Conference on Child, Adolescent and Young Adult Behavioral Health Research and Policy
Tampa 2015
WHO WE ARE

* An international consortium, a rich and growing community of faculty, implementation specialists, program administrators, developers, practitioners, and researchers.

WHAT WE DO

* Consortium members collaborate in technical assistance and research dissemination, and promote networks of learning about evidence-based practice, workforce development, and program

WHAT’S OUR PURPOSE

* Improving the lives of children, youth and families through effective program selection and implementation and workforce development.
Sessions Supported by the Evidence Based Practice Consortium

* **Session 3:** Workforce Development - Integrating academic and behavioral health care program responsibilities

* **Session 14:** Statewide Quality Improvement - Enhancing fiscal viability of child and adolescent mental health clinics

* **Session 36:** MST Building Stronger Families - The power of partnership with child welfare
Sessions Supported by the Evidence Based Practice Consortium

- **Session 47**: Using implementation science to improve child welfare trauma and behavioral health needs in 4 states
- **Session 57**: Centers of Excellence-Dissemination and implementation of evidence based practices within systems of care
- **Session 67**: Building the evidence for the RENEW Transition Model-Theoretical and methodological development
- **Session 77**: Implementation science applications to integrate evidence based practices into complex systems
Interested in Joining Us?

www.ebpconsortium.com

* Rosalyn Bertram, Co-Chair
  bertramr@umkc.edu

* David Bernstein, Co-Chair
  david.h.bernstein@du.edu
MST Building Stronger Families (MST-BSF): The power of child welfare partnership

Cindy Schaeffer, Ph.D.,
Medical University of South Carolina

Elisabeth Cannata, Ph.D.,
Wheeler Clinic

Christine Lau, MSW
Connecticut Department of Children and Families
Presentation Objectives:

• Provide an overview of the MST-BSF treatment program for families involved with the child welfare system due to abuse and neglect where parental substance abuse is identified as a significant concern/treatment need

• Present outcomes

• Articulate the benefits of partnership between model developers/consultants, behavioral health providers and the child welfare system in the development and adherent implementation of an EBP from each partner’s perspective

• Discuss potential barriers and facilitating factors to an effective partnership between behavioral health providers and child welfare to promote family safety and healing in high risk families.
History and Development of MST-BSF: Synergy of reciprocal needs

Child Welfare

Provider

Model Developers
History and Development of MST-BSF

- Child welfare system (DCF) looking for better family intervention for parental substance abuse
  - Rising rates of child maltreatment cases in CT involving substance abuse
  - Difficult to engage such cases in treatment services
  - High rates of reoccurrence (i.e., multiple CPS reports)
  - Already strong investment and positive experience with standard MST (Widespread statewide dissemination of MST for juvenile offenders in CT with successful outcomes)
History and Development of MST-BSF

- Provider (Wheeler Clinic) asking for enhanced intervention for MST clients where parental substance appeared to be interfering with sustainable gains for acting out teens receiving MST
  - Strong track record in adherent implementation of standard MST and MST adaptation
  - Experienced substance abuse treatment provider
History and Development of MST-BSF

• Model Developers (MST) looking to study effectiveness of model ADAPTATION for parental substance abuse

• Randomized clinical trial of MST for Child Abuse and Neglect (MST-CAN) in Charleston, SC just completed with promising results

• However, parental substance abuse had not been a focus in this research
History and Development of MST-BSF

- DCF leadership approached the Family Services Research Center requesting MST-CAN for families with parental substance abuse.
- Began search for a substance abuse treatment model that was:
  - Empirically-supported
  - Adaptable for use within a home-based service delivery model
  - Conceptually compatible with the 9 Principles of MST (e.g., strength-based, present-focused, action-oriented, involvement of natural ecology members)
- Reinforcement-Based Treatment (RBT), developed by Hendree Jones, Michelle Tuten, and Maxine Stitzer at JHU, was selected.
History and Development of MST-BSF

