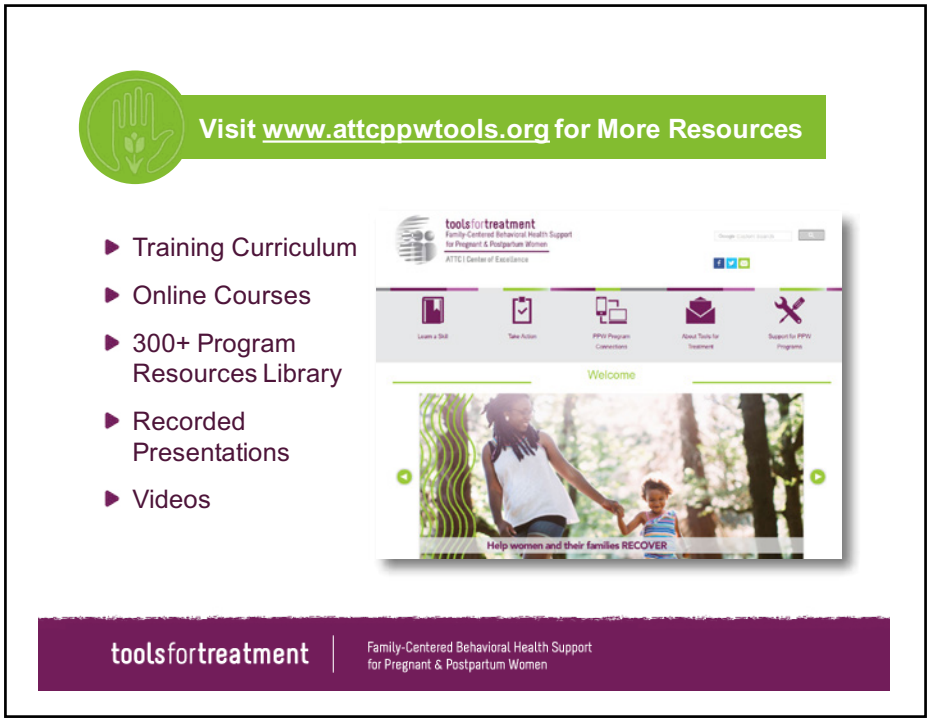
- Trainer: introduce yourself
- Now I'd like everyone to introduce yourself and share your favorite thing about working with families.
- Have everyone say their name, field, and favorite thing about working with families.

Note to trainer: *You can modify this activity based on your audience.*

Slide 5

As part of this curriculum, you all have a participant manual. I'd like us to do a hands-on review of this module's content so you are familiar:

- On page 144, the module begins with the training goals and objectives.
- Next on page 145 you will find all of the presentation slides with room for taking notes.
- Then on page 158 you will find the resources section, which contains a collection of handouts, worksheets, activities, assessments, recommended reading, and a reference list for that module.



Slide 6

For additional resources, visit www.attcppwtools.org. Here you can download the "Easier Together" curriculum and access other resources such as:

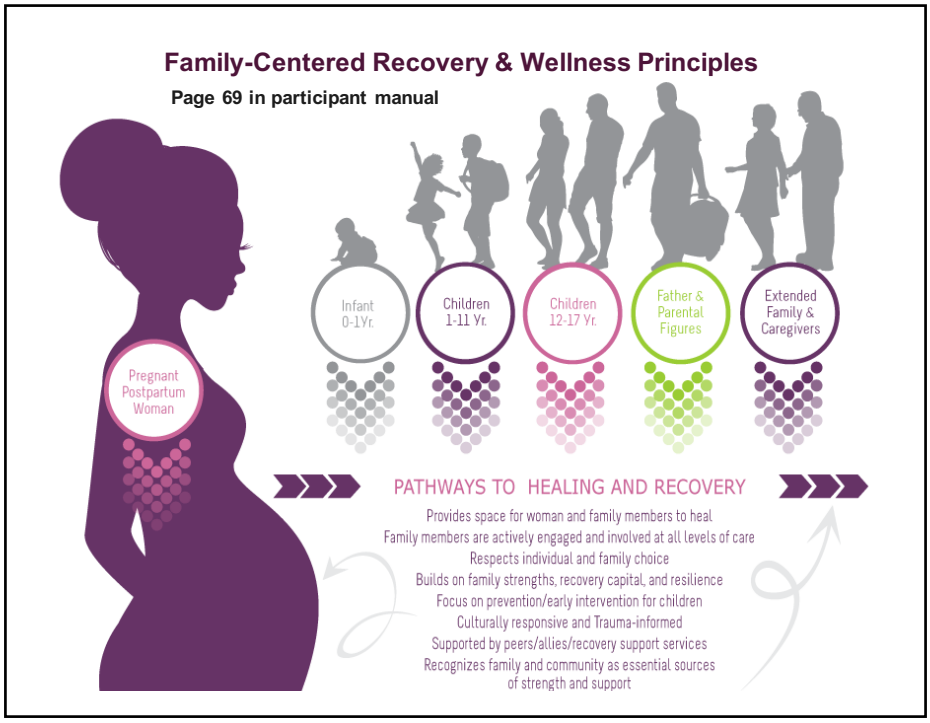
- Training curriculum
- Online courses
- 300+ resources in the Program Resources library
- Recorded presentations
- Videos

Module 5

Slide 7

The goal of this module is to provide a framework for development of family-centered interventions.

These are our learning objectives for Module 5.



Slide 8

- This is a graphic that was developed to embody family-centered care and was presented in earlier modules. In this graphic, you can see that the woman is the vehicle of entry for all family members. She is the initial client that comes into the program to receive services, but through her, our view expands to include all family members. The family becomes the client and we wrap services around all family members to support family strengthening and healing.
- Additionally, this graphic outlines "family-centered, recovery and wellness principles." It is imperative to view family-centered care through the lens of recovery and wellness, not just as a treatment episode. Family-centered care sets families up for sustainable recovery and wellness long after treatment ends.

Note to trainer: *This is available as a handout on page 69 of the participant manual.*

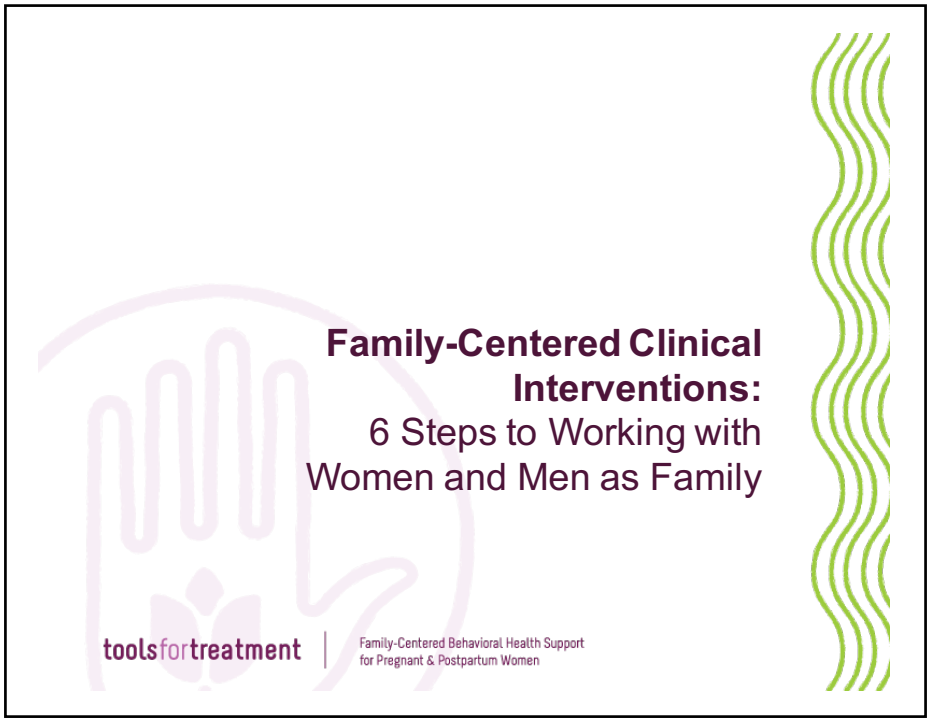
Slide 9

For this module's Culture Conversation, we're going to discuss one culture's view of family. This is an 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). Strength is created through *Whânaungatanga - connections* with the Whânau; 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. This is an example of one culture, one community, and one understanding of the impact of family.

How is the family understood within our agencies, our communities, and families we serve?
As we have shared previously, the family can encompass:

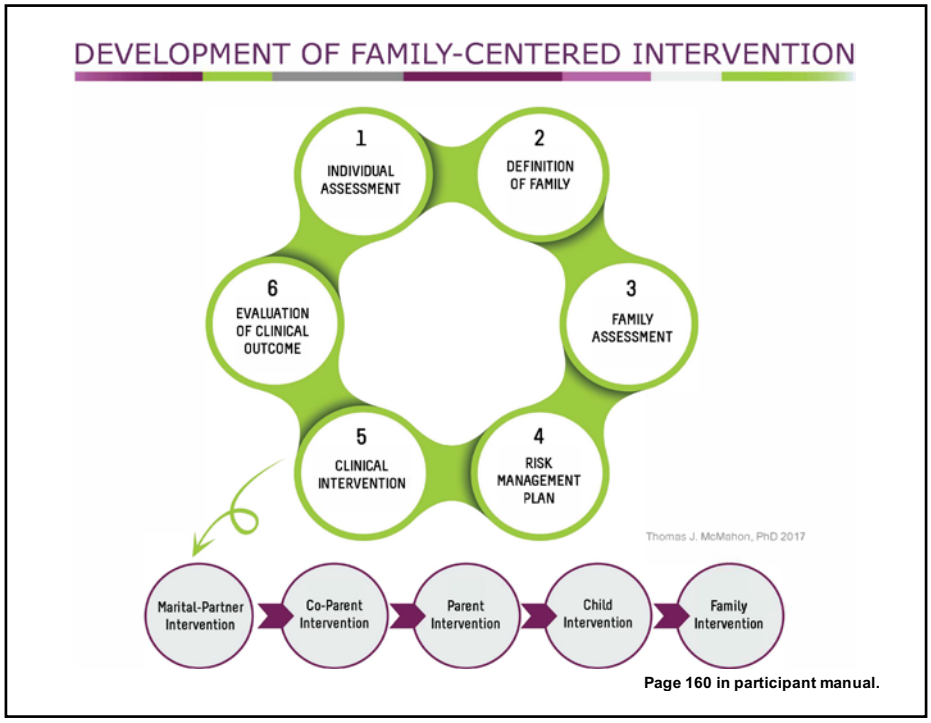
- Parents
- Partners
- Siblings
- Grandparents
- Aunts
- Uncles
- Cousins
- Friends
- Neighbors
- Community supports
- Biological links and non-biological links

As we develop family-centered interventions, we need to constantly evaluate how each family defines itself from its unique cultural lens.



Slide 10

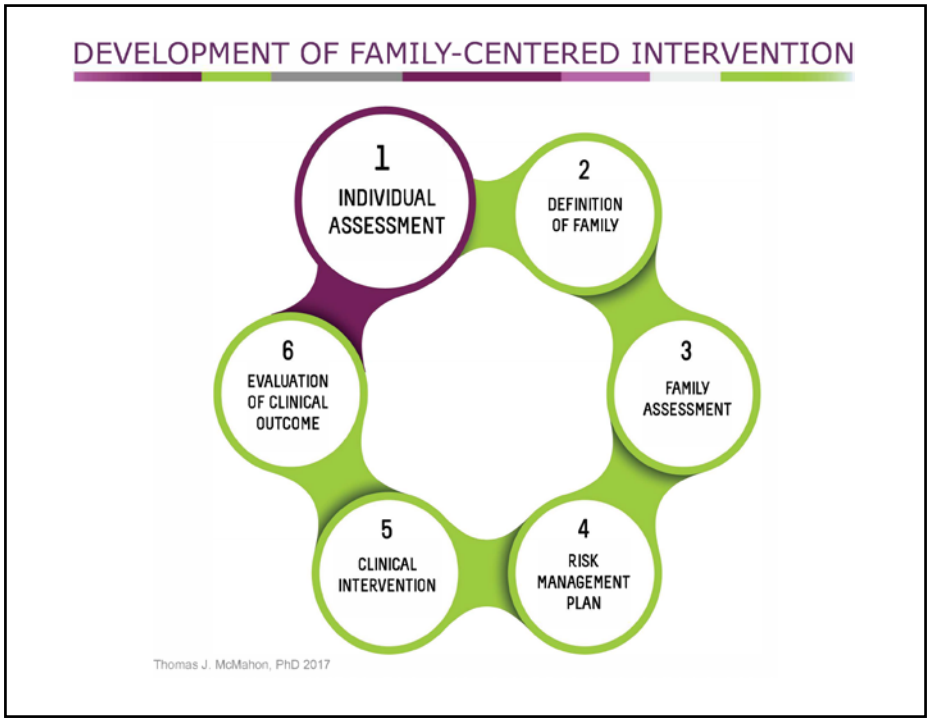
In this section, we will look at how the steps that guide development of family-centered programming in an agency (presented in the previous module) can be adapted to guide development of family-centered interventions.



