

Our Double Epidemic: Hoosier Children Caught in the Opioid Crisis

Indiana Family Impact Seminar
November 20, 2018

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Our Double Epidemic: Hoosier Children Caught in the Opioid Crisis

Our Double Epidemic: Hoosier Children Caught in the Opioid Crisis is the twenty-first in a continuing series designed to bring a family focus to policymaking. The topic was chosen by a bipartisan, bicameral committee of legislators, representing the very audience these seminars are intended to inform.

Family Impact Seminars have been well received by federal policymakers in Washington, DC, and Indiana is one of several states to sponsor such seminars for state policymakers. Family Impact Seminars provide state-of-the-art research on current family issues for state legislators and their aides, Governor's Office staff, state agency representatives, educators, and service providers. One of the best ways to help individuals is by strengthening their families. The Family Impact Seminars speakers analyze the consequences an issue, policy or program may have for families. The seminars provide objective, nonpartisan information on current issues and do not lobby for particular policies. Seminar participants discuss policy options and identify common ground where it exists.

This seminar featured the following speakers:

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The Indiana Seminars are a project of the Indiana Consortium of Family Organizations which includes:

Center for Families, Purdue University;

Department of Early Childhood, Youth, and Family Studies, Ball State University;

Indiana Association for the Education of Young Children;

Indiana Association for Marriage and Family Therapy;

Indiana Clinical and Translational Sciences Institute, CTSI;

Indiana Extension Homemakers Association®; Indiana Family Services;

Indiana University School of Public Health – Bloomington;

Indiana Youth Institute;

National Association of Social Workers – Indiana Chapter;

Marion County Commission on Youth, MCCOY;

Purdue University Extension, Health and Human Sciences.

Issue Overview

The economic costs of the opioid epidemic in the United States exceeded \$1 trillion from 2001 to 2017, with a projected increase of \$500 billion by 2020.¹ As ground zero for the opioid epidemic, the Midwest has seen opioid-related overdoses jump 70% over the last 15 years, compared to 30% for the rest of the U.S.² In Indiana in particular, Hoosiers filled 5.8 million prescriptions for opioids in 2015 (down from 6.3 million in 2014 and 6.9 million in 2013).³ These 2015 prescriptions amounted to a rate of 0.9 filled opioid prescriptions per capita (compared to the 2015 national average of 0.7 per capita), and in the following year (2016), 794 Hoosiers died from opioid-related complications (including overdoses).³

Beyond the economic costs, there are human costs. Many of the 11.7 million adults abusing opioids in the U.S. are parents.⁴ Children whose parents abuse opioids are more likely to be abused, neglected, exposed to opioids prenatally, and be placed into foster care.^{5,6} Further, exposure to abuse and neglect in childhood increases the risk of many developmental, health, and mental health consequences throughout adolescence and adulthood⁷, at a cost of \$80.2 billion a year to society.⁸

These issues are particularly pressing in Indiana, where approximately 55% of all child removals by Indiana's DCS in 2017 (7,015 children) were linked to parental substance abuse.⁹ While the exact role of opioids in rising child welfare numbers is unclear, it is true that the number of children entering U.S. child welfare systems has risen throughout the opioid epidemic, and Indiana has seen one of the nation's largest gains in number of children placed in foster care.¹⁰ The number of children in contact with Indiana's DCS has nearly doubled over the past 5 years – from nearly 15,000 in 2013 to over 29,000 in 2018.¹¹ As state agencies and commissions continue their work on opioid treatment programs, researchers have been uncovering how states like Indiana can work with families, treatment providers, and the courts to keep Hoosier families together and help them thrive. The 2018 Indiana Family Impact Seminar, offered by the Indiana Consortium of Family Organizations (COFO), focused on the intersection of the opioid epidemic and child welfare in Indiana. In the following documents, we provide more information regarding existing research and resources.

Indiana Landscape

Opioid Epidemic

The Numbers:

- Opioid-related overdoses have jumped 70% in the Midwest over the last 15 years, compared to 30% for the rest of the United States ([CDC, 2017](#)).
- In 2015, Indiana medical care providers signed 5.8 million opioid prescriptions – down from 6.3 million in 2014 and 6.9 million in 2013 ([IMS Health, 2016](#)).
- Despite decreased opioid prescriptions by 2015, the following year (2016), 794 Hoosiers died from opioid-related complications (e.g., overdoses) – a rate of 12.6 deaths per 100,000 people (national average: 13.3 per 100,000), according to the National Institute on Drug Abuse ([NIDA](#)).
 - 297 of these deaths were attributed to heroin, specifically, and 304 to synthetic opioids.

Indiana's Efforts:

- [Purdue's "BoilerWoRx" Initiative](#) aims to bring opioid-related resources to all 92 Indiana counties.
- Indiana Governor, Eric Holcomb's ["Indiana's Next Level Recovery" website](#) for Indiana residents in need of resources and information & Indiana Addiction Hotline: 1-800-662-HELP(4357).
- Indiana judges recently held a [conference to discuss solutions](#) for the state.
- Indiana Governor Eric Holcomb recently [signed 4 bills he says will address the opioid epidemic](#) from "every angle" (i.e., increasing the number of opioid treatment/resource locations across Indiana, increasing criminal penalties for dealers and distributors of opioids, expanding systems/policies for monitoring opioid prescriptions written to Indiana residents, and improving overdose- and drug-related data collection from Indiana coroners).
- Multiple [syringe exchange programs](#) – now in **8 (of 92) Indiana counties** -- have over 4,700 participants and a [state-wide syringe return rate of 80%](#).
- Indiana University has launched a [Grand Challenge](#) research grant program.
- The [Indiana Commission to Combat Drug Abuse](#) meets quarterly to collaborate and discuss actions and ideas to defeat the drug epidemic.

Indiana's Child Welfare/Child Protection Systems

- As child welfare [systems are being flooded](#) in states across the U.S., Indiana has seen one of the [nation's greatest one-year increases in children placed in foster care](#).
- There are nearly [double the number of children in contact with Indiana's child welfare system](#) than there were just 5 years ago – from nearly 15,000 in 2013 to over 29,000 in 2018.
- Indiana's [public defenders are not able to keep up](#) with the rising rates.
- According to the U.S. Department of Health and Human Services, of the 28,430 Hoosier children determined to be victims of abuse or neglect, 6,528 had caregivers with histories of substance abuse (DHHS, 2016).
- In SFY 2016, 59 Hoosier children died as a result of abuse or neglect – 21 of which were linked with caregiver substance abuse ([DCS, 2017](#)).
- In December of 2017, the Director of Indiana's Department of Child Services, Mary Beth Bonaventura, resigned from her position. Governor Eric Holcomb appointed [Terry J. Stigdon](#) as the new Director.

Indiana Landscape (cont.)

- Following Bonaventura's resignation the State paid for an audit of [Indiana's Department of Child Services](#) by the outside Child Welfare Policy and Practice Group (CWG) at the request of Governor Eric Holcomb. The [full report](#) was released on June 18, 2018.
 - The [audit revealed](#) that **Indiana's rate of children in foster care is 13 per 1,000 children** – much higher than the national rate of 3.6 per 1,000. Further, CWG reported that nearly 45% of DCS Family Case Managers carry caseloads that exceed state standards.

At the Intersection of Opioid Addiction and Child Welfare in Indiana:

- The recent CWG audit of Indiana's Department of Child Services (DCS) revealed that of all child removals by DCS in 2017, approximately **55% (7,015 removals) were related to parental substance abuse.**
- Volunteers of America of Indiana's [Fresh Start Recovery Center](#) program is a free program for expectant mothers and women involved with the Department of Child Services in the Indianapolis area. The program allows mothers to remain with their children while undergoing treatment for their addiction (vs. more traditional methods that involve child removal).
- Indianapolis' Community Hospital East recently launched a [program to address opioid addiction among expectant mothers](#) via medication-assisted therapies, group therapy sessions with other mothers, individualized counseling, mental health services, and infant health services. The initiative is funded by a [state-awarded grant of \\$570,000.](#)
 - In 2016, Community Hospital East recorded that over [45% of expectant mothers' drug tests were positive](#), and that only **55% of those mothers had clean drug screens at the time of delivery.**

The [Indiana Perinatal Quality Improvement Collaborative](#) is collecting data on drug exposed newborns, and recently approved treatment guidelines for infants with Neonatal Abstinence Syndrome (NAS).

Considerations for Legislators

The Link Between Substance Abuse and Child Maltreatment

- Children whose parents abuse substances are more than twice as likely to abuse their own children decades later.¹²
- Over half (55%) of the cases of Indiana children being removed from their homes were related to parental substance abuse in 2017.¹³
- According to a recent DCS report (2017)¹³, substance abuse during pregnancy is a growing problem in Indiana. From 2016 to 2017, the number of children prenatally exposed to drugs rose more than 250%, from 1,181 to 3,129.
- In 2017, 12,384 Hoosier children entered foster care due to risks and maltreatment were affected by parents' substance abuse.¹³
- According to Indiana DCS (2017)¹³, over-reliance on reactive approaches that primarily address parental addiction by removing children "will not serve Indiana or its citizens well over time" (pg. 57).
 - Indiana DCS and CWG recommends FSSA and the Indiana State Department of Health consider services available for parents struggling with substance abuse that allow them to receive effective treatment and support while keeping their children safely in their homes.¹³

Promising Policy Strategies:

- Treatment: Integrated, multi-pronged approaches to treating the family as a whole unit, rather than treating substance abuse in isolation have been shown, in multiple studies, to produce better outcomes.
 - Family Drug Treatment Courts (FDTCs) use a multidisciplinary and collaborative treatment team of judges, attorneys, social workers, and child welfare advocates to treat parental substance abuse and family problems, as an alternative to incarceration.
 - Parents enrolled in FDTCs are significantly more likely to pursue, receive, and complete treatment.^{14,15}
 - Illinois's Title IV-E Waiver Demonstration Programs integrate intensive case management services with recovery coaches who perform comprehensive clinical assessments, advocate for the family's needs, develop service plans, and reach out to re-engage the parent if necessary.
 - In one study, mothers enrolled in this program were less likely to use substances during pregnancy than mothers who received traditional substance abuse treatment without a recovery coach.¹⁶
 - In 2006 dollars, the waiver demonstration program was estimated to save the state of Illinois \$58,837.¹⁶ Adjusting for inflation, this translates into a savings of \$74,813 in 2018.

Considerations for Legislators (cont.)

- Programs that integrate peer coaches and medication-assisted addiction treatment may help advance goals of parent recovery from addiction and improving parenting skills. These programs may also enhance parent-child bonds and promote child safety and permanency.^{17,18,19,20,21}
 - Peer-coach programs have been associated with reduced risk of relapse, increased retention and satisfaction with treatment, better relationships with providers²², and
 - less homelessness.²³
 - However, peer-coach programs require additional resources (such as training and supervision), and more research is needed to understand the benefits of peer-coaches for specific family circumstances.²⁴

- Sobriety Treatment and Recovery Teams (START) were introduced with Kentucky's Title IV-E Waiver Demonstration Program. START models partner with local drug addiction treatment providers and the courts to connect families with child welfare workers who are specially trained in substance use, and peer coaches/mentors (who are themselves recovered) for support.
 - Children of families participating in START faced only one-third the risk of abuse or neglect faced by children of families who received traditional substance abuse treatment.^{24,25}
 - Mothers who participated in START achieved sobriety at twice the rate (66%) of comparable mothers not enrolled in START (33%).²⁶
 - The START model was recently implemented in Monroe County, Indiana.²

- Prevention: Monitoring and surveillance programs/tools can help to track opioid prescribing trends among Indiana physicians.
 - A recent study²⁷ of Indiana's Prescription Drug Monitoring Program (PDMP; called "INSPECT" in Indiana) found the following:
 - Over 1.5 million Hoosiers were prescribed opioids in 2014.
 - 18.4% of these Hoosiers were identified as engaging in at least one opioid-related risk behavior, such as seeking multiple prescribers or pharmacies ("doctor shopping") or combining opioids and benzodiazepines.
 - This study found that prescribing a second opioid increases the likelihood of these risk behaviors tenfold.²⁷
 - PDMPs like Indiana's INSPECT are helpful for identifying opioid users who are at the highest risks of engaging in dangerous substance use.

Considerations for Legislators (cont.)

Helping Hoosier Children Go Home From the Child Welfare System

- Children of parents with substance abuse problems typically remain in foster care for longer periods of time. They are also less likely to be reunified with their families.²⁸
 - In Illinois, only 14% of substance-exposed infants who entered care in 1994 were reunified with their families before January of 2002.²⁹

Promising Policy Strategies:

- Strategies that integrate child welfare services with substance abuse treatment yield promising results for promoting family reunification.
 - Illinois Waiver Demonstration program:
 - Participating families were 1.28 times more likely to achieve family reunification within three years, across a three-year period, compared with those who only received substance abuse treatment. ^{16,30}
 - Participation in this program also narrowed racial gaps in the likelihood of family reunification in a three-year period. ¹⁶
 - Findings from START (Kentucky's Title IV-E Waiver Demonstration Program):
 - Among families in the child welfare system due to parent opioid use, each additional month of medication-assisted treatment increased parents' odds of retaining or regaining custody of children by 10%. ³¹
 - 77.6% of children served by START remained with or were reunified with a biological parent.³²
 - In another study, children from families served by START were half as likely to be in state custody, compared to families receiving traditional services. This suggests that participation in START not only helps parents bring children home, but helps parents keep their children at home in the first place.²⁶

Treating the Family to Benefit the State

Martin Hall, PhD

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Dr. Hall serves as the evaluator for the Sobriety Treatment and Recovery Team (START) program in Kentucky and also conducts research on the epidemiology of nonmedical prescription drug use, particularly in understudied populations (e.g., rural Appalachians; institutionalized youth; women on probation and parole). Previous studies have focused on establishing and understanding subtypes of nonmedical prescription drug users, as well as the relationship between health status and nonmedical prescription drug use. Dr. Hall was a National Institute on Drug Abuse Postdoctoral Fellow at the University of Kentucky College of Medicine and completed a clinical Post-Masters Interprofessional Fellowship in Psychosocial Rehabilitation and Recovery at the Durham (NC) Veterans' Affairs Medical Center.

**INDIANA FAMILY
IMPACT SEMINAR**

NOVEMBER 20, 2018

**MARTIN T. HALL, PHD, MSSW
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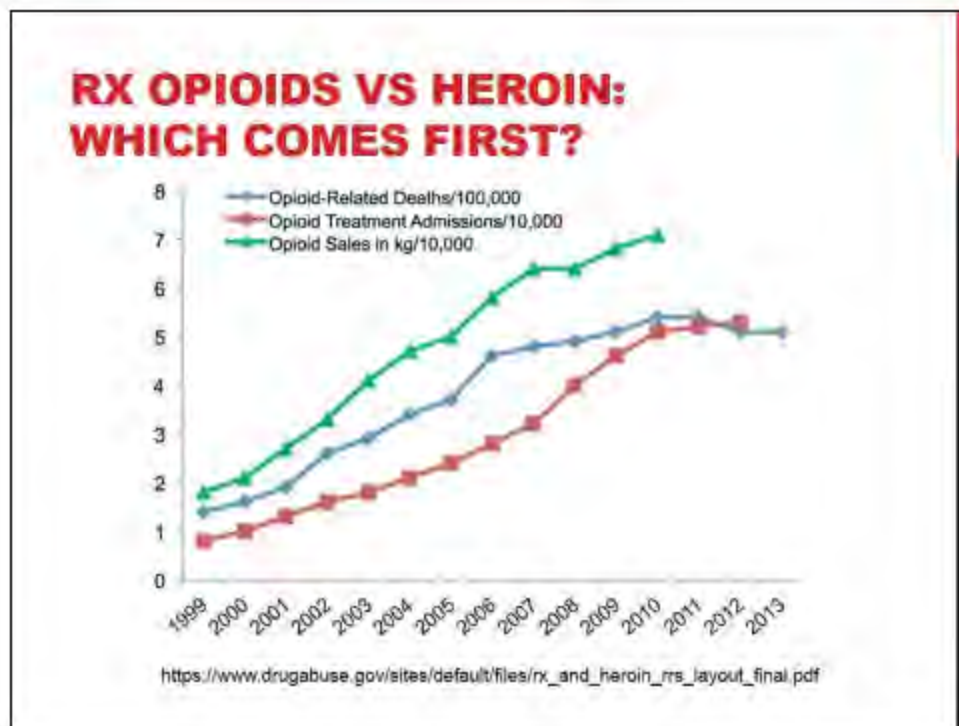
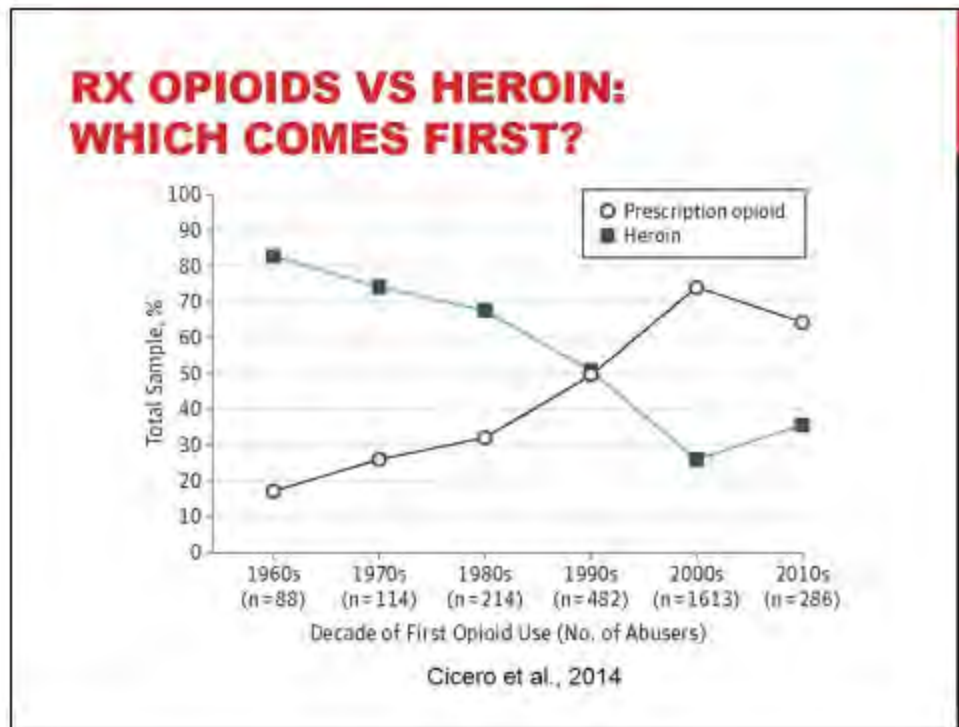
Treating the Family to Benefit the State

AIMS

1. What factors led to the opioid epidemic?
2. Overview of Sobriety Treatment and Recovery Teams (START), a promising intervention for families with co-occurring substance use and child maltreatment
3. Opioid-using families in START – does medication-assisted treatment improve outcomes?

WHAT FACTORS LED TO THE OPIOID EPIDEMIC?

Treating the Family to Benefit the State



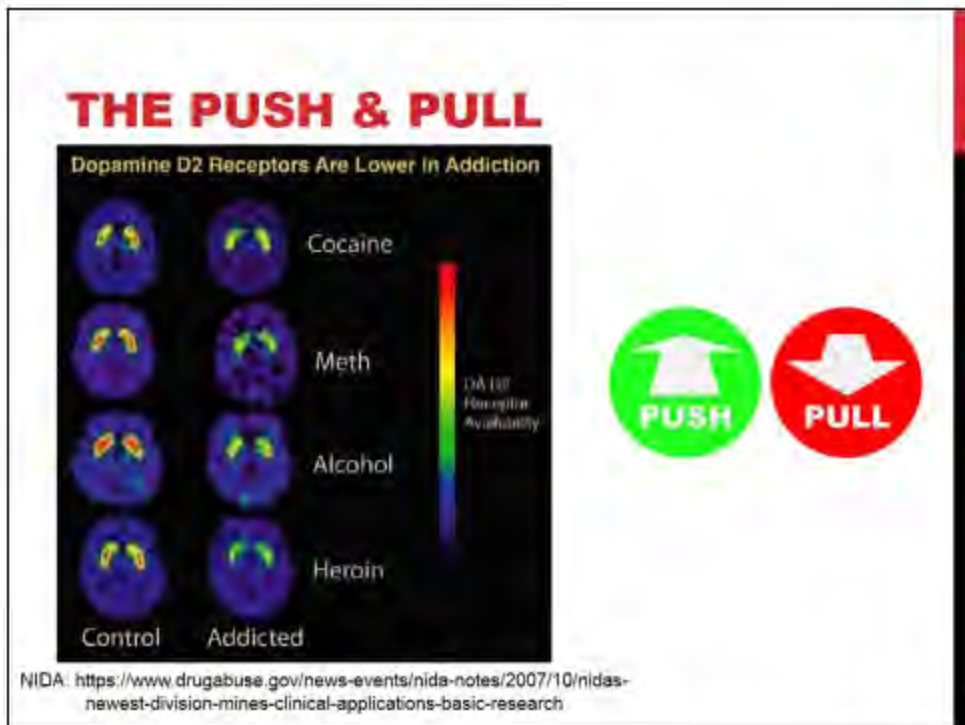
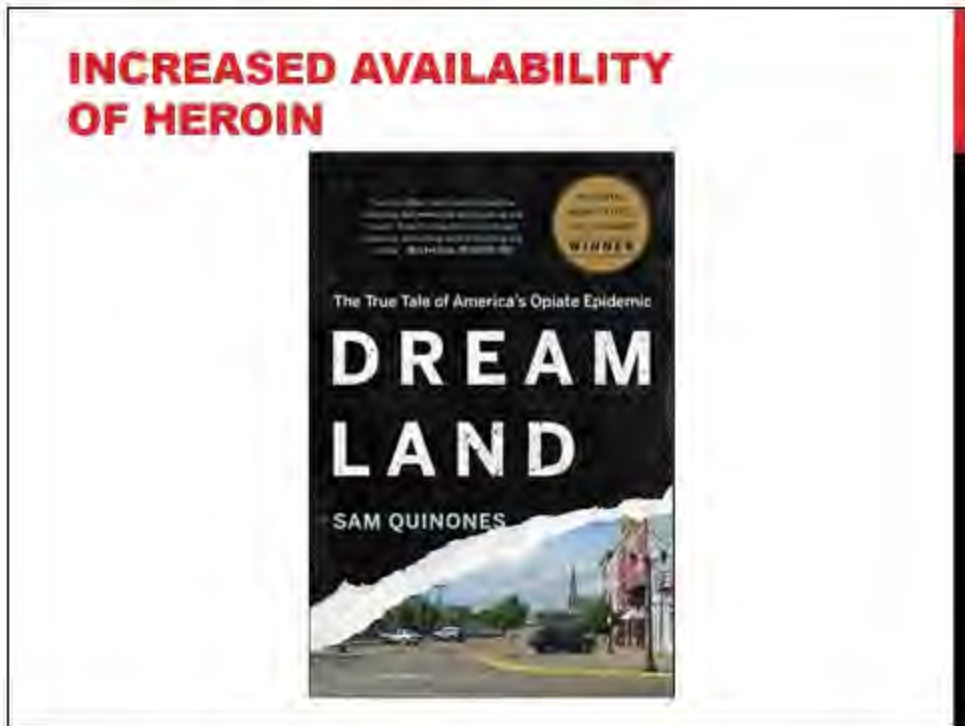
Treating the Family to Benefit the State



AN ANTHROPOLOGICAL LENS

The transaction of prescriptions / medications from provider to patient provides **perceived benefits to both parties**, thus **reinforcing their use** (van der Geest et al., 1996).

Treating the Family to Benefit the State



PREVALENCE OF OPIOID USE DECLINING

Some **good** news:

- Among 12th grade students in the U.S., past-year *nonmedical use of prescription opioids* declined from **9.2%** in 2009 to **4.2%** in 2017 (Johnston et al., 2018).