Slide 11

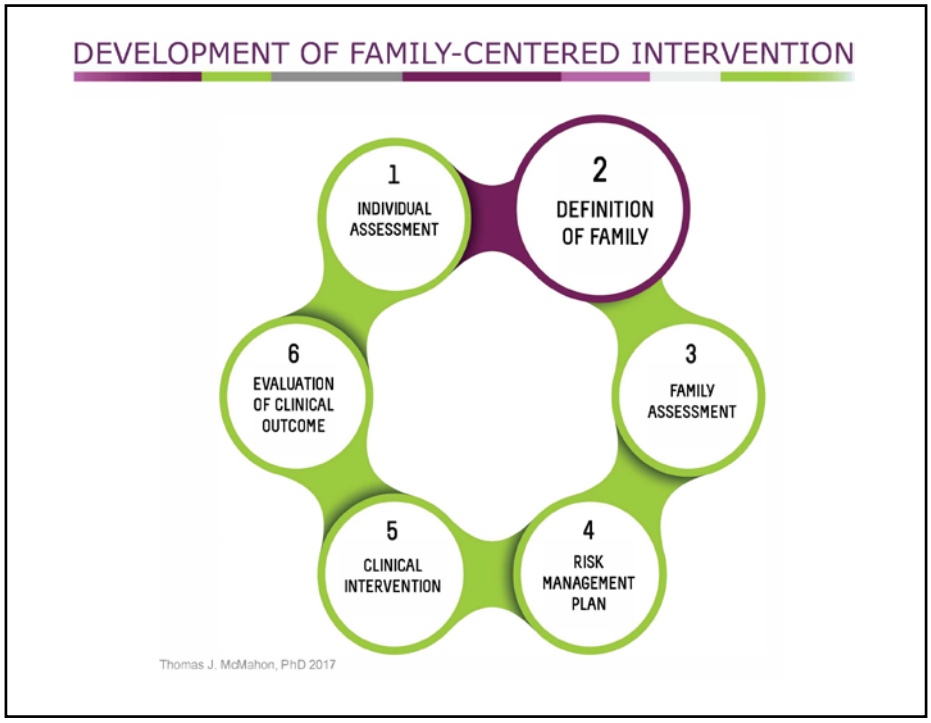
This visual adapts the cycle we examined in Module 4 for development of family-centered programming into a 6-step framework for development of family-centered clinical interventions for a specific family. We will take a look at each of the components.

Note to trainer: This handout is available on page 160 in the participant manual.



Slide 12

1. The first step is **Individual Assessment.** In this step, the assessment of the mother is likely be carried out upon entry into the PPW program. She is likely also the primary contributor to any initial family assessment.

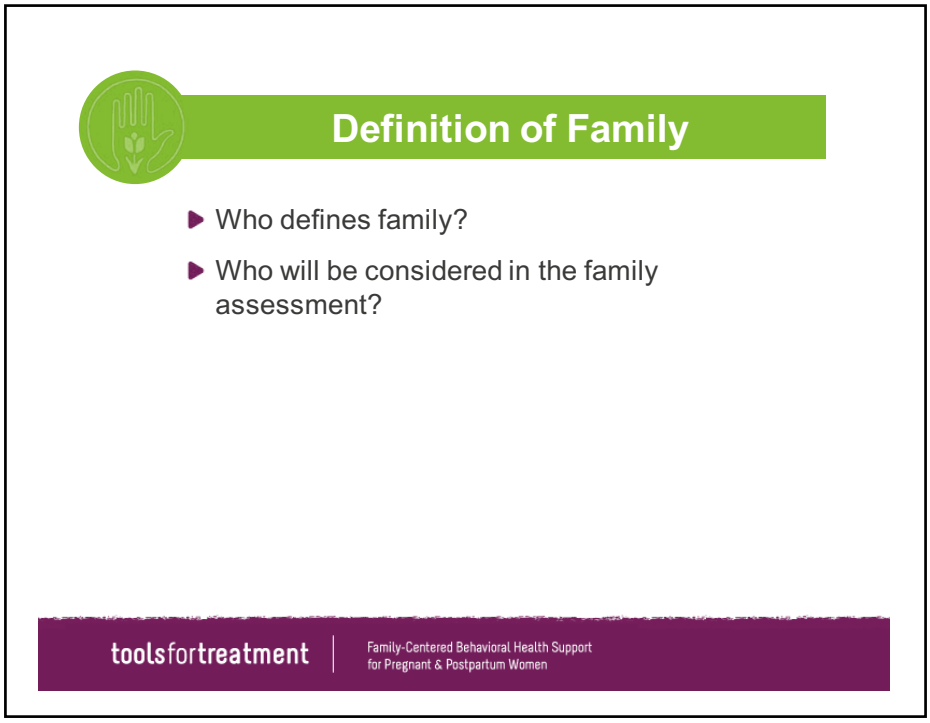


Slide 13

2. The second step is **Definition of Family.** It is important to note that clinicians should work with clients to broadly define family in a cultural context. Definition of family may differ considerably for mothers, fathers, and children in response to differences in race, ethnicity, religion, marital status, sexual orientation, socioeconomic status, and other sociocultural influences.

Definition of family involves two questions:
1) *Who defines family?* and
2) *Who will be considered family during the period of treatment for purposes of the family assessment and intervention?*

We will examine these questions next.



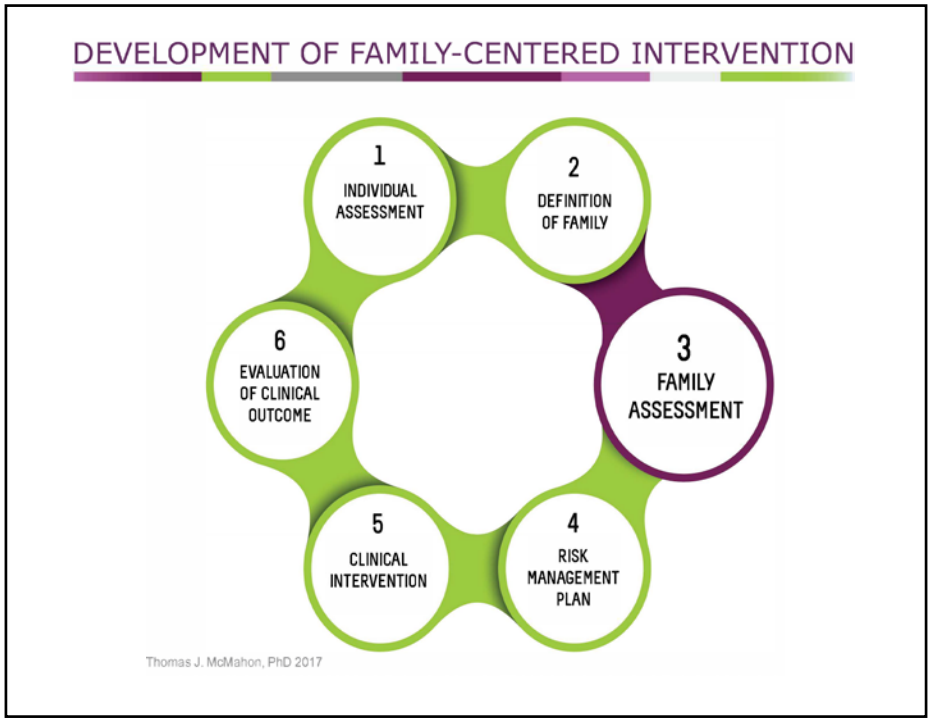
Slide 14

Who defines family? Generally, the client defines her family with a counselor or clinician for the purposes of family assessment or intervention. This may be complicated by several ethical and legal issues. For example, there are ethical issues concerning the definition of family for counselors and clinicians who work with children.

- Who decides how family is defined for the child?
- Who decides who participates in family assessment and intervention pursued on behalf of the child?
- What happens when definition of family differs for different members of the same family?
- How do legal mandates influence definition of family?
- What happens if a mother prefers a father not be involved in a child's life, but there is a legal mandate stipulating a right to visit?

The point here is that the client generally defines her family for herself, but her ability to do so for others may be limited and complicated by ethical and legal issues involving the rights and obligations of others, including their children and the fathers of their children.

Who will be considered in the family assessment? This may change with time. When mom enters treatment, her vision of the people and relationships that must be included to ensure that her treatment and long-term recovery can succeed may be limited. She may not be able to see past herself and her unborn child. Over time, however, clinicians can help her broaden her perspective to include the people and relationships that must be addressed to ensure that her long-term recovery is successful and not derailed post-treatment. The father of her child/children is one of these important relationships to consider. Learning how to make problematic relationships more workable is best done with the safety and support that a program and its staff can offer.



Slide 15

3. The third step is **Family Assessment.** This starts with the clinician reviewing with the mother her relationship with the people who would ordinarily be defined as family and deciding who should be included in a broader assessment of her family system during her current treatment episode.

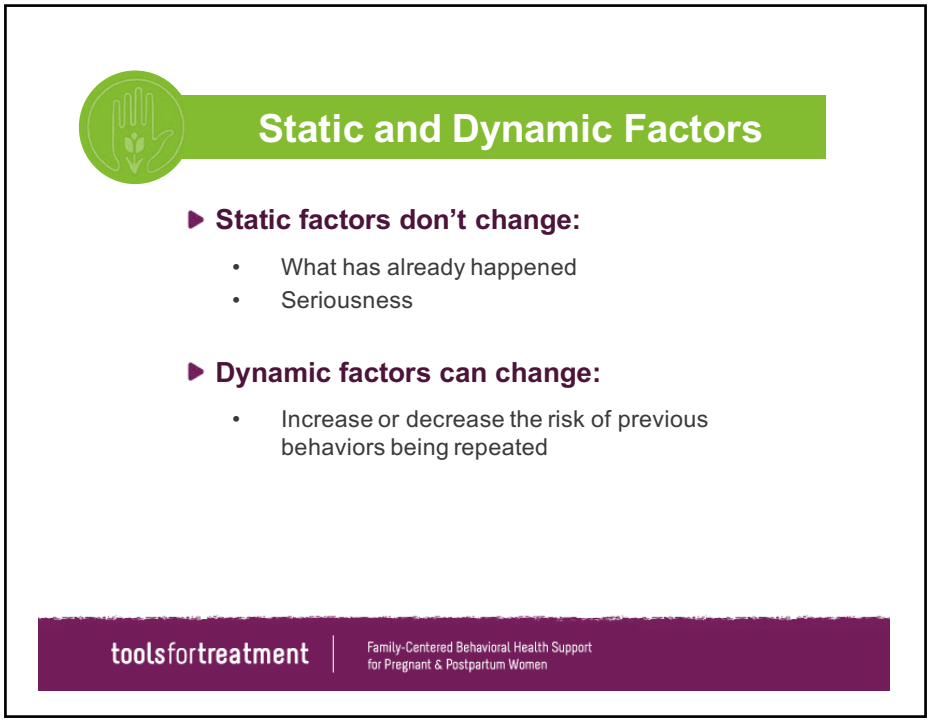
Someone involved in her family assessment may not necessarily be involved in her family-centered intervention. One of the goals of a family assessment is to collaboratively decide what type of family interventions may be helpful and who should be involved. Comprehensive family assessments must always be pursued with sensitivity to ways that cultural factors influence the structure and functioning of family systems.

Methods and tools: As noted in the participant manual, genograms, timelines, ecomaps, structured tasks, and survey measures can be useful tools to integrate into a family assessment.

- Genograms are an easy way to diagram family relationships over generations. Timelines illustrate a family's history. There is an **excerpt of a TIP on pages 161-166 in your participant manual** with more information. Self-report measures can be used with individuals and couples (to get both sides). Family-centered tasks offer clinicians an opportunity to watch how a couple or a family operates.
- Including at least one member of the previous generation in the assessment can bring to light intergenerational trauma, IPV, mental health problems, and substance use.

Safety: Assessments needs to include any risk for harm to self and others due to substance use (and other risks). This should lead to planning of how to ensure safety:

- Within the program - requires understanding people's legal status, involvement of CPS, presence of restraining orders, etc.
- Outside the program - how will the risk for harm to family members be managed if the family is outpatient or when the family leaves the program?

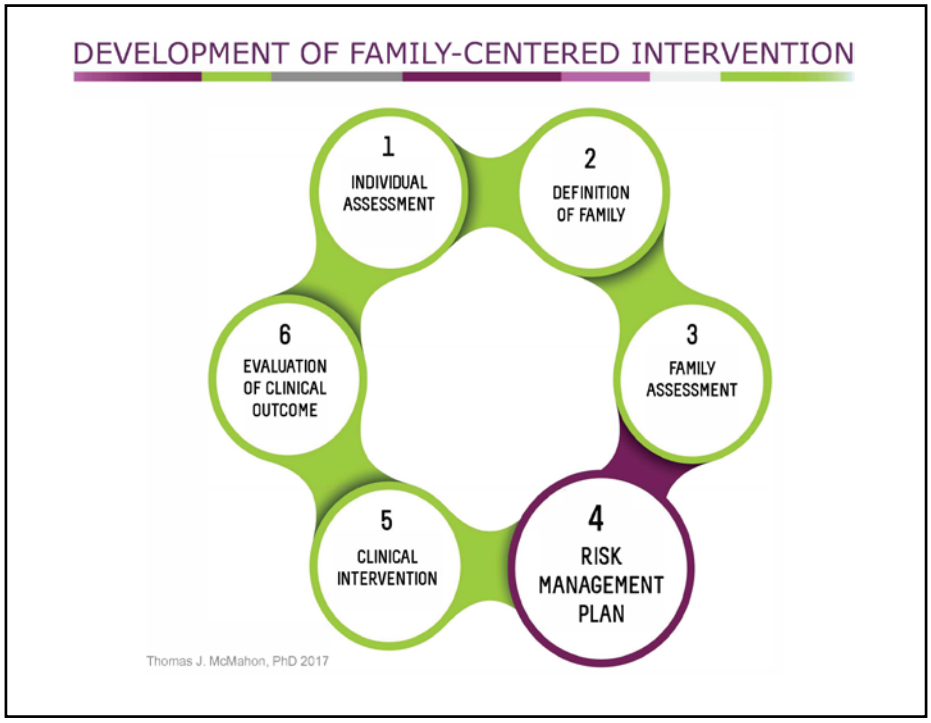


Slide 16

Our next step will be development of a risk management or safety plan for the family in question. What is needed to ensure safety and plan for how possible risks will be managed both in the program and in the community?