SOBRIETY TREATMENT AND RECOVERY TEAMS (START)

Treating the Family to Benefit the State

START OUTCOMES

- Women in START have **higher rates of abstinence** than a matched comparison group of non-START women receiving child welfare services (66% vs. 37%)
- Children receiving START are **less likely to enter out-of-home placements** than children served by usual child welfare services (21% vs. 42%)
- For every **\$1** spent on START, **\$2.52** is saved on out-of-home placement costs

(Huebner et al., 2012)

START OVERVIEW

- Child welfare-based model serving families with **co-occurring** substance use and child abuse / neglect
- **Integrates** child welfare, addiction treatment, courts, community partners
- Teams consist of CPS worker and recovery mentor **dyads**
 - Receive specialized training (e.g., motivational interviewing)
- **Reduced caseloads**: 12-15 families for each dyad
- **Intensive** service delivery model that **intervenes quickly** upon receipt of CPS referral
- Initiated in KY in 2007 and has served over 1,000 families across 5 counties

IMPROVING OUTCOMES FOR OPIOID-USING FAMILIES IN START

BACKGROUND

- For families in the child welfare system, **reunification rates are lower for parents with opioid problems than for parents with alcohol** (Choi & Ryan, 2007; Grella et al., 2009) **or cocaine problems** (Choi & Ryan, 2007)
- **Medication-Assisted Treatment (MAT)** has been identified by the World Health Organization (2004) as **the most effective treatment** for opioid use
 - Roughly 1.3 million individuals with opioid use disorders could benefit from MAT but are not receiving it (Jones, Campopiano, Baldwin, & McCance-Katz, 2015)

Treating the Family to Benefit the State

BACKGROUND

- **Study Aims:**

- Aim 1: Describe patterns of MAT utilization among parents with a history of opioid use who received START
- Aim 2: Compare child outcomes for families in the START program with a history of opioid use who received MAT services to those who reported opioid use but did not receive MAT

METHODS

Treating the Family to Benefit the State

METHODS

Study sample

- Closed START cases with at least one adult in the family with opioid use (served between 2007 – 2015)

Measures

- Demographics (age, gender, race, and county)
- Household opioid use (one adult opioid user vs. two or more adult opioid users)
- Medication-assisted treatment
 - use of prescribed methadone, buprenorphine, and naltrexone
 - dichotomized as either no MAT (0) versus more than 1 month of MAT (1), as well as total months of MAT received during the START program
- Permanency: child(ren) remained with parent vs. all other outcomes (e.g., placed with relative; adoption)

RESULTS

Treating the Family to Benefit the State

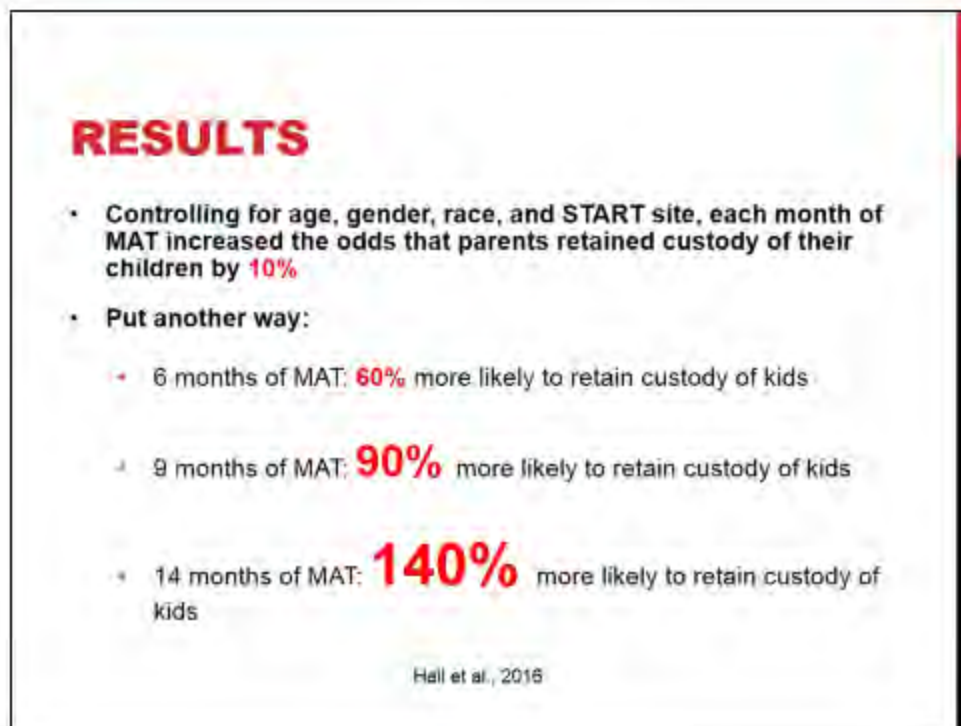
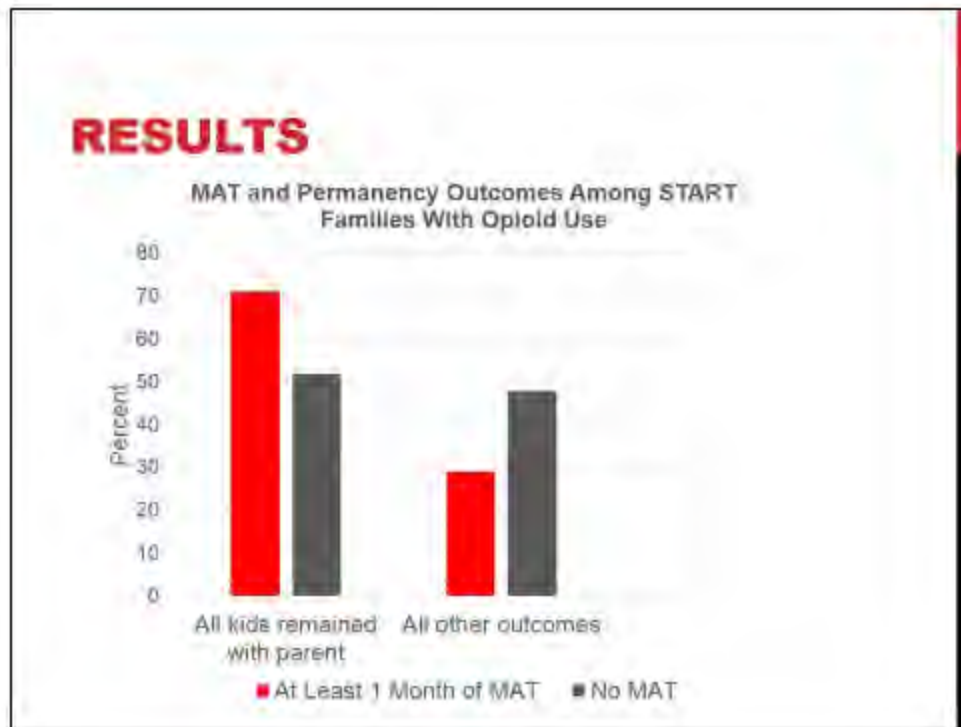
DEMOGRAPHIC CHARACTERISTICS OF 596 OPIOID USERS (REPRESENTING 413 FAMILIES) IN THE KENTUCKY START PROGRAM

Variable	n	(%)
Gender		
Men	204	(34.2)
Women	392	(65.8)
Race		
African American	49	(8.2)
Hispanic/Other	0	(1.0)
White	547	(90.8)
Age		
18-24	245	(41.1)
25-29	189	(31.7)
30 and older	162	(27.2)
County		
Boyd	104	(17.4)
Daviess	3	(.5)
Jefferson	107	(17.9)
Kenton	212	(35.5)
Martin	80	(13.4)

RESULTS, CONT.

- 55 individuals (9.2%) received at least 1 month of MAT
Range: 0 – 760 days of MAT
 - Average: 214 days (about 7 months)
 - About 1/3 received 3 months or less;
 - Another 1/3 received between 3 and 9 months;
 - Last 1/3 received between 9 months and 2 years

Treating the Family to Benefit the State



Treating the Family to Benefit the State

DISCUSSION, CONT.

- **Duration of MAT is also positively associated with:**
 - **Reduced illicit opioid use** (Condelli & Dunteman, 1993),
 - **Reduced use of other drugs and criminal activity** (Simpson & Sells, 1982), and
 - **Risk of viral infection and STDs** (Greenfield & Fountain, 2000)
- **Interventions may be needed to:**
 - **educate** the child welfare workforce on the benefits of MAT
 - improve practical service **linkages** between MAT providers and child welfare systems, the courts, 12-step drug addiction treatment providers

ACKNOWLEDGEMENTS

- Purdue University Center for Families
- Kentucky START leadership
- Kentucky Department of Community Based Services
- The Children's Bureau, an office of the Administration on Children & Families, U.S. Department of Health and Human Services

Thank you!
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Treating the Family to Benefit the State

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Treating the Family to Benefit the State

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Parental Substance Use and Child Welfare

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Dr. Ryan is the Co-Director of the Child and Adolescent Data Lab an applied research center focused on using data to drive policy and practice decisions in the field. He is currently involved with several studies including a randomized clinical trial of recovery coaches for substance abusing parents in Illinois (AODA Demonstration) , a foster care placement prevention study for young children in Michigan (MI Family Demonstration), a Pay for Success (social impact bonds) study focused on high risk adolescents involved with the Illinois child welfare and juvenile justice system and a study of the educational experiences of youth in foster care (Kellogg Foundation Education and Equity). He is currently serving on the editorial board of four journals (Child Maltreatment, Social Work Research, Residential Treatment for Children and Youth and Child Welfare).



Parental Substance Use and Child Welfare

OVERVIEW

- 01 Opioids Impact on Child Welfare**
- context is important
- 02 Parental Addiction and Child Welfare**
- 03 Potential State Response**



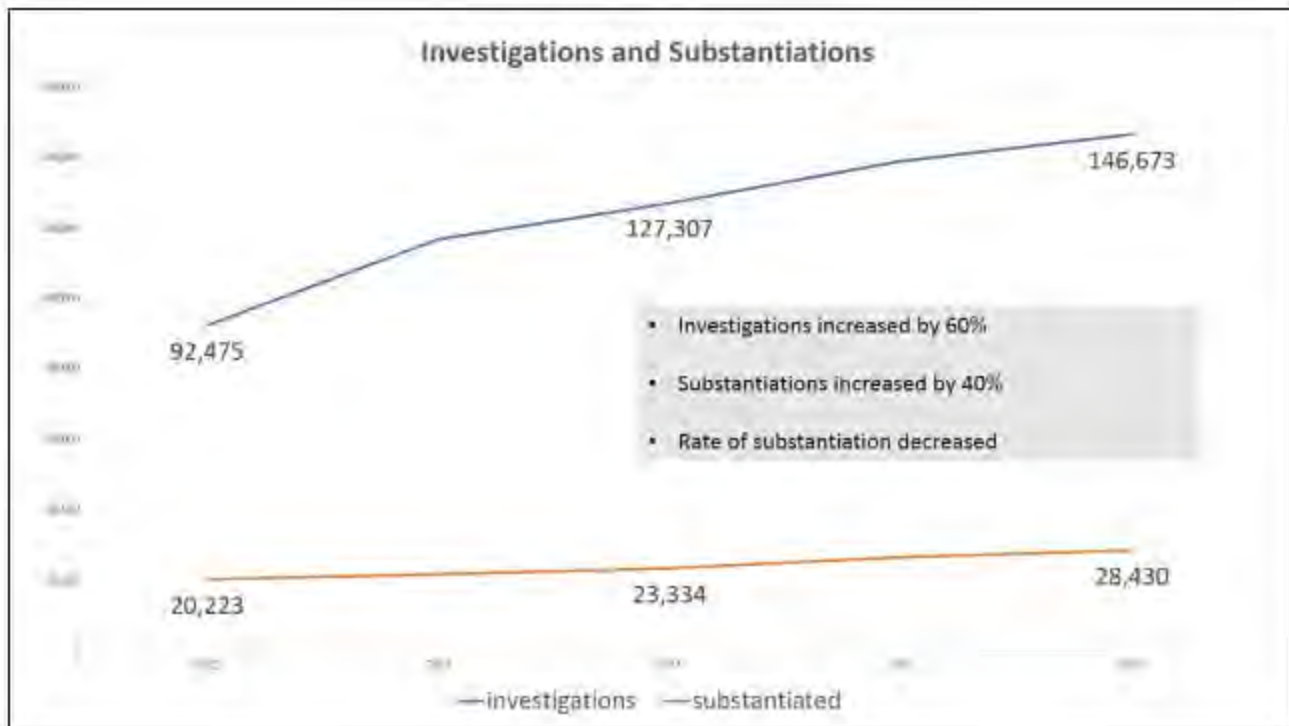
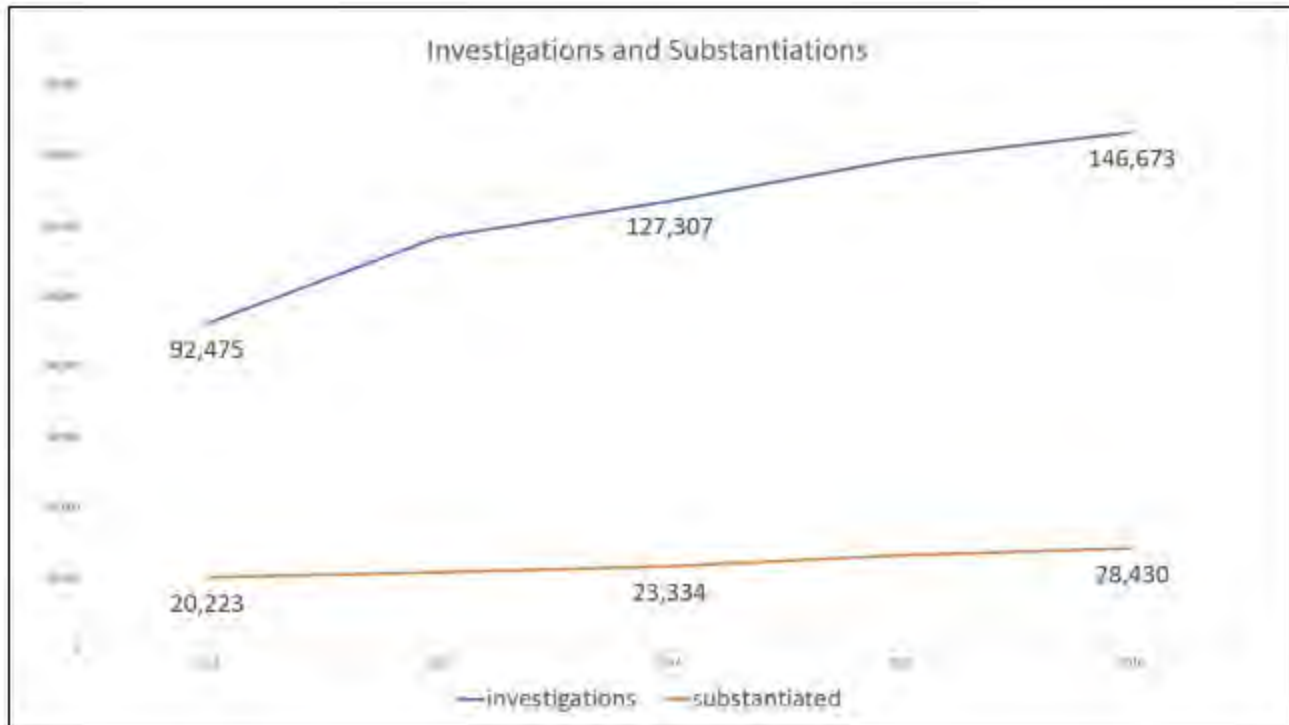
Parental Substance Use and Child Welfare

Harnessing the Power of These Data Require Bridges/Links

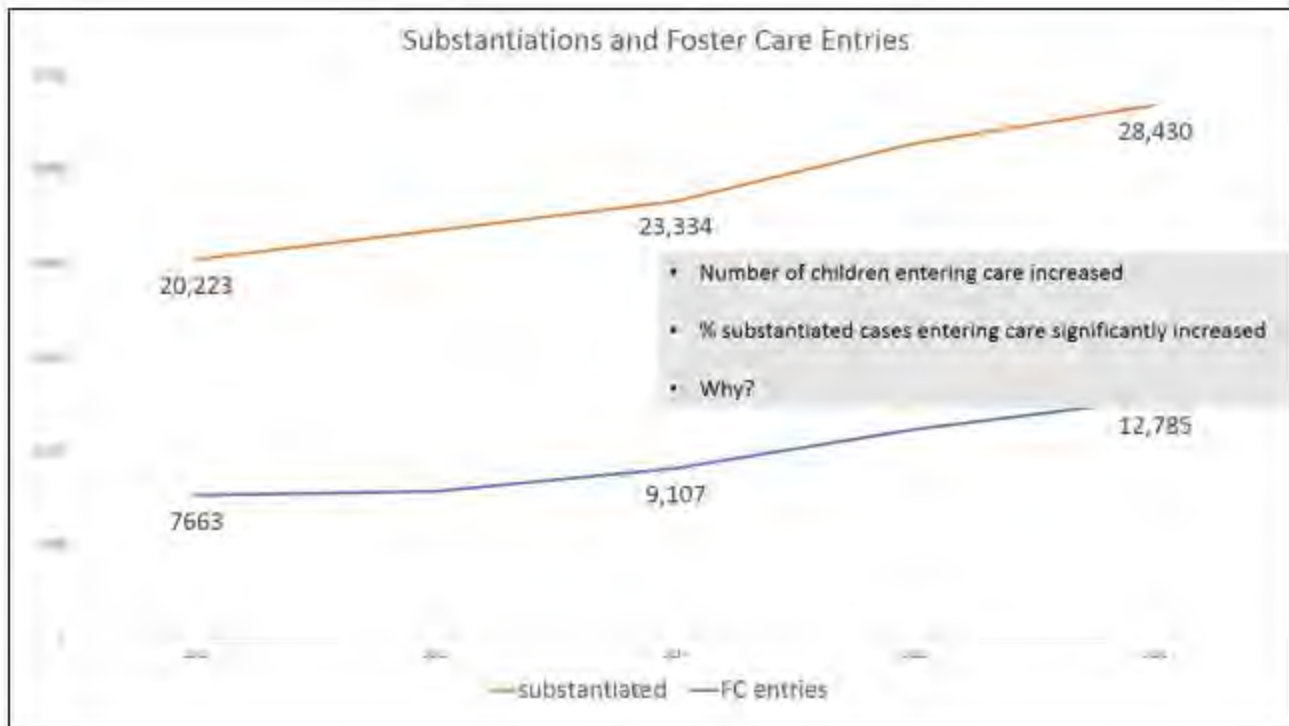
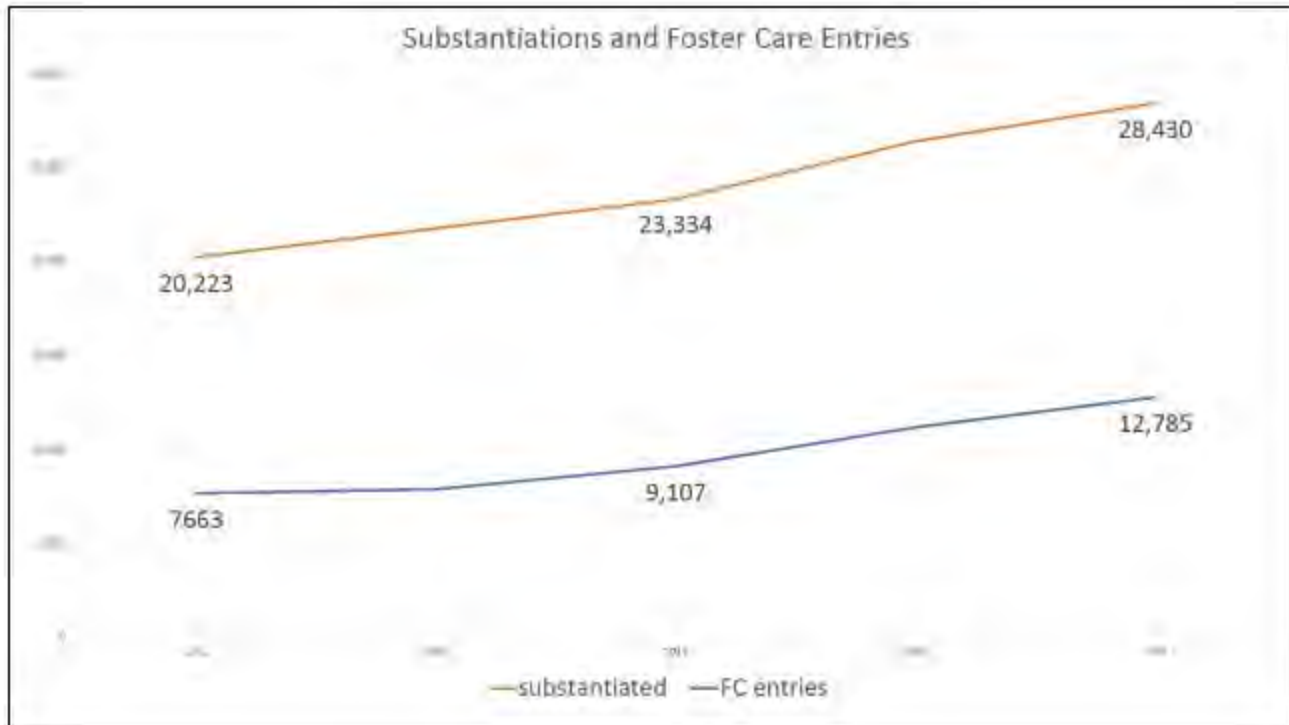


PART ONE
Opioids Impact on Child Welfare
- context is important

Parental Substance Use and Child Welfare



Parental Substance Use and Child Welfare



Parental Substance Use and Child Welfare

PART TWO **Parental Addiction and Child Welfare**

Parental Substance Abuse Estimates

- Parental substance abuse increases the risk of child maltreatment
- Evidence is compelling, exact mechanisms are less certain.
- Estimates vary widely with regard to child welfare populations
 - Boston foster care: 43 to 50%
 - California, New York, and Pennsylvania foster care: 65% to 78%
 - Los Angeles and Chicago foster investigation: 66%
 - NSCAW foster care 43%
 - Indiana – reason for removal 25.8% in 2012 to 55% in 2017 (child welfare eval, June 2018)
- Most states have very little data on the role of substance abuse in their child welfare system – and this is a major obstacle for (1) understanding the scope of the problem and (2) effectively and efficiently addressing the problem.
- 19 case file reviews is not an appropriate or adequate approach

Parental Substance Use and Child Welfare

Parental Substance Abuse and Outcomes

- Parental substance abuse should have a significant impact on child welfare performance metrics
- First time foster care placements stable (approximately 15% between 2012 and 2016)
- Maltreatment in care stable (less than 1% between 2012 and 2016)
- Children experience recurrence stable (approximately 6.7% between 2012 and 2016)
- Exits to reunification has increase (60% in 2012 to 70% in 2016)
- Time in care stable (median is approximately 13 months)
- Movements between foster homes is stable (approximately 90% with 2 or less)
- Number of TRPs decreased (2,047 in 2012 to 1,266 in 2016)
- What to make of these estimates? New population or increase of same population?