Both static factors and dynamic factors need to be considered.

- *Static factors* – are things that don't or can't change, such as what has already happened and its seriousness. *Example:* the father or partner has punched the mother and broken her cheekbone, or the mother has stabbed the father. These are markers of what might happen between this couple (worst scenarios). The program needs to know what people are capable of doing.
- *Dynamic factors* – are those things that can change. *Example:* the same couple has a heated argument due to stress because the father lost his job. Given their past behaviors, this change in job status may increase the likelihood of previous violent behaviors being repeated. The program must pay attention to the direction behaviors are moving in. If the father gets a new job, things will likely move in the direction of decreasing the likelihood of those behaviors being repeated. Safety management requires paying attention to where things stand regarding dynamic factors and watching for signs of movement of how things are changing over time to increase or decrease safety.



Slide 17

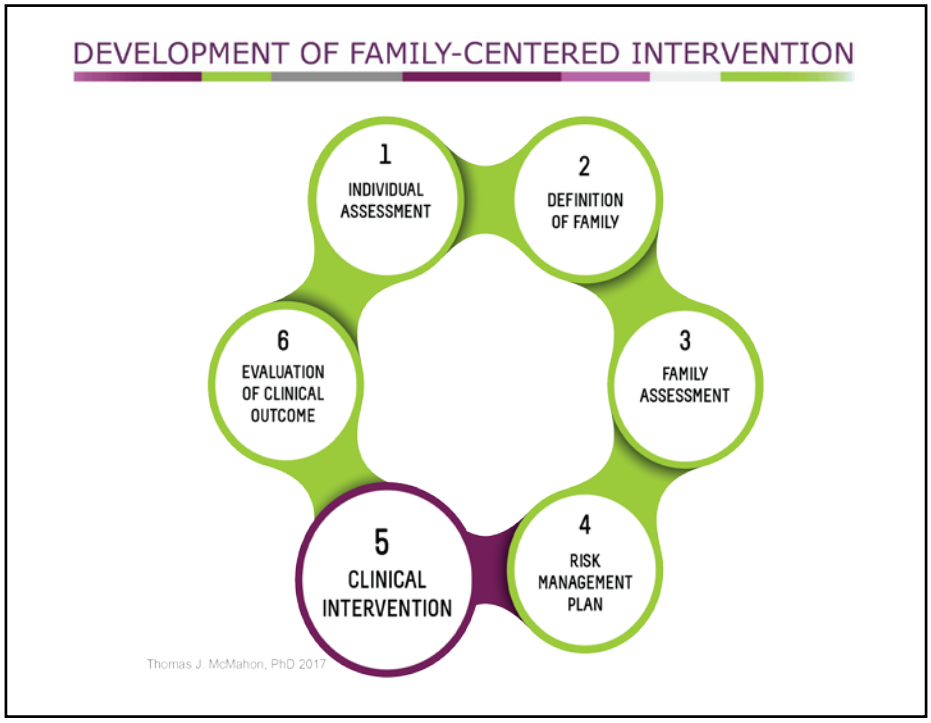
4. A Risk Management Plan is a comprehensive safety plan developed collaboratively with the client, a treatment team, and significant others to decrease risk for a specific adverse or undesirable event for this family. A safety plan usually focuses on using available resources to decrease, as much as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

- Part of managing risk may be clarifying what is the Child Protective Services plan around visitation? What are the conditions of a restraining order if one is place? Does there need to be additional clarification regarding what the visitation plans are?
- Also important is understanding when it is appropriate to get legal support or have legal mandates put in place. Example: there is a restraining order in place, but the couple has decided to resume their relationship while mom is in treatment. They ignore the order thinking it no longer applies since they are on better terms. Violating the restraining order puts them at risk. If they should have a serious fight, then they could not only be arrested for assault, but also for violating the restraining order, which may be a more complicated offense.
- Do family members need to better understand what needs to be in place for the future, such as helping mom prepare for discharge from a residential program? Example: mom is planning on moving back in with the father at the end of treatment. She also has a restraining order against him. Does she need to withdraw this restraining order so they will not be violating it? Such clarification is part of managing risk.

Slide 18

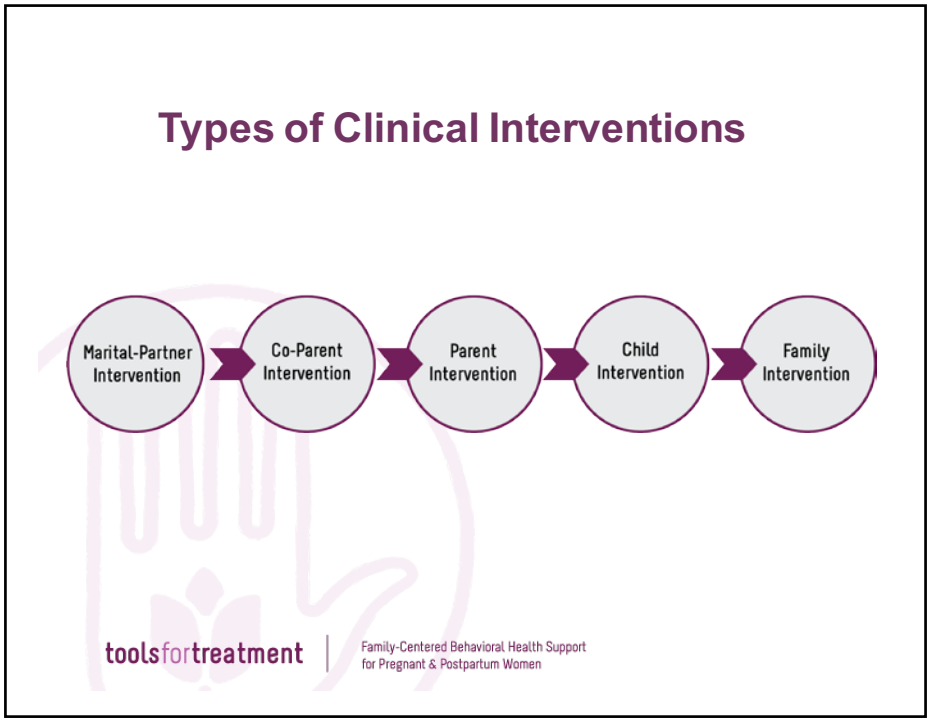
Partnering with child welfare is essential when providing family-centered care. In this video clip, Kathryn Icenhower of SHIELDS for Families, a program in Compton, CA, and Blanca Vega of the LA Department of Children and Family Services talk frankly about the significant challenges and benefits such a partnership presented for them personally and for their agencies.

Note to trainer: *This video is 4:12 minutes long and also available online at https://vimeopro.com/attcnetwork/bring-them-all/video/236123169. If time allows, ask, "Any thoughts about what you just heard in the video?"*



Slide 19

5. Clinical interventions selection is the next step. Agencies may make different types of family-centered interventions available in either a group or individual format. It is important to note again that family-centered interventions must always be pursued with sensitivity to the ways family structures, values, and functioning vary with cultural context. Let's look at the basic types of interventions more closely.



Slide 20

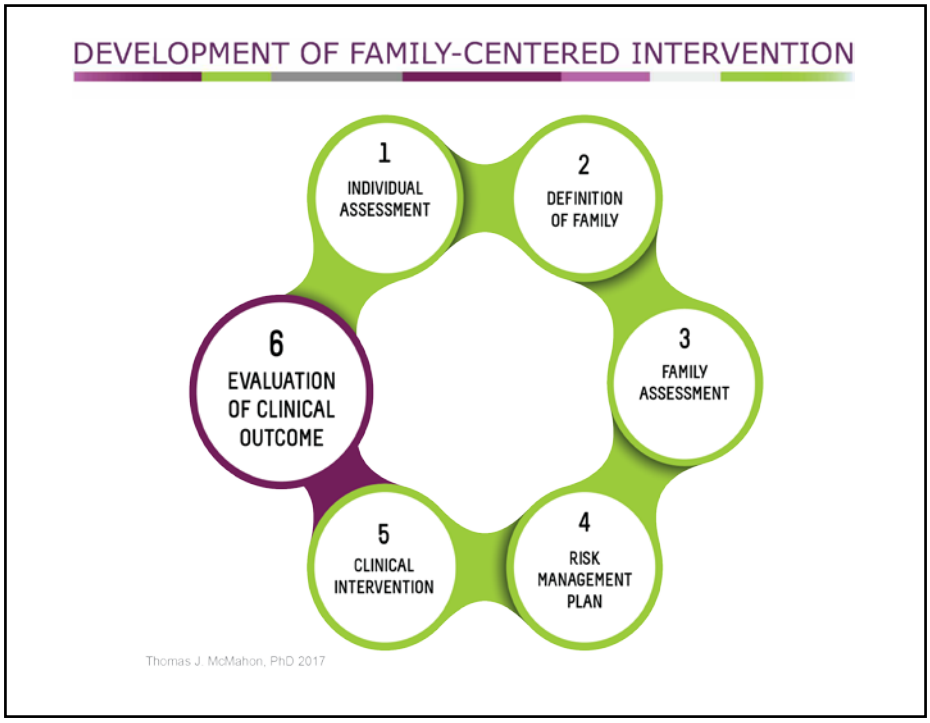
When working with an individual family, the identified needs are specific. Some or all of the needed interventions may be provided in-house. Some may have to be accessed externally.

- **Marital – Partner interventions** – For couples choosing to remain together and experiencing difficulties other than parenting. E.g. Difficulties with intimate partner violence, continued substance use as a couple, questions about whether to remain together, communication problems, concerns about fidelity, etc.
- **Co-parenting interventions** - It may be part of a marital-partner intervention or it may be the primary form of intervention for couples who have ended their sexual relationship or partnership.
- **Parenting interventions** – For the fathers and other co-parents, the parenting interventions would match what is being done with the mothers. Links to some of the more popular interventions for use with fathers are in the resources section. There has been work on defining the components of these programs for men, and there is evidence that men like them, but evidence on whether they really work as advertised is evolving.
- **Child intervention** - Some programs include interventions where children of parents who are in treatment meet without the parents. It is separate from family interventions. In a moment, we'll look at a short video about these.
- **Family intervention** – These are carried out with parental figures and children in whatever configuration there is – mom and children, dad and children, mom and dad and children, etc.

Slide 21

- Services for children, such as those offered by SHIELDS for families in Compton, CA, give a child a place to talk about what it has been like to live with a parent with a substance use disorder. It is also an opportunity to educate children in a developmentally appropriate way about the nature of addiction. Some programs also offer summer camps with daylong programming for kids who have a parent with substance use issues.

Note to trainer: *This video is 3:17 minutes long and also available online at https://vimeopro.com/attcnetwork/bring-them-all/video/236123803.*



Slide 22

6. Evaluation of Clinical Outcomes is the sixth step - How will the clinical outcomes be evaluated for this family? What markers will you use?

Any program of assessment and intervention designed to better meet the needs of families should include some simple but formal ways to assess what is being done both in terms of how it is being received by the family members involved and the extent to which it is promoting change within the family you are working with.

Slide 23

- Pioneers in the field such as Kimberly Craig, CEO of CHEEERS Recovery Center, and a former PPW grantee, in Phoenix, AZ, can offer insights on the evaluation process:

"It was over 15 years ago that we moved our programs toward being gender-specific and trauma-informed - which for many programs meant WOMEN only - and eventually and slowly we added her children. Our service delivery methods have changed over time and continue to change. As recently as 5 years ago, family-centered care for many of us meant we made some outreach phone calls to family members to tell them about the holiday dinner and visitation hours at our treatment facility, or we mailed them a family packet with program rules, do's and don'ts. It was also common (and may still be) that males (fathers) and extended family members were not allowed on the campus of our programs and certainly not without an escort. Now we are asking that actual services be provided to the entire family, not just outreach and courtesy calls. 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. We have new information in front of us and we have to embrace it, believing we will improve our programs and outcomes for families as a result."

Slide 24

Ask participants:

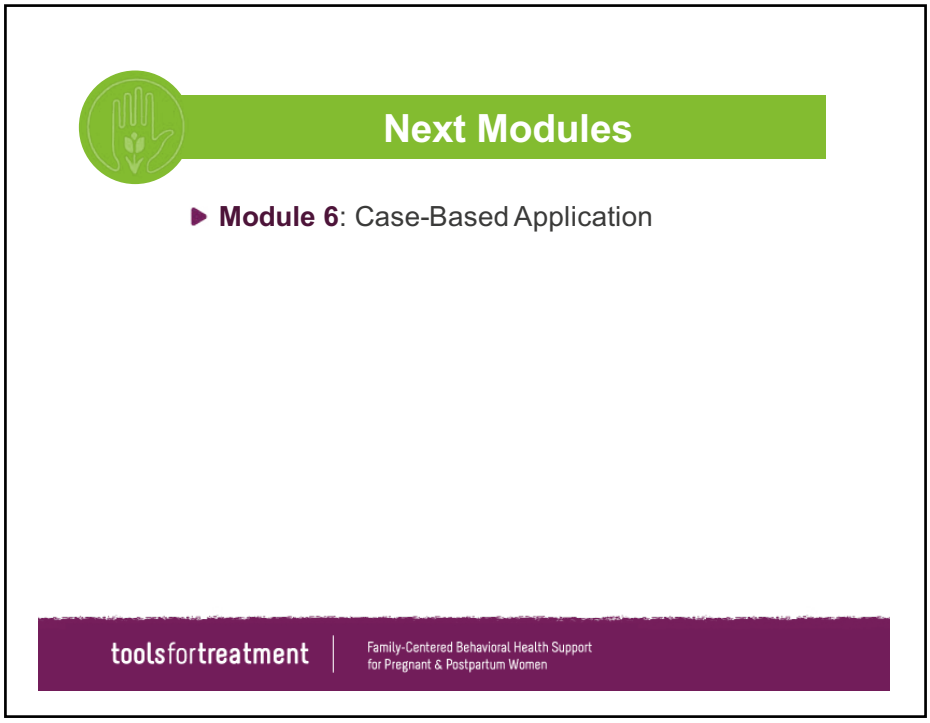
- What are your thoughts regarding Kimberly's observations?
- Would you place your agency's level of family centeredness closer to the past (how things used to be) or closer to the future?
- Where would you place the level of family-centeredness of your own practice?

Note to trainer: *Modify this activity based on the audience and time constraints.*

Slide 25

How has your impression of building family-centered programming changed?

Note to trainer: *Modify this activity based on the audience and time constraints.*



Slide 26

This is the next module in this training series. Make sure to check your participant manual for more information and resources.

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

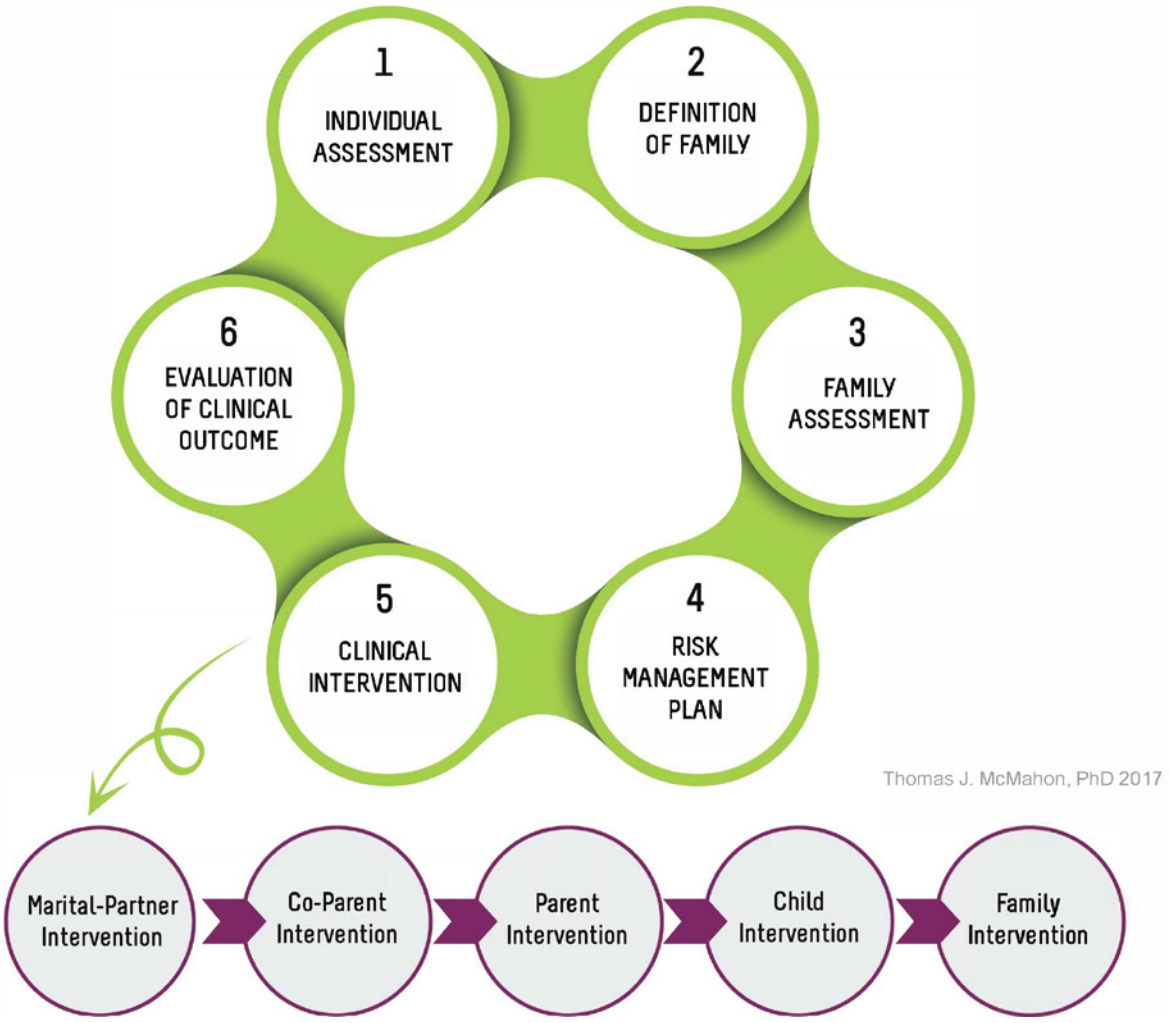
The strength of the individual derives from the resiliency and/or impact of the family. Families may provide wellbeing, nurture and protect children, care for members who need it, offer material and emotional support, and pass on culture, knowledge, values, and attitudes (Mental Health Commission, 2009).

Special Populations/Next Steps:
As an example of how families are different, we can look at the concept of *Whânaungatanga,* which shares "strength is created through *Whânaungatanga, connections* with the Whânau (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

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Consensus Panel Chair

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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

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Originating Office

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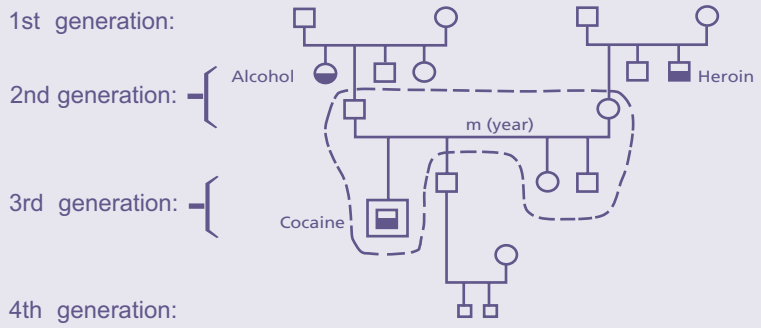
NCADI Publication No. BKD551
Printed 2006

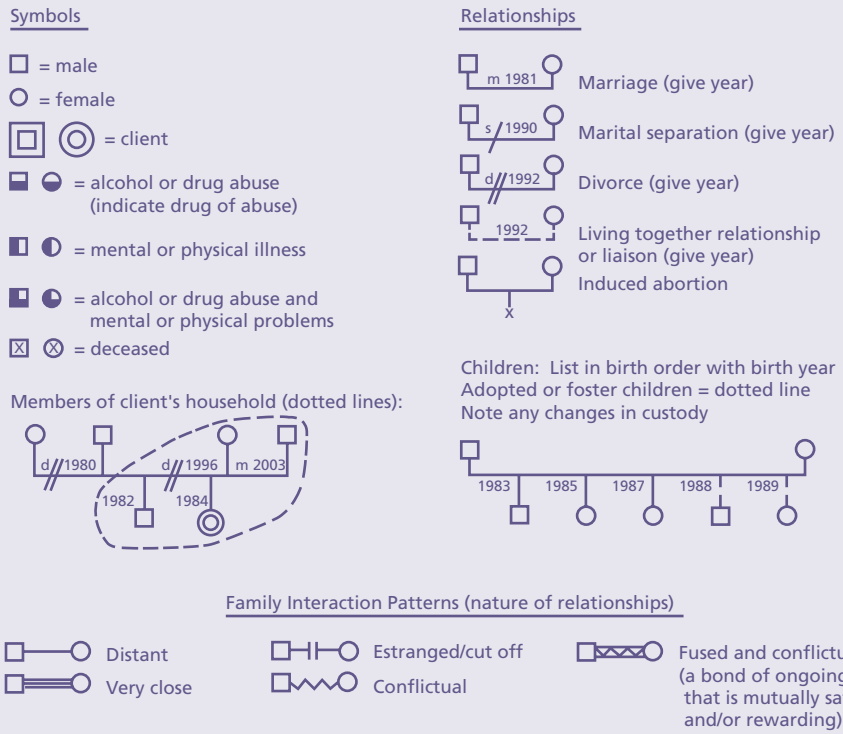
Appendix 6-A. Format and Symbols for Family Genogram*

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

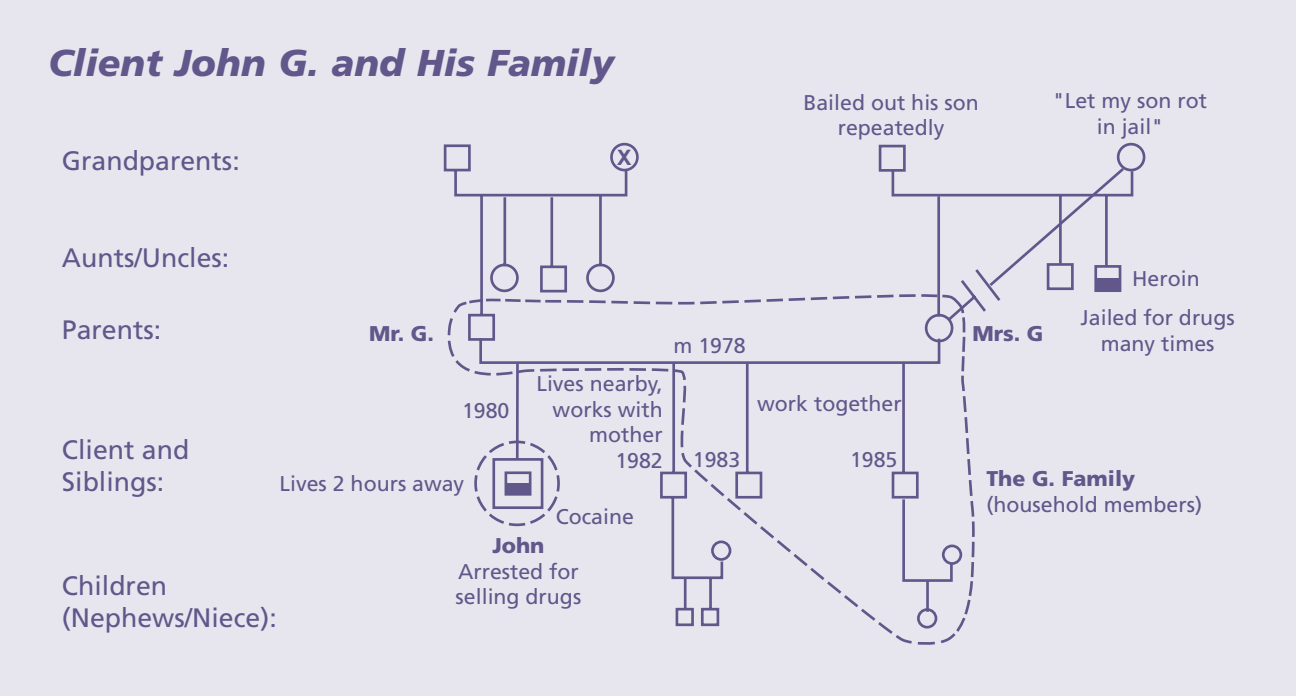


Symbols Useful for Genograms



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

Module 5



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.