PART THREE

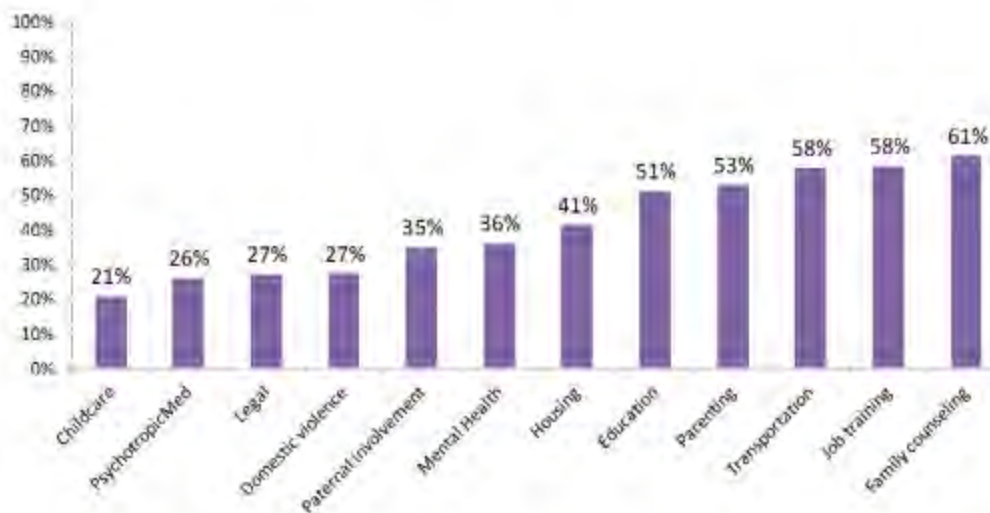
Potential State Response

Parental Substance Use and Child Welfare

Illinois Substance Abuse and Child Welfare

- Basic problem in Illinois – children in substance abusing families were not returning home
 - 15% of SEI were reunified after 7 years
- Started with formal standardized assessment (data driven approach)
 - Juvenile Court Assessment Project (JCAP)
 - AOD assessment based on DSM IV & ASAM criteria
- So if substance abuse is a problem – we can understand WHY is it a problem?
- And then we can think about how to solve this problem?

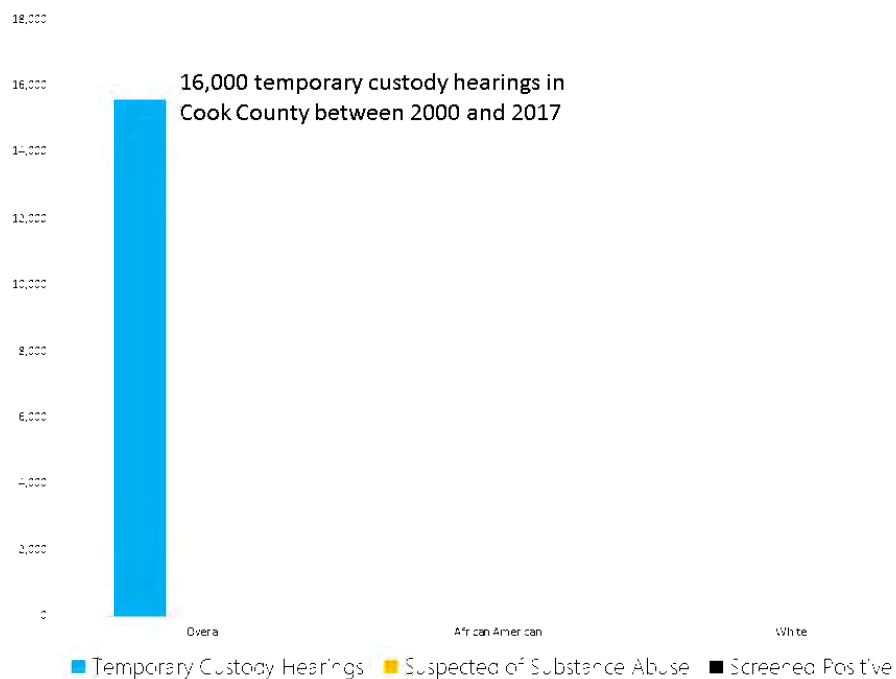
Family Problems and Service Needs



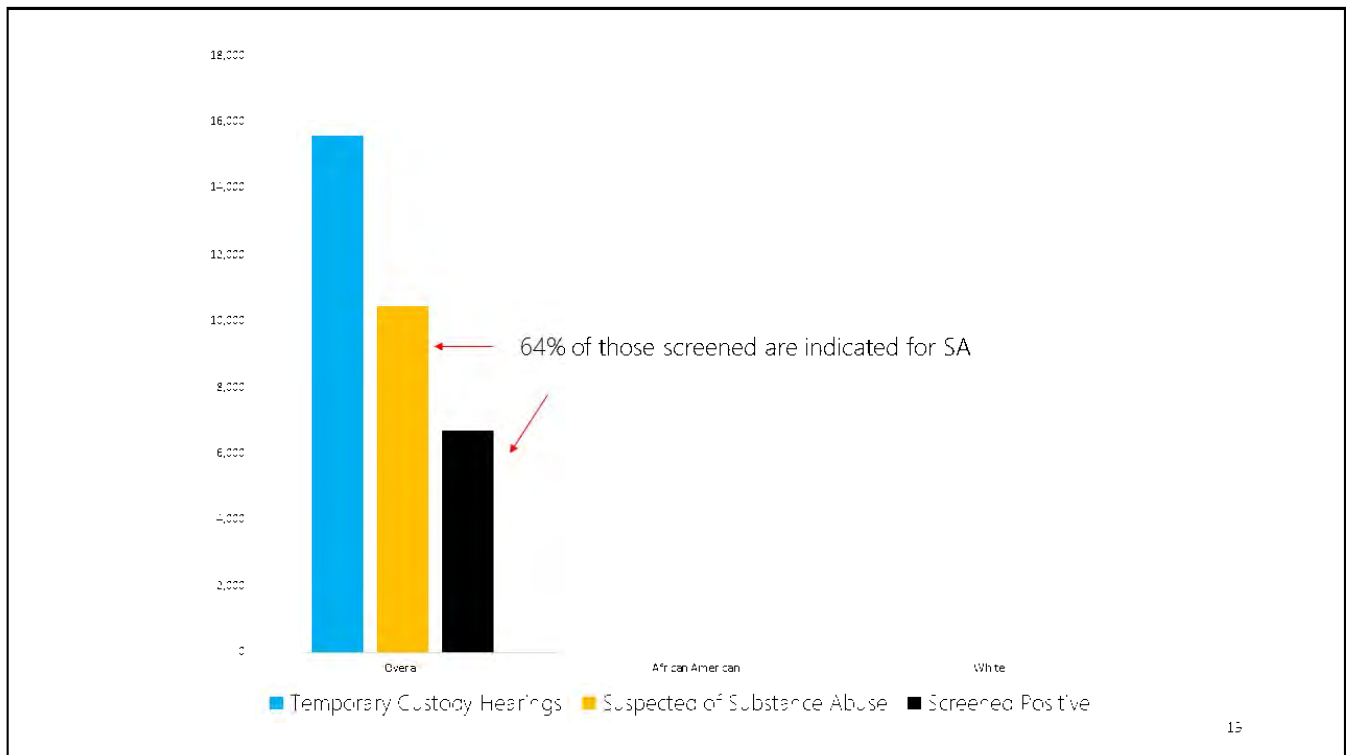
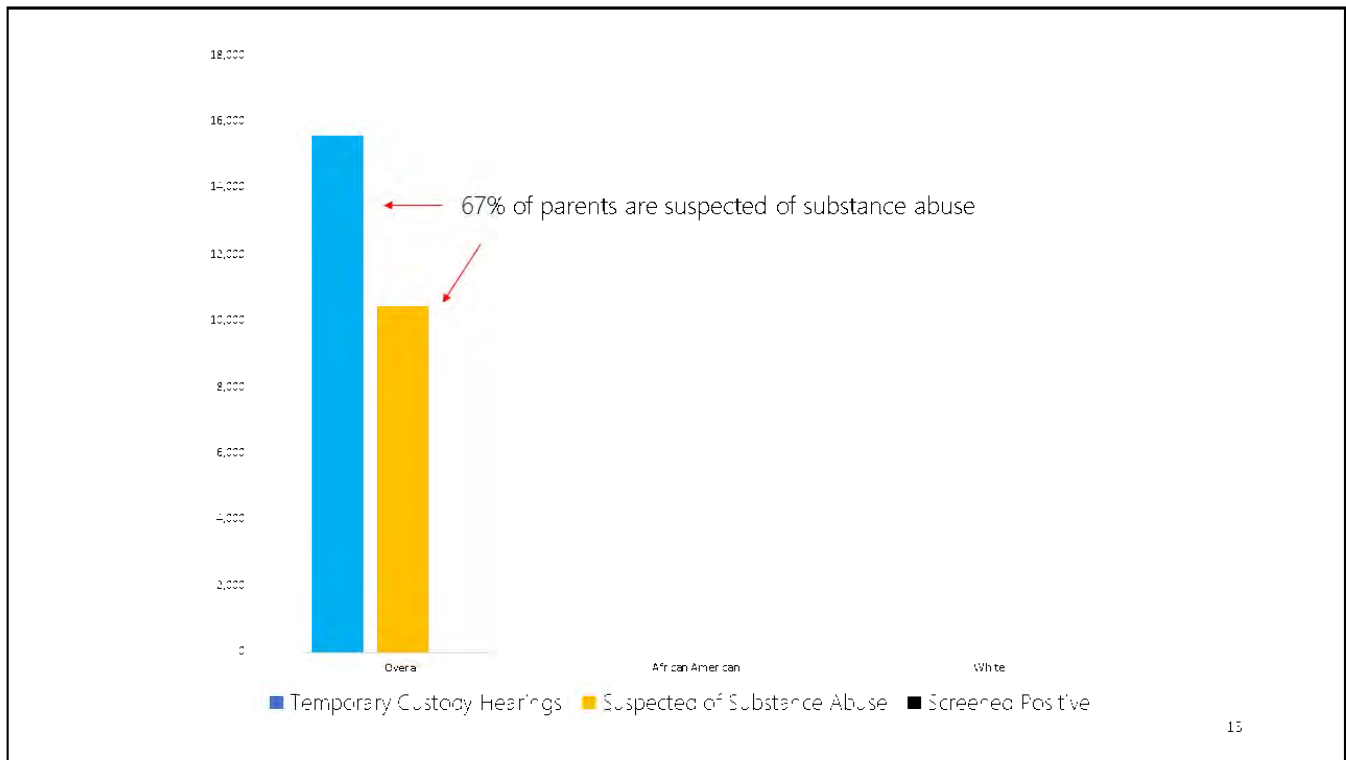
Parental Substance Use and Child Welfare