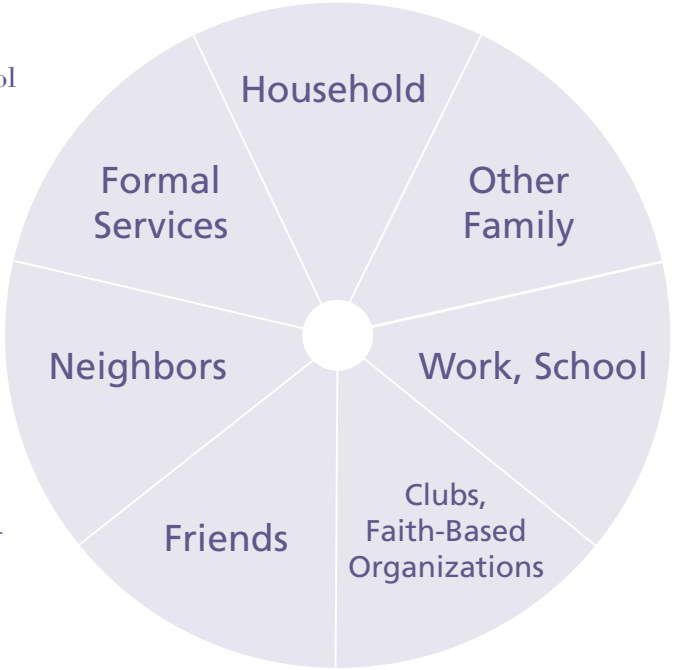
Instructions

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 left-most 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(Version%202%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/ffcu?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:

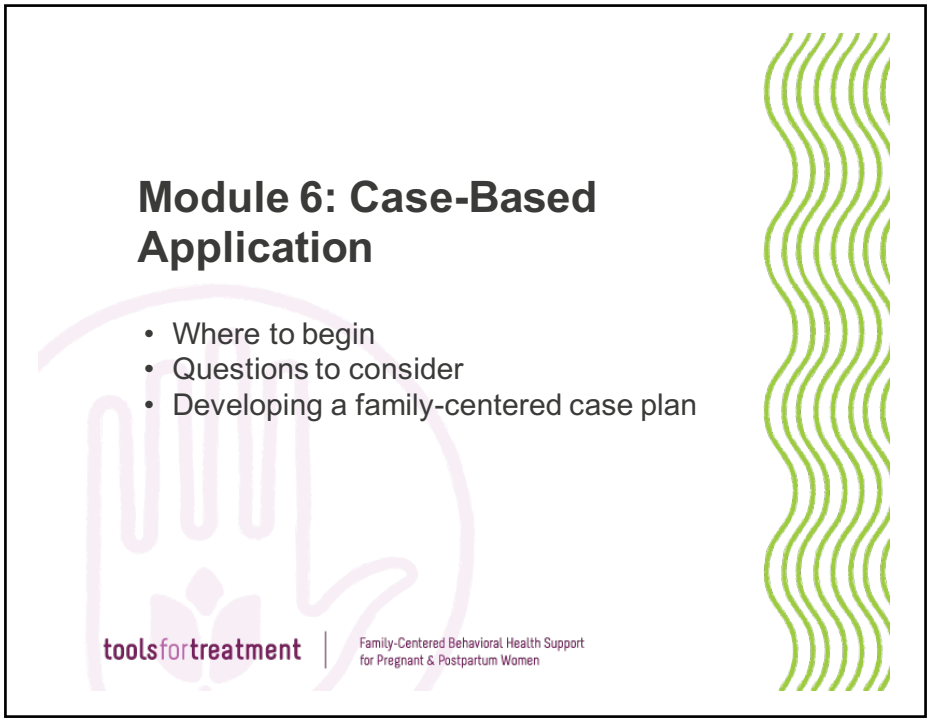
1. Apply steps for developing family-centered interventions using a fictional client case study.
2. Apply the principles and interventions to a case study using a culturally inclusive and family-centered approach.
3. Use a case study exercise to inform decisions at both an organizational and clinical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

Design and Time

Section	Description	Components	Time
Introduction to module	Overview of module.	•Title & acknowledgements •Participant introductions •Review of module 6 in participant manual and PPW website •Goals & objectives	5 minutes
Where to begin	Briefly review 6-step development of family-centered intervention. Review core clinical interventions that are part of family-centered care.	•Development of Family-Centered Intervention graphic •Core clinical interventions •Culture conversation	3 minutes
Questions to consider	Review two key tools to help develop a family-centered case plan. These worksheets will be used with a case study in this module.	•Family-Centered Intervention: Questions to Consider worksheet (pages 190-191 of participant manual) •Family-Centered Case Plan worksheet (blank version on page 192 and completed example version on pages 194-195 of participant manual)	7 minutes
Developing a family-centered case plan	Review client case study individually (3 minutes). Complete Family-Centered Intervention: Questions to Consider worksheet in small group (5 minutes). Group debrief on results of activity (5 minutes). Complete Family-Centered Case Plan in small group (10 minutes).	•Client case study (page 196 of participant manual) •Family-Centered Intervention: Questions to Consider worksheet (pages 190-191 of participant manual) •Family-Centered Case Plan worksheet (page 192 of participant manual)	27 minutes
Wrap up	Concluding remarks for module.		3 minutes

Slide 1

Welcome to Module 6 of "Easier Together: Partnering with Families to Make Recovery Possible."



Slide 2

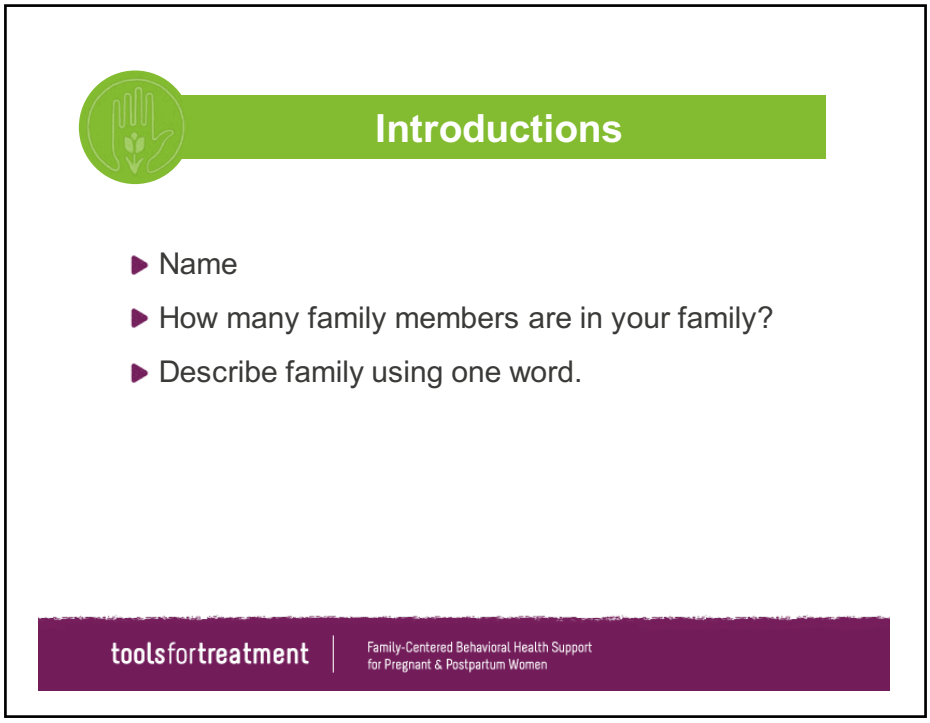
- During Module 6 of the "Easier Together" curriculum, we will discuss how one can begin to apply family-centered principles and clinical interventions.
- We will also review some questions one can consider for applying family-centered care.
- Afterwards, we will go through the framework and work through a case study in small groups to assist us with developing a family-centered case plan.

Slide 3

Our thanks to Diana Kramer and Kimberly Craig for their expertise and many contributions in the development of this module.

- Diana Kramer currently works with Native American Connections as the SAMHSA Program Director of the Pregnant and Postpartum Women's Project with a focus on improving the lives of individuals, children, and families with the integration of physical, mental, and behavioral health services. Previously, Ms. Kramer worked at the Arizona Department of Health Services, Division of Behavioral Health Services as the Cultural Competency and Workforce Development Manager.

- Kimberly Craig is the CEO/President of the CHEEERS Recovery Center in Phoenix, Arizona where she leads an organization that meets the needs of individuals who have serious mental illness and substance use disorders. Prior to CHEEERS, Kimberly served as Vice President of Women's and Children's Programs for 11 years with Center for Hope in Phoenix, where she developed and managed evidenced-based programs for pregnant and post-partum women and their families. This program was a recipient of SAMHSA PPW funding in 2011 and successfully expanded services to engage fathers and the younger and older children of the women.



Slide 4

Before we get started, I'd like to do some brief introductions.

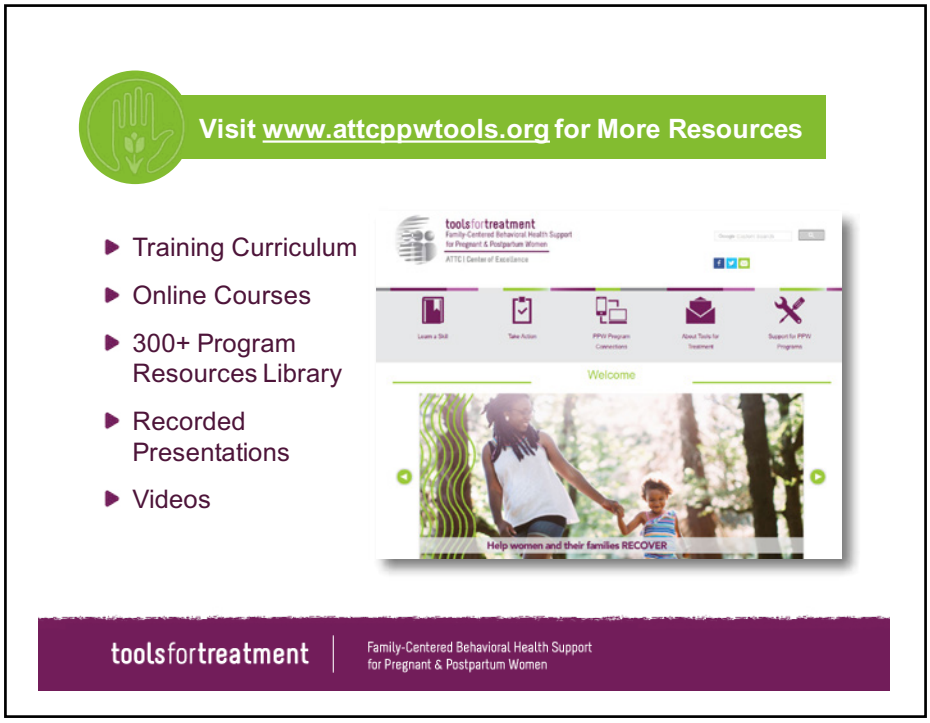
- Trainer: introduce yourself
- Now I'd like everyone to introduce their self. This curriculum is meant to be interdisciplinary and collaborative, let's get to know what is important to you with family-centered services.
- Have everyone say their name, how many family members are in your family, and describe family using one word.
- For example: My name is Jane, there are 3 in my family, and my word is loving.

Note to trainer: *You can modify this activity based on your audience.*

Slide 5

As part of this curriculum, you all have a participant manual. I'd like us to do a hands-on review of this module's content so you are familiar:

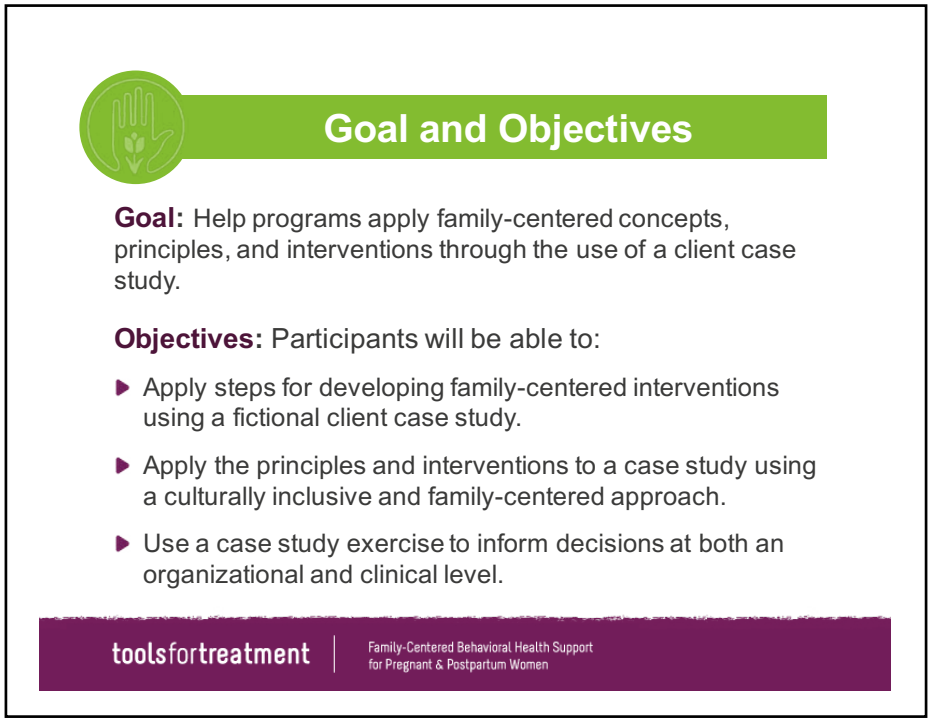
- On page 174, the module begins with the training goals and objectives.
- Next on page 175 you will find all of the presentation slides with room for taking notes.
- Then on page 188 you will find the resources section, which contains a collection of handouts, worksheets, activities, assessments, recommended reading, and a reference list for that module.



Slide 6

For additional resources, visit www.attcppwtools.org. Here you can download the "Easier Together" curriculum and access other resources such as:

- Training curriculum
- Online courses
- 300+ resources in the Program Resources library
- Recorded presentations
- Videos

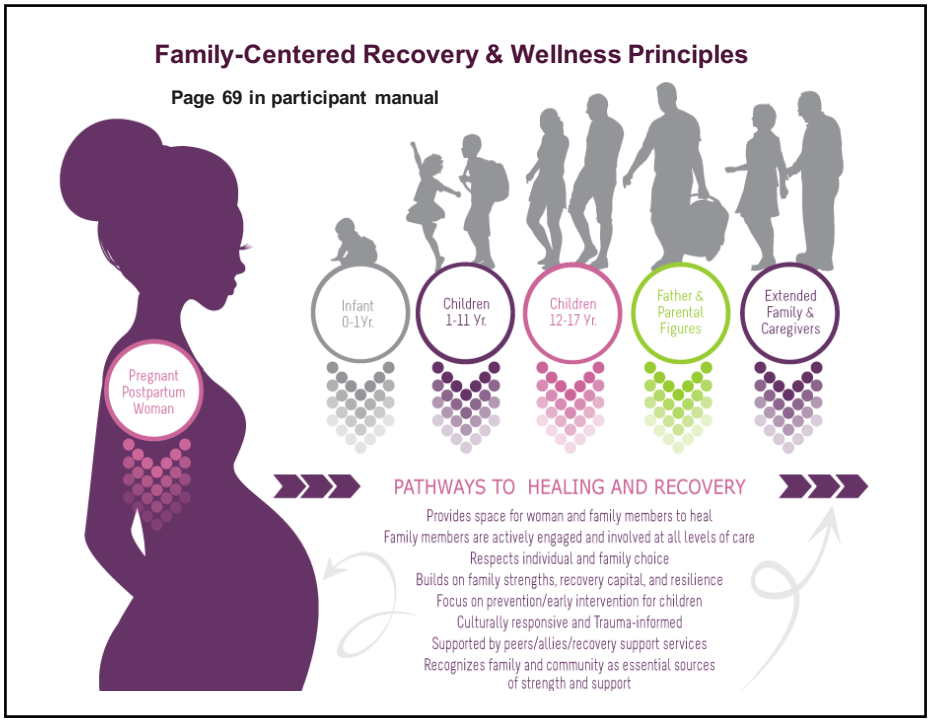


Slide 7

The goal of this module is to help programs understand family-centered concepts, principles, and interventions through the use of a client case study.

These are our learning objectives for Module 6:

- Apply steps for developing family-centered interventions using a fictional client in a 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.



Slide 8

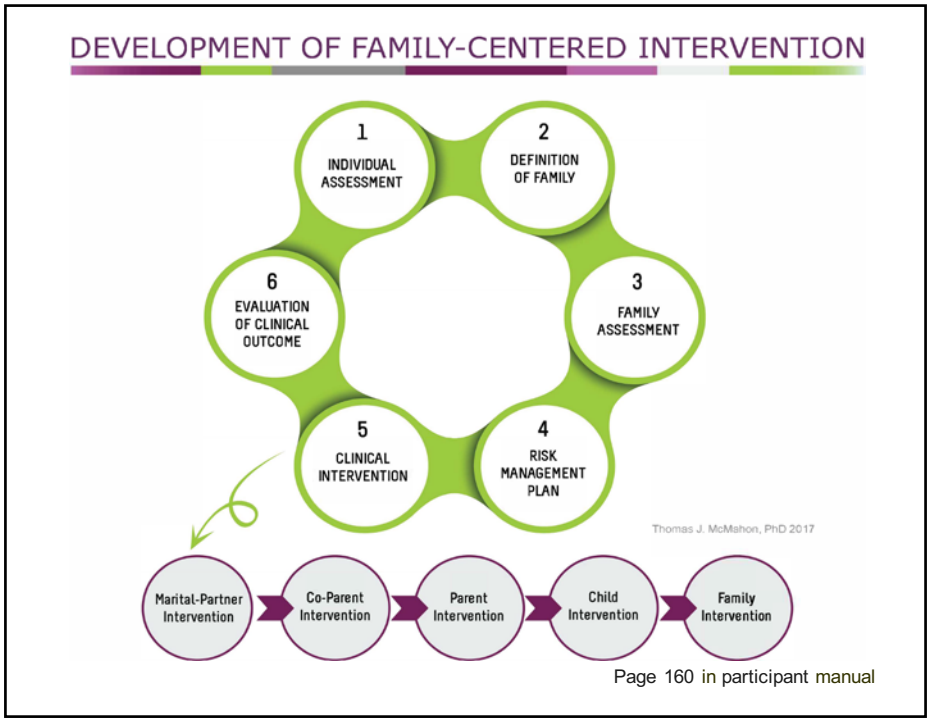
- This is a graphic that was developed to embody family-centered care and was presented in earlier modules. In this graphic, you can see that the woman is the vehicle of entry for all family members. She is the initial client that comes into the program to receive services, but through her, our view expands to include all family members. The family becomes the client and we wrap services around all family members to support family strengthening and healing.
- Additionally, this graphic outlines "family-centered, recovery and wellness principles." It is imperative to view family-centered care through the lens of recovery and wellness, not just as a treatment episode. Family-centered care sets families up for sustainable recovery and wellness long after treatment ends.

Note to trainer: *This is available as a handout on page 69 of the participant manual.*

Slide 9

- This module is designed to assist all in attendance regardless of discipline, role or professional orientation the opportunity to look at family-centered care and intervention by applying it to a case study.
- Today's session will illustrate how the family-centered principles and interventions can be applied to real life scenarios including the decision-making processes on the administrative and clinical intervention levels for programs.
- We anticipate that the application of these principles through the provided case study will highlight or reveal the information, provisions, or even changes that are needed to implement family-centered care in one's programming
- Before we begin reviewing the case study, we are going to briefly review the six steps of family-centered invention on page 160 in the participant manual that were discussed in module 5.

Note to trainer: *This module applies the core principles and interventions that were discussed in Modules 4 and 5. In order for participants to find this module meaningful and fully participate in the exercise, they must be familiar with the content in Module 4 and 5 prior to this session.*



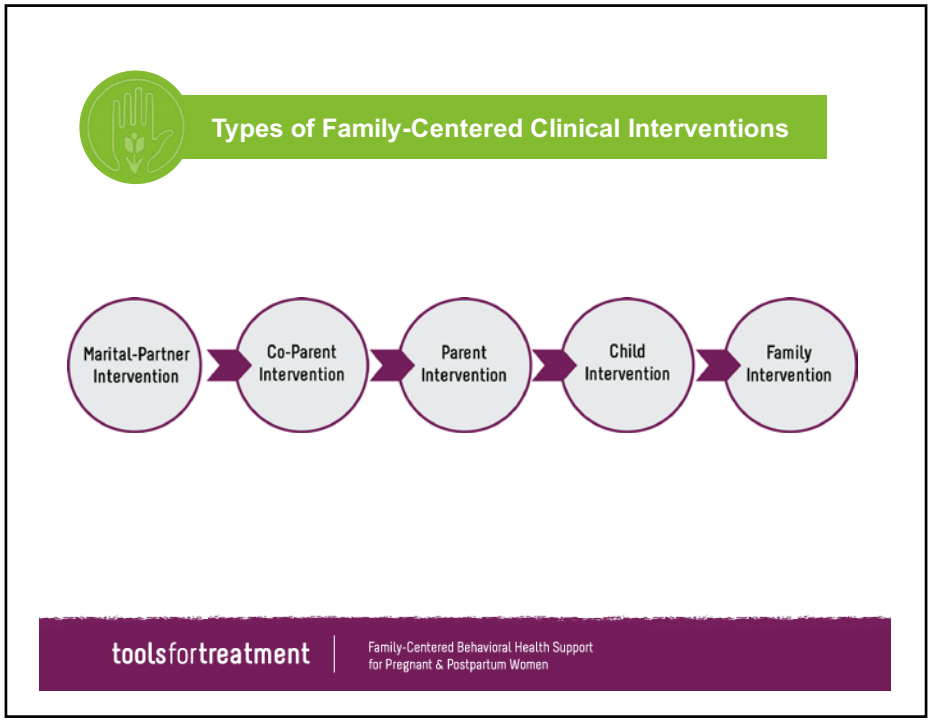
Slide 10

As reminder, the 6 steps listed here are the identified components we must consider when implementing family-centered care in our programming. Programs for families must contain the following elements:

- **Individual Assessment:** For purposes of this training the woman is the person who completes an individual assessment. The individual assessment gathers her background, mental and physical health history, social and economical status, cultural considerations, and establishes a diagnosis.
- **Definition of Family:** Implementation of family-centered care requires that we work with the individual to establish a definition of family. It is important to note that clinicians should work with clients to broadly define family in a cultural context. The definition of family may differ considerably for mothers, fathers, and children in response to differences in race, ethnicity, religion, marital status, sexual orientation, socioeconomic status, and other sociocultural influences. In general, the definition of family involves two questions:
  1. Who defines family?
  2. Who will be considered family during the period of treatment for purposes of the family assessment and intervention?
- **Family Assessment:** After the family members have been identified in a broad, culturally sensitive, and inclusive manner there needs to be a decision about who will be included and involved in the family assessment. Just as the individual assessment identifies the needs of the individual, the family assessment will identify the needs of the family members. One of the goals of a family assessment is to collaboratively decide what type of family intervention may be helpful and who should be involved.
- **Safety Planning:** Another key component of effective family-centered care must involve safety planning for the entire family. This includes assessing risk concerns and planning with the entire family what the safety and contingency plans will be in order to reduce, prevent, and lessen harm to any single family member including children, mothers and extended family members. This requires input and understanding of any person's legal status, involvement of Child Protective Services,

presence of restraining orders, etc.

- **Clinical Interventions:** This step refers to the actual services that will be provided to the individual family members. Because family-centered care requires a variety of services to meet the family's need, a clinical intervention is no longer limited to individual or group counseling for the primary individual. We will review these interventions briefly as well.
- **Evaluation and Clinical Outcomes:** Family-centered care must also include evaluation of the clinical outcomes. This is done at both the program and individual level. For the family-centered plan, we need to think about what the goal is for the family as a unit. Also, what do we hope the outcome for the family will be? This will inform our decisions around service and intervention planning.



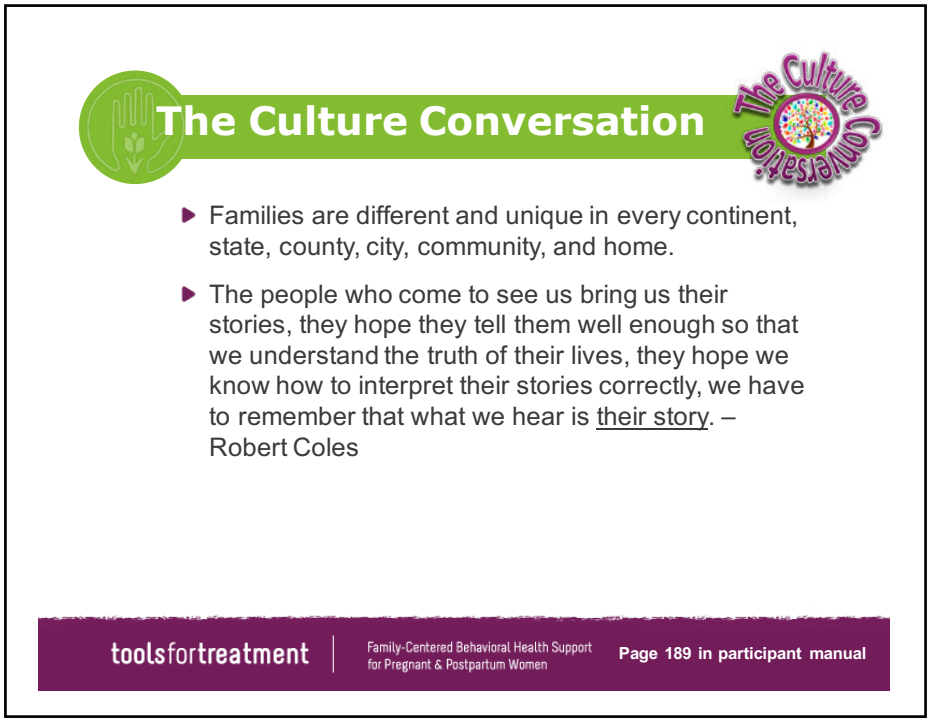
Slide 11

These are the core services that that need to provided or that programs need to make provisions for implementing and delivering family-centered care. It is important to remember the program offering family-centered care does not need to be the only service provider. Community connections and collaboration with a variety of service providers may be how these services are provided.