Recovery Coach: Roles and Responsibilities

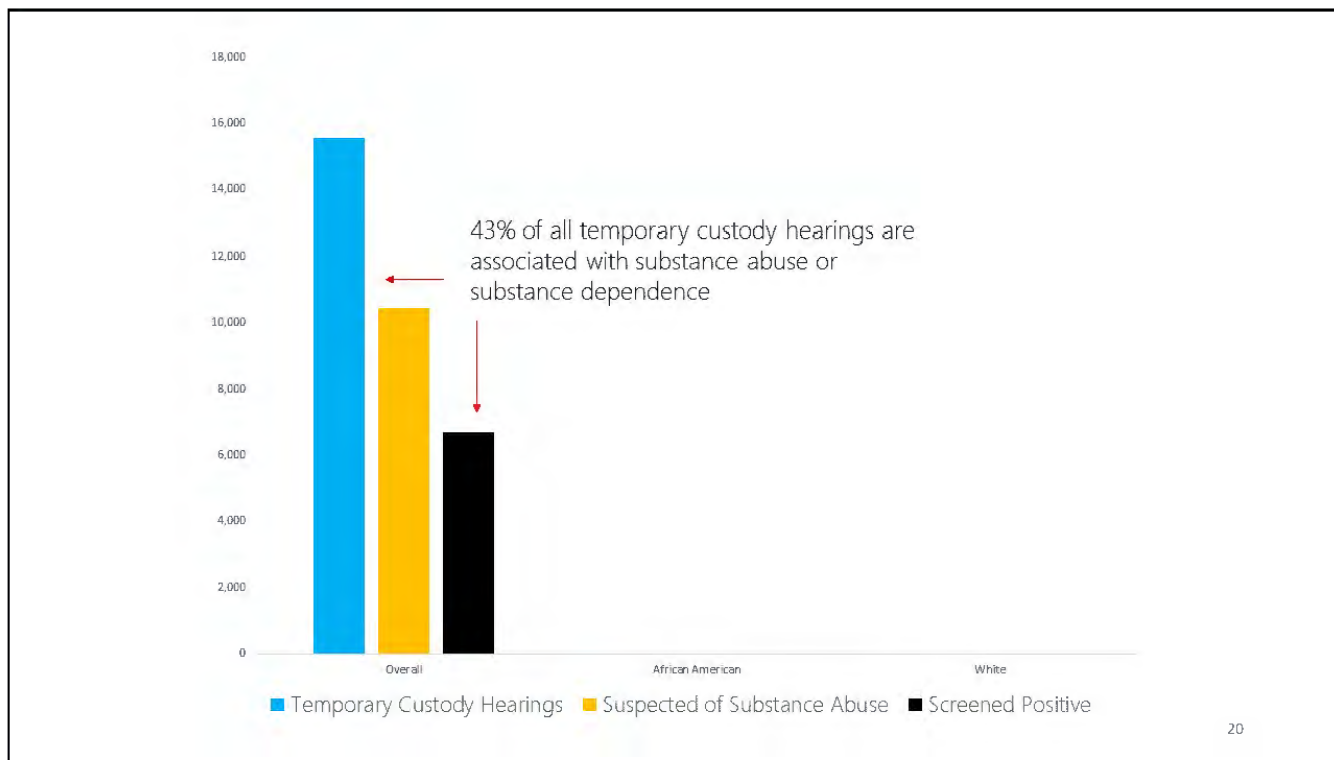
- Caseworkers have too many services to manage – and substance abuse TX is challenging
- Specialty case managers produce better outcomes
- RC's work in collaboration with caseworker; not a replacement
- Provide ongoing assertive outreach and re-engagement efforts
- Assists in removing barriers in engaging, retaining and re-engaging parents
- Coordinate AOD planning efforts
 - arrange staffings, participate in family meetings, testify in court
- Urinalysis testing
- Standardized monthly reporting to worker & the courts
- Locate parents!



Parental Substance Use and Child Welfare



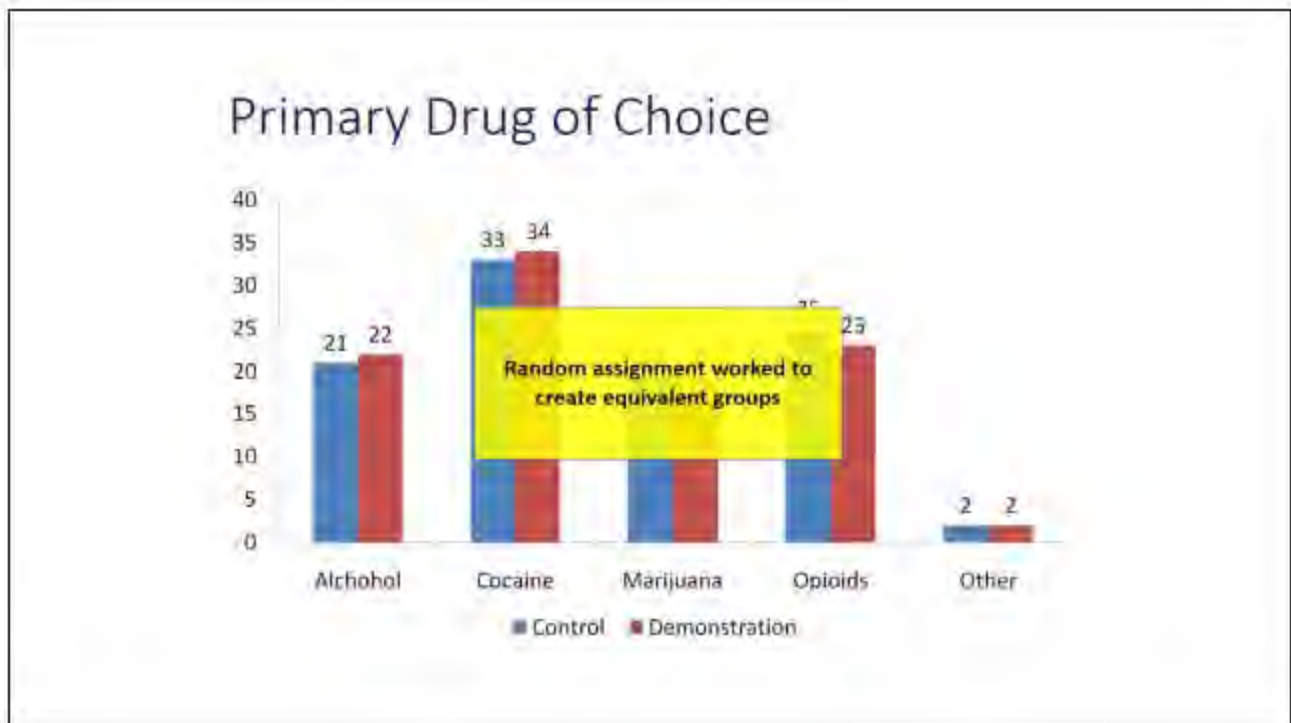
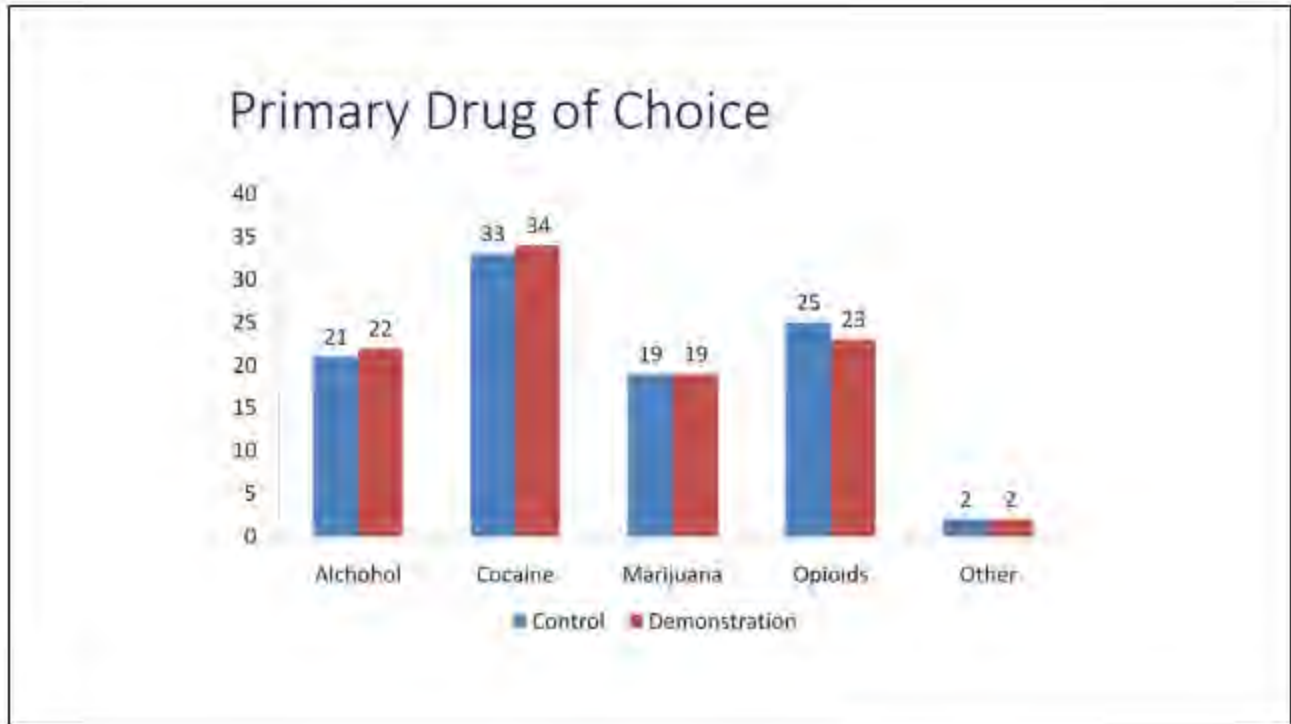
Parental Substance Use and Child Welfare



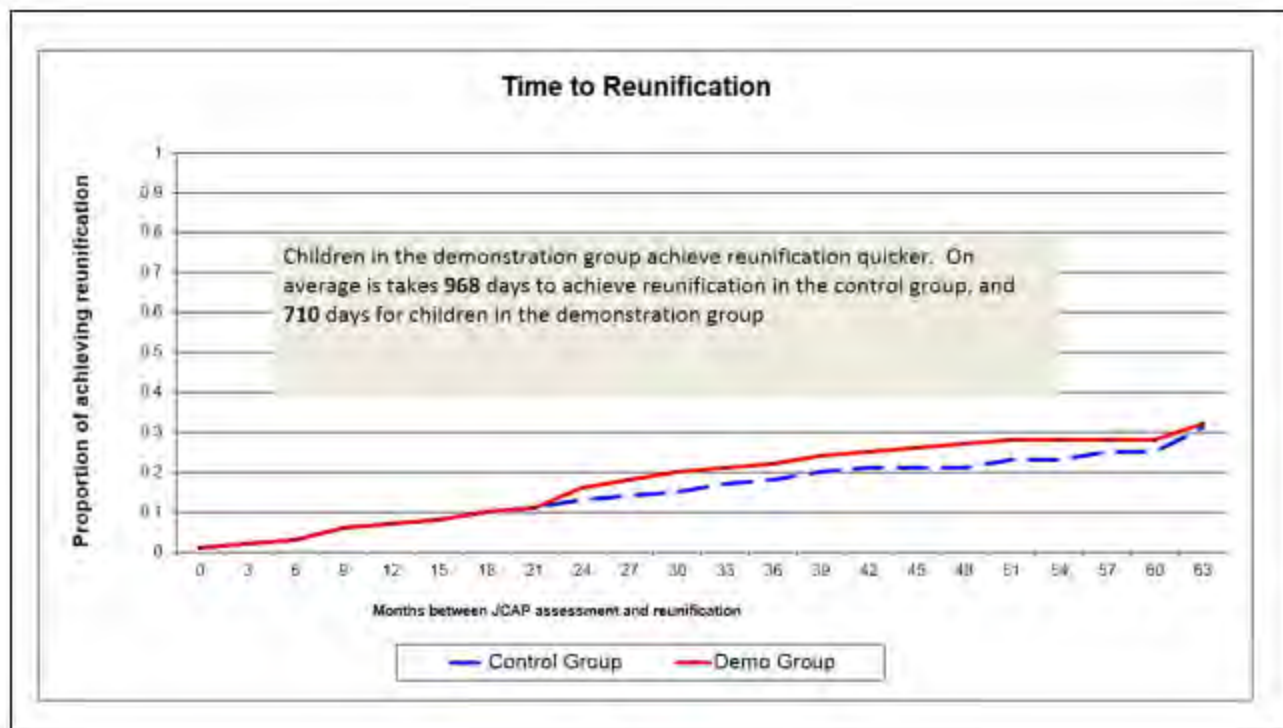
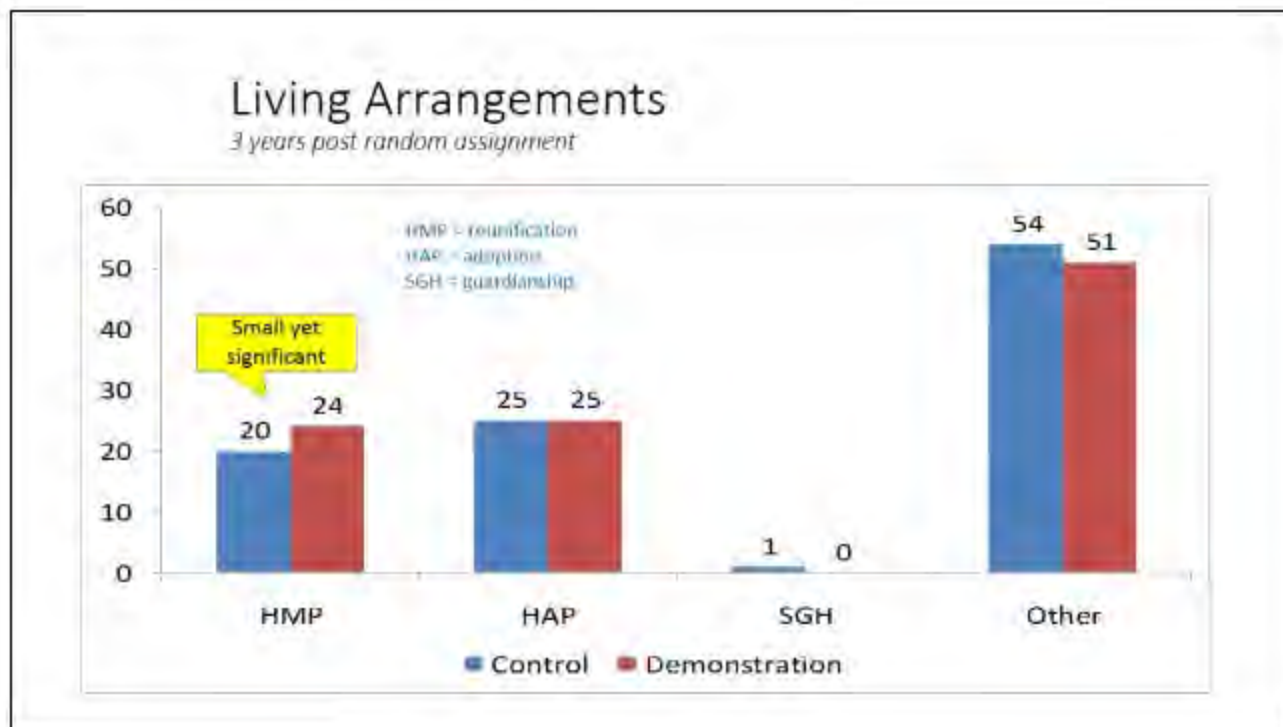
Employed Random Assignment Caregiver Demographics