- **Marital – Partner Interventions:** This refers to interventions designed and provided to couples who intend to pursue, or maintain a relationship. Areas addressed may include: intimate partner violence, continued substance use as a couple, questions about whether to remain together, communication problems, and concerns about fidelity.
- **Co-parenting Interventions:** These interventions may be part of a marital-partner intervention or may be the primary form of intervention for couples who have ended their sexual relationship or partnership. The development of a parenting plan may be done without marital or partner inventions. Sometimes programs will decide that couple's counseling is not going to be an option and a parenting plan and co-parenting intervention is the least that can be done.
- **Parenting Interventions:** It is important to note that family-centered care differs from traditional women-centered programming in that it provides direct parenting interventions for everyone that will parent the child. Family-centered care involves parenting classes for fathers, and could also include parenting classes for the caregivers of the children as identified in the family assessment. There are father-specific parenting interventions and resources available. Please note that safety planning for the family must include parenting education and interventions. We know for this population in particular that risk of abuse increases when expectations are unrealistic and when there is a fundamental lack of understanding as to the developmental stages (age appropriate activity and behavior) for children. This is true for all care givers involved with the children.
- **Child Interventions:** This refers to services provided directly to the children to address any and all developmental, behavioral, or support issues that are needed. Services must be provided based on what is developmentally appropriate. Provisions for meeting the needs of older children up to

the age of 17 years should be included. Programs will also need to consider as a part of their "defining family" if children who are no longer in the care of the mother will receive services such as in the case of mothers who have contact with children but have lost parental rights. Will these children be considered a part of the family-centered interventions? Consider that with kinship placement, regardless of legal status, the mother may be involved in the lives of the older children and it may be appropriate to provide services to them.

- **Family Intervention:** This refers to interventions designed for the parents and children in whatever configuration there may be such as mom and children, dad and children, or mom and dad and children. This may include therapeutic interactions and parent-child therapy.



Slide 12

- According to SAMHSA, cultural competence is the ability to interact effectively with people of different cultures. In practice, both individuals and organizations can be culturally competent. A family's 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. It 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.
- Our families are different and unique in every continent, state, county, city, community, and home. They all have a culture. We must listen, be understanding, open, and willing to experience the discomfort of different.
- When we are working with:
  - 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)
  - Income levels (low income, middle income, high income)
  - Tribal and non-tribal communities
  - Types of families (younger, communal, religions, patriarchal, matriarchal)

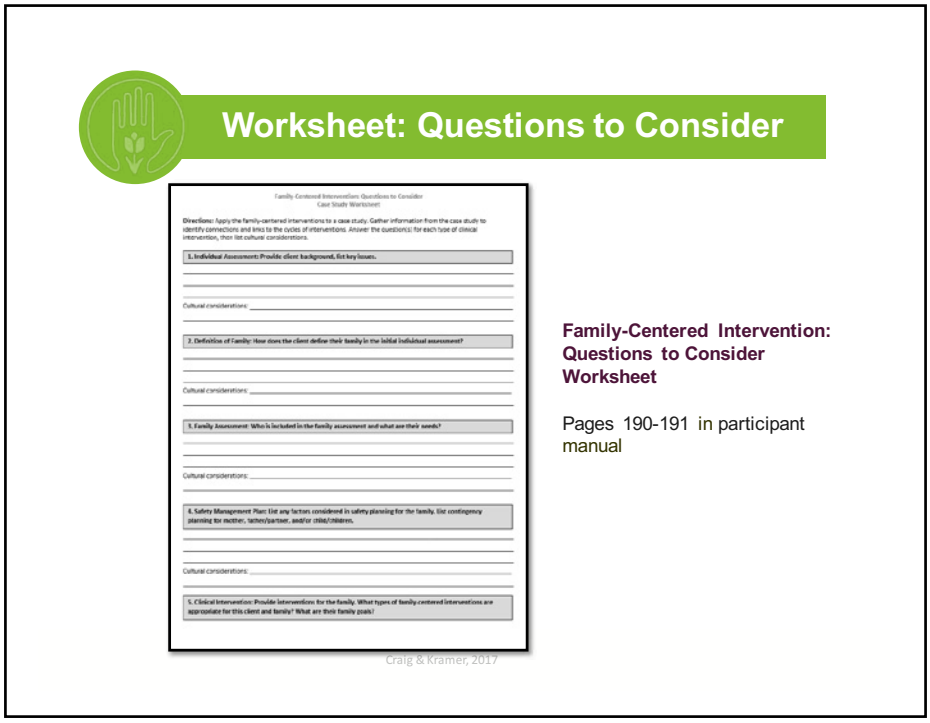
We must begin the conversation with the individual and listen to their story of their family. Our family plan works in collaboration with the individuals we serve and the interventions we develop and refine together.

- Now let's move on and see how cultural considerations work across all the family-centered intervention steps with a case study and family-centered plan.

Slide 13

In this next section, we will review a client case study and determine the overall family-centered case plan in small groups.

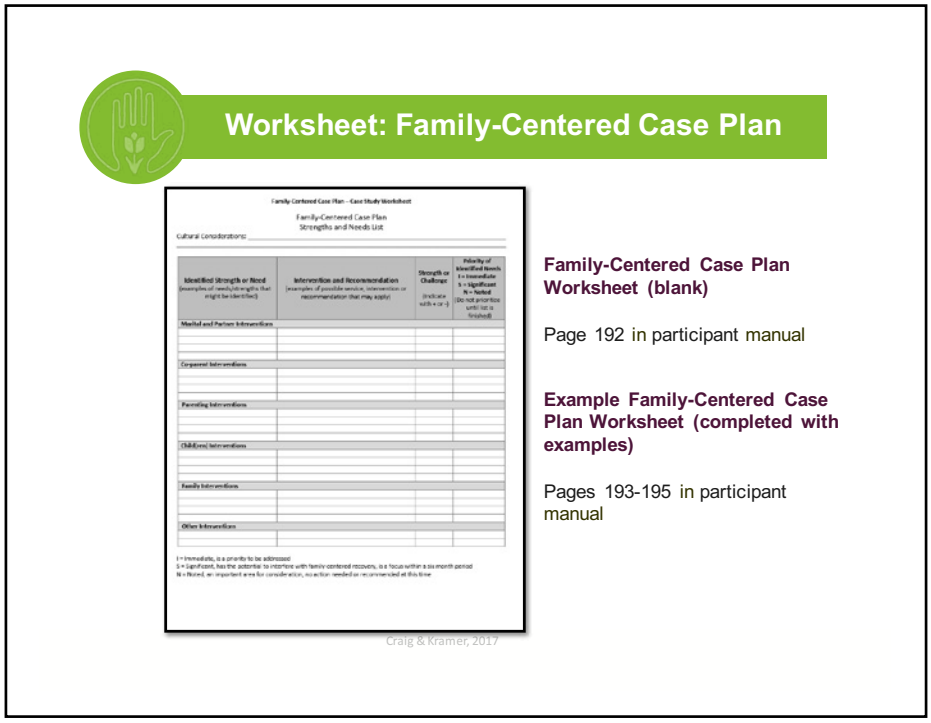
Note to trainer: *Depending on the group size, please have the teams break into groups of 5 or 6. Encourage those in attendance to choose their group by having representation from various disciplines or departments if possible. Each group will develop a family-centered case plan for our case study.*



Slide 14

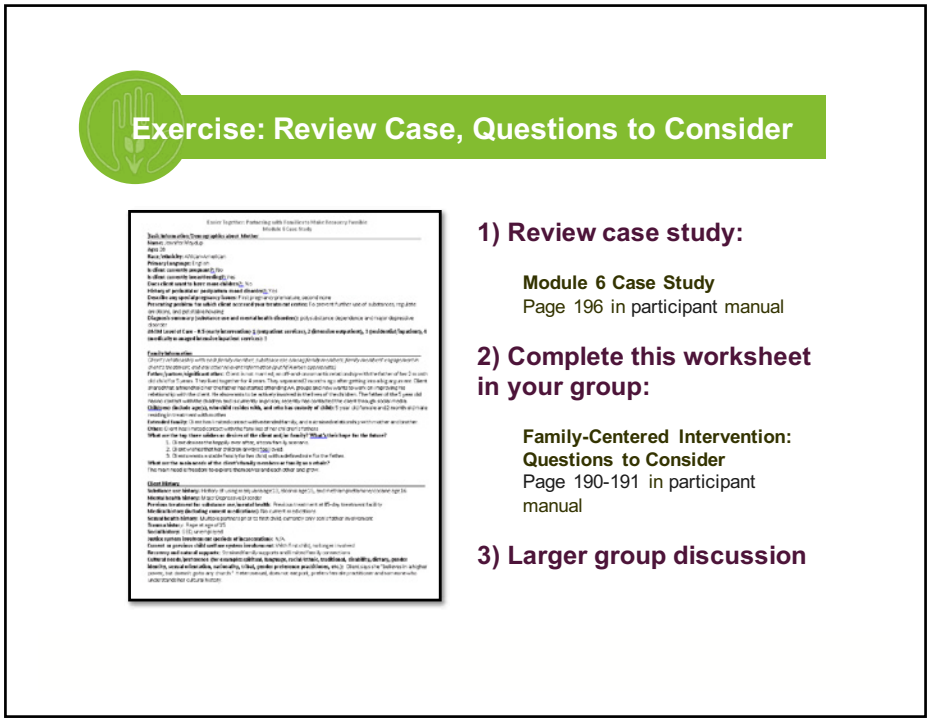
Before we take a look at the case study, we are going to review some useful worksheets to help you develop a family-centered case plan. Please turn to *Family-Centered Intervention: Questions to Consider worksheet* on pages 190-191 of the participant manual.

- On this page are the core components of family-centered interventions and some questions that I would like you to consider as you review the case study. These questions will assist in the development of a family-centered and culturally inclusive case plan.
- For example, as you review the case study in your group, think about the key issues or things that are significant about the person in each of the areas. Since you only have a summary of the individual assessment and case plan, write down notes about the key information that will be important to include or address in each of these areas.
- This worksheet is only intended to assist you in applying family-centered care and practices to a case.
- Here are some key questions you should consider:
  1. Of the information provided, what is significant or key information?
  2. How did the client define family based on the information you have?
  3. Who would you include in the family assessment?
  4. What factors need to be considered in terms of safety, and what additional information do you need to develop a safety plan?
  5. What interventions will you recommend for the family?
  6. What might be the goal for this family?
  7. What are the cultural considerations to note for the development of a family-centered plan?



Slide 15

- Another tool you can use is the Family-Centered Case Plan Worksheet. The participant manual contains a blank worksheet (page 192), as well as a completed worksheet with examples to give you ideas of possible family-centered interventions (pages 193-195).
- Please turn to page 192 so we can review the blank worksheet. This tool helps one prioritize needs and interventions at different levels for families. At the top of the page, write down any cultural considerations for this family that should be kept in mind as the interventions are considered. The first column is the Identified Strength or Need. In this column, you can make notes on the needs and strengths of the family members. The second column is the Intervention and Recommendation. Under this column, you would note the services, programs, counseling, etc. needed to help meet the identified need or strength. In the third column you indicate whether the identified issue is a strength or challenge (indicate with plus or minus sign). When you have finished filling out the first three columns, proceed to prioritizing the interventions using the fourth column. Anything that should be addressed as soon as possible should be noted with an "I" for immediate and high priority. If the need is significant, but not urgent, you can note it with an "S," which indicates that the need should be addressed within six months. If the need doesn't require action for the next six months or if there isn't a recommended intervention at the time, note that need with a letter N for "noted."
- Let's briefly discuss examples of how you could populate this worksheet. On pages 193-195 of the participant manual, you will find an example of a completed Family-Centered Case Plan to provide ideas of what you might include.

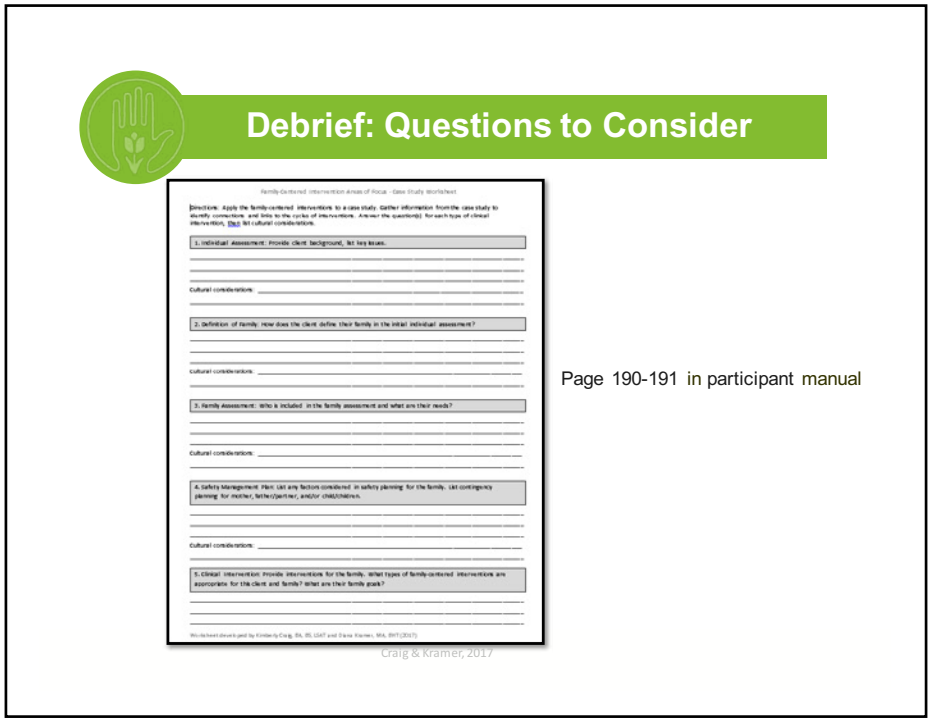


Slide 16

Now, let's learn more about our fictional client by reviewing the case study on page 196 of the participant manual. Let's take 3 minutes to read the case individually, and then each group will have a 5-minute discussion about the case using the *Family-Centered Intervention: Questions to Consider* worksheet on pages 190-191 of the participant manual. Please identify a group member who will report out to the larger group.

Note to trainer:

- Have participants review case individually for 3 minutes.
- After 3 minutes, have previously assigned groups get together to discuss the case and take notes on the *Family-Centered Intervention: Questions to Consider* worksheet on pages 190-191 of the participant manual.
- After 5 minutes, come back together in a large group and share what you discussed in your small groups. Have groups identify a representative from who will serve as the spokesperson and provide a brief summary about each group's discussion (discussion instructions on next slide).



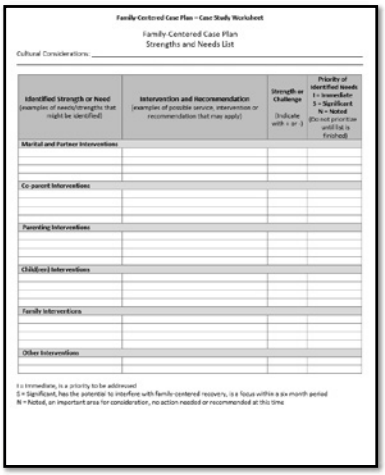
Slide 17

- Now let's talk about the activity we just completed. Some of you may have felt as if the case study didn't provide all the information we needed, and therefore, didn't feel as if you could develop a comprehensive assessment. This is why it's important to have a complete and comprehensive assessment process for both the individual and family. It is often said in the field that our service planning is only as good as the assessment we have, and the same is often true of the outcomes. If we do not know what the issues are, it's unlikely that interventions will promote any successful outcome for the family.

Note to trainer: *Listed below are questions to help guide your discussion. This exercise may create more questions than answers, but is intended to get both clinical/direct service staff and program administrators thinking about what programming elements they may need to expand or revise or incorporate to gather information to develop the family-centered plan.*

- *When you were applying these questions or reading the case study, did you feel you were using the family-centered perspective or lens?*
- *How many of you felt you had enough information in the case study?*
- *What information was missing or what did you need more information about?*
- *Where would this missing information be available?*
- *How would you go about obtaining the information?*

Exercise: Develop 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 (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 1 = Immediate 2 = 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			

1 = Immediate, is a priority to be addressed
2 = 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

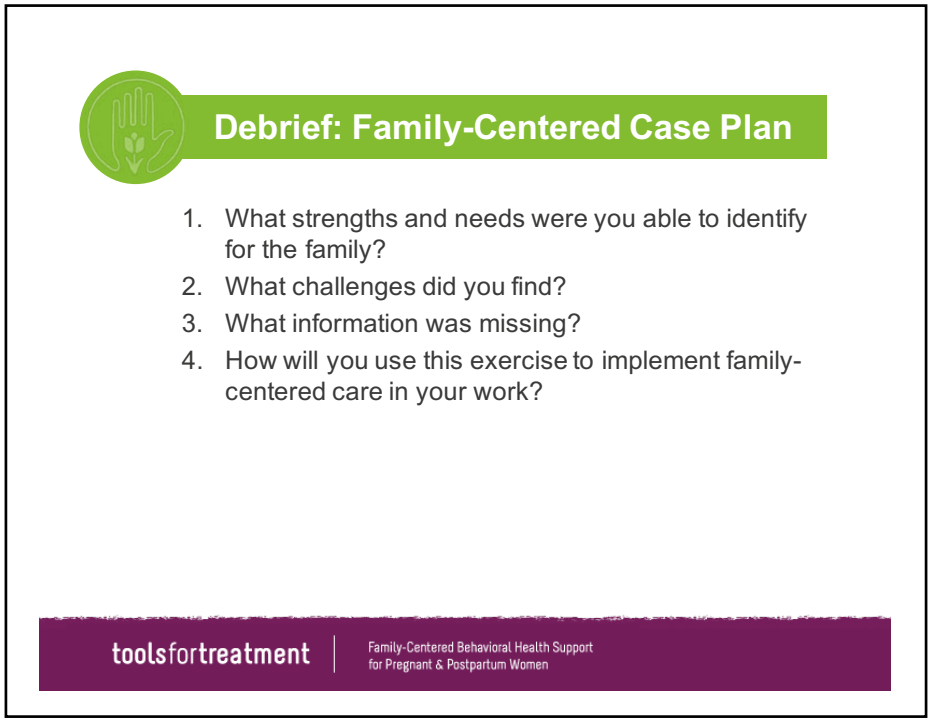
Page 192 in participant manual

Slide 18

- In our small groups, let's practice developing a family-centered plan using our case study.
- As previously mentioned, the *Family-Centered Case Plan* worksheet on page 192 is designed to help you identify the strengths and needs of the family in order to determine what culturally sensitive services or interventions will be needed within a certain time frame. We will be using this worksheet for this part of the activity.
- Using information gathered from the case study, identify the strengths and needs for the family in each of the intervention areas as well as the intervention you are recommending for each.
- Then note a (+) or (–) in the third column to indicate whether the issue is a strength or challenge.

- Do not prioritize the interventions until you have completed the list. After your group has identified the needs in each area, determine which interventions are a priority, which are significant, and which ones are just note-worthy and will not require action or recommendation. Use the key at the top of the fourth column to note the priority levels.
- To give you an idea of what this may look like, refer to the *Example Family-Centered Case Plan* on page 193 of your participant manual.
- You will have 10 minutes to complete this worksheet within your group.

Note to trainer: *You can modify the time for this activity based on your group size and schedule.*

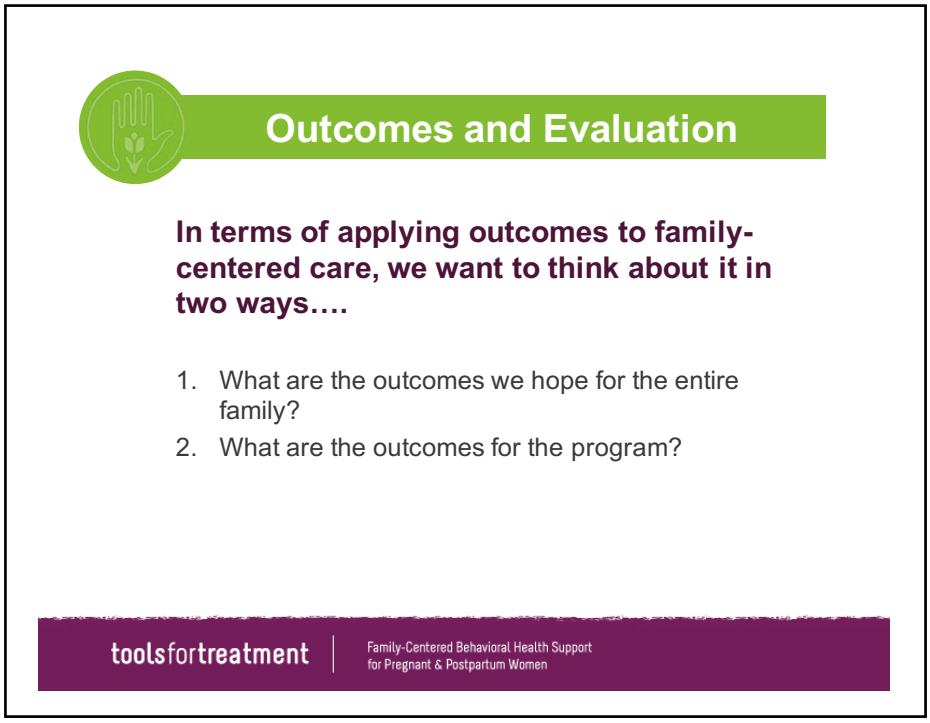


Slide 19

- Let's discuss what your groups came up with. Who would like to share with the larger group what your group came up with?

Note to trainer: *Listed below are some additional questions to help guide your group discussion.*

- *Besides having some limited information in the case, what were some other challenges you experienced while doing this exercise?*
- *Was this activity helpful for understanding family-centered care?*
- *Based on this activity, what information do you now know you will need to gather to complete a family-centered case plan?*
- *Regardless of our role in the agency or system, what changes will you or your team need to make to provide family-centered care?*
- *What might the challenges be, and what are your easy shifts?*
- *What partners might you consider bringing to the table to provide information? Where might this information be available now?*
- *What collaborations will be important to have, improve, or maintain?*
- *Family-centered care requires collaboration, not just cooperation or coordination of care. What does collaboration mean for your agency or program?*



Slide 20

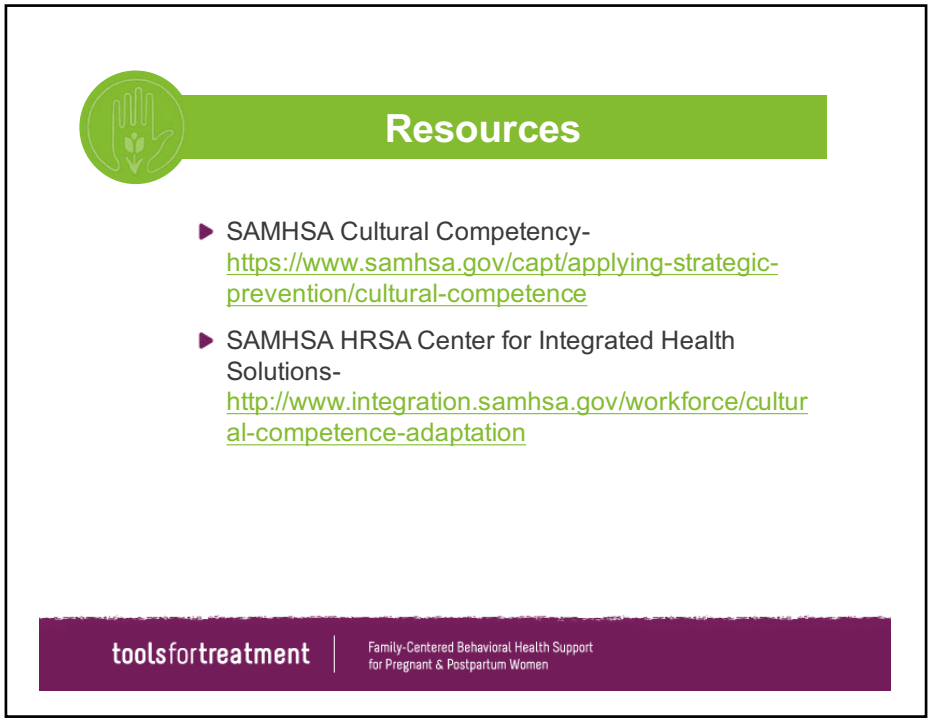
- The final step in family-centered care consists of outcomes and evaluations.
- We know that outcomes and program evaluation can be challenging, but it is very important.
- When applying outcomes to family-centered care, we want to consider two things:
  1. What are the outcomes we hope for the entire family
  2. And what are the outcomes for the program.
- How we measure and look at outcomes for the family is important not only for the program's success, but most importantly for the family. Too often in our field, outcomes are defined and set by the programs and not the individuals, which is problematic. It is important to remember that the family needs to determine what their end goal and successful outcome will be. Also, it's important that families define and experience success.
- For example, a goal for one family might be family reunification, while another family may have a goal to establish a long term parenting plan without reunification.
- Helping families determine their goals and positive outcomes can be a part of the service planning process. Family-centered care requires a broad family goal that considers the strengths, needs, and preferences for the family unit, including the mother, father, children, and extended family.
- There may also be some cultural considerations. For example, culture can influence one's definition of nuclear family, concepts of shared parenting, and positive outcomes.
- All of this requires an evaluation of our mission, values, services, and barriers.
- Some examples of program outcomes in family-centered care can be:
  - Increase the number of family members who actually receive services specific to parenting.
  - Increase the number of parenting plans completed by families.
  - Development of safety planning that encompasses all systems and family members to reduce the likelihood of harm.
  - Development of a family-friendly environment and program that encourages father and family member involvement.

Slide 21

- We are nearing the end of this module.
- With a show of hands:
  - How many can take away at least one thing from the training?
  - How many thought of ways you can improve your program and looked for ways to "make it happen," versus reasons it can't happen?

Slide 22

- As a reminder, many states, cities, agencies, and/or communities may have family inclusion services or work with families whose culture or practice are family-centered or communal families.
- This does not mean we are all working together using the same language, interventions, or practices for family-centered care.
- The hope is to shift together and continue to grow our collaborations to utilize family-centered interventions, techniques, and practices which utilize similar languages and concepts that support our families from a global perspective.
- There will always be cultural considerations and adaptations for families and the communities we serve. This is core to family-centered programming.
- When we utilize a common language and have a common goal which unites us such as family-centered care, we are stronger.
- When we focus on the unique needs of the individual and family we are working with, they are stronger.



Slide 23

- This concludes the sixth module in this training series.
- These are the resources used for this module. You can refer to these sites for further information on cultural competency.

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?

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

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?

_____

_____

_____

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

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

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

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

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

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

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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

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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.

toolsfor**treatment**

Family-Centered Behavioral Health Support
for Pregnant & Postpartum Women

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