Variables	Control (N=1,200)	Demonstration (N=2,450)
Age	32 yrs.	32 yrs.
% African American	83%	80%
% Mother only	58%	57%
% Father only	14%	15%
Employment problems	21	24%
Housing problems	57%	56%
Mental health problems	24%	26%
Prior SEI	43%	46%

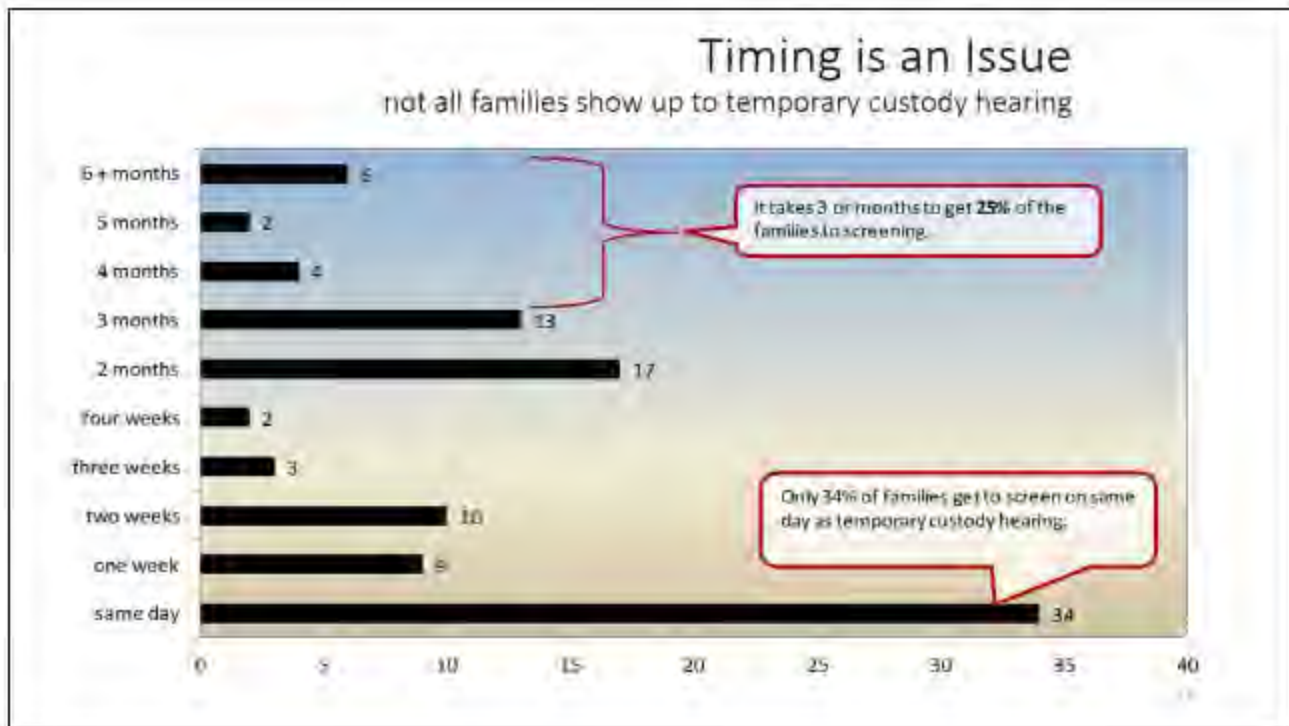
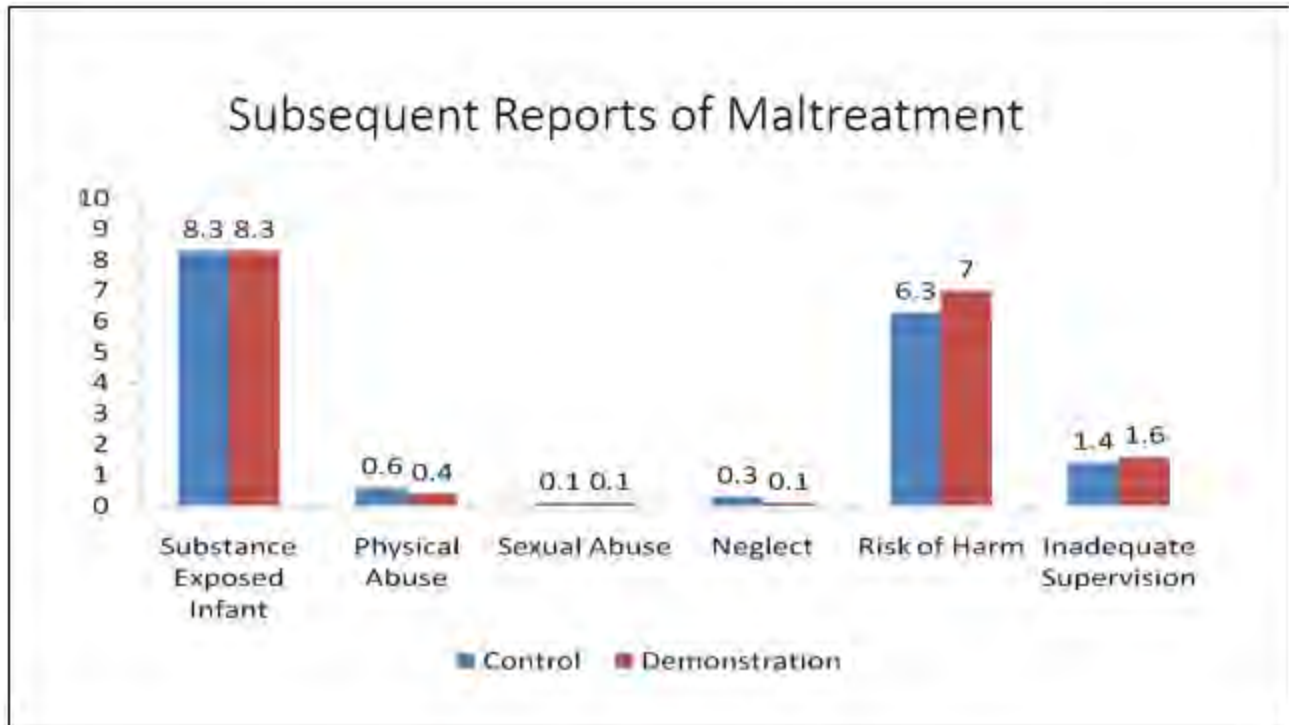
Parental Substance Use and Child Welfare



Parental Substance Use and Child Welfare



Parental Substance Use and Child Welfare



Parental Substance Use and Child Welfare

OUTCOMES IMPROVE when assessments and referrals happen in a timely manner

Families assessed 3+ months of temporary custody hearing (*delayed*)



Families assessed within 2 months of temporary custody hearing (*early*)



Parental Substance Use and Child Welfare

Summary and Implications

- Substance abuse is a long standing problem in child welfare (awareness could explain some increase)
- Child Welfare and Substance Abuse agencies generally don't work together.
- Standardized screening indicates that 43% of the parents associated with a foster care placement meet criteria for substance abuse or substance dependence
- Innovative partnerships between child welfare and substance abuse can improve outcomes and generate big savings
- Recovery Coaches improve outcomes - but need to engage families early
- Improving child welfare systems requires the regular consumption of data (information)
- IMPROVE DATA COLLECTION METHODS, no more guessing, no more case reviews
- HOW ARE SUBSTANCE ABUSE RELATED CASES CHALLENGING THE CW SYSTEM IN INDIANA?
- DEVELOP AN APPETITE FOR EVALUATION AND FINDINGS THAT ARE NOT ALWAYS POSITIVE

Assessing the Impact of Policies on Families

Family Impact Checklist: Using Evidence to Strengthen Families

Questions policymakers can ask to bring the family impact lens to policy decisions:

- How are families affected by the issue?
- In what ways, if any, do families contribute to the issue?
- Would involving families result in more effective policies and programs?

These questions sound simple, but they can be difficult to answer. The Family Impact Checklist is one evidence-based strategy to help ensure that policies and programs are designed and evaluated in ways that strengthen and support families in all their diversity across the lifespan. This checklist can also be used for conducting a family impact analysis that examines the intended and unintended consequences of policies, programs, agencies, and organizations on family responsibility, family stability, and family relationships.

Family impact analysis is most incisive and comprehensive when it includes expertise on (a) families, (b) family impact analysis, and (c) the specifics of the policy, program, agency, or organization. Five basic principles form the core of a family impact checklist. Each principle is accompanied by a series of evidence-based questions that delve deeply into the ways in which families contribute to issues, how they are affected by them, and whether involving families would result in better solutions. Not all principles and questions will apply to every topic, so it is important to select those most relevant to the issue at hand.

The principles are not rank-ordered and sometimes they conflict with each other. Depending on the issue, one principle may be more highly valued than another, requiring trade-offs. Cost effectiveness and political feasibility also must be taken into account. Despite these complexities, family impact analysis has proven useful across the political spectrum and has the potential to build broad, bipartisan consensus.

More detailed guidelines and procedures for conducting a family impact analysis are available in a handbook published by the Family Impact Institute at www.familyimpactinstitute.org.

Principle 1. Family responsibilities.

Policies and programs should aim to support and empower the functions that families perform for society—family formation, partner relationships, economic support, childrearing, and caregiving. Substituting for the functioning of families should come only as a last resort.

How well does the policy, program, or practice:

<u>Strong</u>	<u>Adequate</u>	<u>Limited</u>	<u>N/A</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Help families build the capacity to fulfill their functions and avoid taking over family responsibilities unless absolutely necessary?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Set realistic expectations for families to assume financial and/or caregiving responsibilities for dependent, seriously ill, or disabled family members depending on their family structure, resources, and life challenges?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Address root causes of assuming financial responsibility such as high child support debt, low literacy, low wages, and unemployment?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Affect the ability of families to balance time commitments to work, family, and community?

Principle 2. Family stability.

Whenever possible, policies and programs should encourage and reinforce couple, marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself. How well does the policy, program, or practice:

<u>Strong</u>	<u>Adequate</u>	<u>Limited</u>	<u>N/A</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strengthen commitment to couple, marital, parental, and family obligations, and allocate resources to help keep the marriage or family together when this is the appropriate goal?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Help families avoid problems before they become serious crises or chronic situations that erode family structure and function?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Balance the safety and well-being of individuals with the rights and responsibilities of other family members and the integrity of the family as a whole?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Provide clear and reasonable guidelines for when nonfamily members are permitted to intervene and make decisions on behalf of the family (e.g., removal of a child or adult from the family)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Help families maintain regular routines when undergoing stressful conditions or at times of transition?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recognize that major changes in family relationships such as aging, divorce, or adoption are processes that extend over time and require continuing support and attention?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	provide support to all types of families involved in the issue (e.g., for adoption, consider adoptive, birth, and foster parents; for remarried families, consider birth parents, stepparents, residential and nonresidential parents, etc.)?

Principle 3. Family relationships.

Policies and programs must recognize the strength and persistence of family ties, whether positive or negative, and seek to create and sustain strong couple, marital, and parental relationships.

How well does the policy, program, or practice:

<u>Strong</u>	<u>Adequate</u>	<u>Limited</u>	<u>N/A</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recognize that individuals' development and well-being are profoundly affected by the quality of their relationships with close family members and family members' relationships with each other?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Involve couples, immediate family members, and extended family when appropriate in working to resolve problems, with a focus on improving family relationships?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assess and balance the competing needs, rights, and interests of various family members?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Take steps to prevent family abuse, violence, or neglect?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acknowledge how interventions and life events can affect family dynamics and, when appropriate, support the need for balancing change and stability in family roles, rules, and leadership depending upon individual expectations, cultural norms, family stress, and stage of family life?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Provide the knowledge, communication skills, conflict resolution strategies, and problem-solving abilities needed for healthy couple, marital, parental, and family relationships or link families to information and education sources?

Principle 4. Family diversity.

Policies and programs can have varied effects on different types of families. Policies and programs must acknowledge and respect the diversity of family life and not discriminate against or penalize families solely based on their cultural, racial, or ethnic background; economic situation; family structure; geographic location; presence of special needs; religious affiliation; or stage of life.

How well does the policy, program, or practice:

<u>Strong</u>	<u>Adequate</u>	<u>Limited</u>	<u>N/A</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Identify and respect the different attitudes, behaviors, and values of families from various cultural, economic, geographic, racial/ethnic, and religious backgrounds, structures, and stages of life?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respect cultural and religious routines and rituals observed by families within the confines of the law?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recognize the complexity and responsibilities involved in caring for and coordinating services for family members with special needs (e.g., cognitive, emotional, physical, etc.)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ensure the accessibility and quality of programs and services for culturally, economically, geographically, racially/ethnically, and religiously diverse families?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work to ensure that operational philosophies and procedures are culturally responsive and that program staff are culturally competent?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acknowledge and try to address root causes rather than symptoms of the issue or problem (e.g., economic, institutional, political, social/psychological causes)?

Principle 5. Family engagement.

Policies and programs must encourage partnerships between professionals and families. Organizational culture, policy, and practice should include relational and participatory practices that preserve family dignity and respect family autonomy.

How well does the policy, program, or practice:

<u>Strong</u>	<u>Adequate</u>	<u>Limited</u>	<u>N/A</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Provide full information and a range of choices to families, recognizing that the length and intensity of services may vary according to family needs?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Train and encourage professionals to work in collaboration with families, to allow families to make their own decisions (within the confines of the law), and to respect their choices?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Involve family members, particularly from marginalized families, in policy and program development, implementation, and evaluation?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Affirm and build upon the existing and potential strengths of families, even when families are challenged by adversity?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Make flexible program options available and easily accessible through co-location, coordinated application and reimbursement procedures, and collaboration across agencies, institutions, and disciplines?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Establish a coordinated policy and service system that allows localities and service providers to combine resources from various, diverse funding streams?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acknowledge that the engagement of families, especially those with limited resources, may require emotional, informational, and instrumental supports (e.g., child care, financial stipends, transportation)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Connect families to community resources and help them be responsible consumers, coordinators, and managers of these resources?

- Build on social supports that are essential to families' lives (e.g., friends; family-to-family support; community, neighborhood, volunteer, and faith-based organizations)?
- Consider the whole family (even if it is outside the scope of services) and recognize how family decisions and participation may depend upon competing needs of different family members?

The Institute aims to strengthen family policy by connecting state policymakers with research knowledge and researchers with policy knowledge. The Institute provides nonpartisan, solution-oriented research and a family impact perspective on issues being debated in state legislatures. We provide technical assistance to and facilitate dialogue among professionals conducting Family Impact Seminars in 26 sites across the country.

The Family Impact Institute adapted the family impact checklist from one originally developed by the Consortium of Family Organizations. The suggested citation is
 Policy Institute for Family Impact Seminars. (2000). *A checklist for assessing the impact of policies on families* (Family Impact Analysis Series No. 1). Madison, WI: Author.

The checklist was first published in Ooms, T., & Preister, S. (Eds.). (1988). *A strategy for strengthening families: Using family criteria in policymaking and program evaluation*. Washington DC: Family Impact Seminar.

For more information on family impact analysis, contact the Family Impact Institute at Purdue University

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(765) 494-0979

www.familyimpactinstitute.org



Key Terms

Acronyms:

DCS: Department of Child Services

CWG: Child Welfare Policy and Practice Group

(this group conducted the recent audit of DCS ordered by Governor Holcomb)

CHINS: Child In Need of Services (this is a designation by a court of children determined to be “in need of DCS services”)

FSSA: Family and Social Services Administration

FDTCS: Family Drug Treatment Courts

PDMP: Prescription Drug Monitoring Program

INSPECT: Indiana Scheduled Prescription Electronic Collection and Tracking
(Indiana’s PDMP)

START: Sobriety Treatment and Recovery Team

Definitions:

Peer-coaches: Volunteers who work with parents in the child welfare system, who themselves: (1) are in recovery from drug and/or alcohol addiction – having achieved least three years of sustained sobriety, and (2) have had experiences relevant to child abuse and neglect and/or the child welfare system.

Recovery coach: A professional who: a) works with parents, child welfare caseworkers, and treatment agencies to remove barriers to addiction treatment; b) engages parents in treatment; and c) makes efforts to re-engage parents if necessary. Recovery coaches provide ongoing support to addicted parents and their families.

Substance-exposed infants: Infants who have been prenatally exposed to addictive substances due to maternal substance use during pregnancy. These infants often experience withdrawal symptoms shortly after birth as well as high risks for developmental abnormalities.

Title IV-E Waiver demonstration programs: These programs permit states to flexibly use federal funds to test new approaches to child welfare service delivery and financing. States can design a range of approaches to reforming child welfare and improving outcomes related to: safety, permanency, and well-being. These programs require a rigorous evaluation design (e.g., randomized clinical trial).

Medication-assisted treatment: The use of FDA-approved medications, in combination with counseling and behavioral therapists, to treat substance use disorders. Medications commonly used to treatment opioid addiction include Methadone, Naltrexone, and Buprenorphine.

Intensive case management: More involved case management than traditional models; case managers build relationships with clients based on trust and respect.

Permanency: In child welfare services, permanency planning refers to identifying and working toward a permanent living situation and permanent caregiver for a child.

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Sponsoring Organizations and Descriptions

The **Center for Families at Purdue University** focuses on improving the quality of life for families and strengthening the capacity of families to provide nurturing environments for their members. To accomplish this, the center works with four important groups whose efforts directly impact quality of life for families: educators, human service providers, employers, and policymakers. With informed sensitivity to family issues, these groups have the power to improve the quality of life for families in Indiana and beyond.

The Department of Early Childhood, Youth, and Family Studies at Ball State includes programs that promote the development, education, and well-being of children from birth through adolescence and foster healthy family functioning. Our impactful programs provide students with valuable training for real-world application, be it in the classroom, community, or the home. The Early Childhood Education programs focus on the preparation of teachers for preschool and K-3 classrooms, with an emphasis on engaging with families and community. The Family and Child program includes three interrelated concentrations: child development, child life, and family studies. Students graduate equipped to work in a variety of settings—from child care centers to hospitals to family service agencies—or primed to pursue graduate or doctoral studies.

Indiana Association for the Education of Young Children's (IAEYC) mission is to promote and support quality care and education for all young children birth through age eight in Indiana. Indiana AEYC is the state's largest and most influential organization of early childhood care and education professionals and parents promoting and supporting quality care and education for all young children. Over 2,200 members represented through sixteen local chapters, and a budget of over \$6 million dollars. Indiana AEYC supports early care and education professional development through the T.E.A.C.H. (Teacher Education and Compensation Helps) scholarship project, the Indiana Non Formal Child Development Associate (CDA) project and by conducting the largest statewide conference. Indiana AEYC also supports highest level of early care and education facilities by partnering with the Indiana FSSA/DFR/Bureau of Child Care to implement Paths to QUALITY™ and the Indiana Accreditation Project for over 820 early childhood facilities statewide.

The **Indiana Association of Marriage and Family Therapy** is part of the American Association of Marriage and Family Therapy. Since the founding of AAMFT in 1942, they have been involved with the problems, needs and changing patterns of couples and family relationships. The association leads the way to increasing understanding, research and education in the field of marriage and family therapy, and ensuring that the public's needs are met by trained practitioners. The AAMFT provides individuals with the tools and resources they need to succeed as marriage and family therapists.

The **Indiana CTSI** seeks to improve the health of individuals and communities by supporting highest-quality research and partnerships. We provide access to resources, services, training, education and funding opportunities.

Indiana Extension Homemakers Association® exists to strengthen families through continuing education, leadership development, and volunteer community support. We share information on new knowledge and research with our members and communities, promote programs on developing skills and family issues, and we support projects which help children and families in today's world.

Sponsoring Organizations and Descriptions (cont.)

Indiana Family Services represents families and respond to their needs by strengthening member agencies and creating alliances to promote excellence in advocacy and service for families throughout Indiana. Member agencies offer a wide variety of programs, including counseling, sexual abuse assessment, homemaker services, children's programs, services for victims of domestic violence, as well as many other diverse programs for over 90,000 individuals, approximately 80 percent of whom are low income. These services are offered regardless of race, creed, or color on a sliding fee scale supported by local United Ways and governmental grants.

The programs of Human Development and Family Studies and Youth Development at the **Indiana University School of Public Health – Bloomington** are dedicated to improving public health across Indiana through workforce development, community engagement, research, with teaching at the forefront of innovative public health education in Indiana. By reimagining public health through a comprehensive approach that enhances and expands disease prevention, the school is reshaping how parks, tourism, sports, leisure activities, physical activity, and nutrition impact and enhance wellness. With nearly 3,000 students in an array of undergraduate and advanced degree programs and more than 130 faculty in five academic departments our faculty and students conduct research, learn, teach, and engage with communities across a broad spectrum of health, wellness, and disease-prevention topics.

The **Indiana Youth Institute** promotes the healthy development of Indiana children and youth by serving the people, institutions and communities that impact their well-being. It is a leading source of useful information and practical tools for nonprofit youth workers, educators, policymakers, think tanks, government officials, and others who impact the lives of Hoosier children. In addition, it is an advocate for healthy youth development on the local, state, and national level.

MCCOY champions the positive development of youth through leadership on key issues, strengthening organizational capacity, and increasing the support of the youth worker community. As advocate, resource, capacity builder, and independent convener, MCCOY works to build a community where all youth can thrive, learn, engage, and contribute and where all adults support the positive development of youth.

The mission of the **National Association of Social Workers – Indiana Chapter** is to promote the quality and integrity of the Social Work profession while supporting social workers in their mission to serve diverse populations and to ensure justice and equality for all citizens of the state.

Purdue Extension Health and Human Sciences provides informal educational programs that increase knowledge, influence attitudes, teach skills, and inspire aspirations. Through the adoption and application of these practices, the quality of individual, family, and community life is improved. Health and Human Sciences Extension is a part of the mission of the College of Health and Human Sciences at Purdue University and the Purdue Extension Service.