- Annie E. Casey Foundation provided support for model clinical integration activities:
  - Cross-model training
  - Treatment manual development
  - Quality assurance mechanisms
Full Partnership in the Development of MST-BSF

- Frequent meetings (at least 1x/week) during the first year, prior to taking cases, to specify and refine model components
  - State and local DCF stakeholders
  - Wheeler Clinic administrators and clinical supervisor
  - FSRC faculty
- Decisions made regarding:
  - Guidelines for collaboration between DCF caseworkers and MST-BSF therapists
  - Managing child safety in the event of relapses
  - Identifying and referring families
  - Training of DCF caseworkers in the MST-BSF model
- Stakeholder meetings (monthly) to oversee implementation continue today
MST - BSF Concept of “TEAM”

- Goes beyond the staff of the MST-BSF program
  - All cases assigned to a specific protective services team (workers and supervisor) at DCF who get trained in the model
  - DCF supervisor attends weekly MST - BSF consultation
  - Team also includes members of the client’s natural ecology

- Choreographed collaboration between the treatment provider team and the child protective services (DCF) workers:
  - DCF and MST share responsibility and management of the case at every level
  - Collaborative presentation of the program and expectations to the family
    - Initial “scripted” presentation to family enhances motivation
    - Clarifying rules and expectations at the start
    - “Relapse is part of recovery” and will not automatically result in removal of the children, if safety plan has been implemented
  - Periodic “Investment Check-ups” with family, MST-BSF and DCF throughout the intervention
MST Building Stronger Families
An Integration of Evidence-Based Practices to Improve Outcomes for Families
Parental Substance Abuse and Child Protection System

- A leading cause of child maltreatment
- Presents unique child safety concerns
- Necessitates multiple treatment providers
- Traditional SA treatment system not well adapted to needs of this population
- Have poorest outcomes of all CPS cases
Multisystemic Therapy – Building Stronger Families (MST-BSF)

• Designed specifically for co-occurring problem of parental substance abuse and child maltreatment
  ▫ One-stop shop: mental health, substance abuse, psychiatry, and case management
  ▫ Comprehensive treatment for all family members
  ▫ Services delivered in the home
  ▫ Risk management is shared between provider and child welfare

• Intensive – most appropriate when youth are at imminent risk of removal
The Multisystemic Therapy Approach

- Based on ecological systems and family systems theories
  - Behavior determined by systems in which individual is embedded
  - Ecology members main agents of change
- Present-focused and action-oriented
- Family strengths are levers for change
- Emphasis on personal responsibility
- Sustainability is a focus from beginning
Interventions Target Individualized Risk Factors for Child Maltreatment

**CHILD**
- Aggression
- Noncompliance
- Difficult Temperament
- Age
- Delayed Development

**PARENT**
- Depression
- Substance Abuse
- Low Self-Esteem
- Poor Impulse Control
- Antisocial Behavior
- Poor Knowledge of Child Development
- Negative Perception of Child
- History of Maltreatment as a Child

**SOCIAL NETWORK**
- Social Isolation
- Dissatisfaction with Social Supports
- Low use of Community Resources
- Limited Involvement in Community Activities

**FAMILY**
- Marital Status - Single
- Unsatisfactory Marital/Partner Relationship
- Spouse/Partner Abuse
MST-BSF Service Delivery

- Co-occurring SA and maltreatment in past 180 days
- At least one youth in report is ages 6-17
- An MST-BSF clinical team:
  - 3 masters-level therapists (full time)
  - 1 masters-level supervisor (full time)
  - 1 bachelors-level case manager (full time)
  - 1 psychiatrist or APRN (20% time)
- Caseload 4 families per therapist (max. 12 total)
- Services delivered in home and community
- 24/7 crisis availability
- 6-9 months of services
- Extensive quality assurance system
Empirically-Supported Interventions Delivered in an Ecological Framework

- All families receive:
  - Family safety planning – for maltreatment and relapses
  - Functional analysis of force/physical discipline
  - Reinforcement-Based Treatment (RBT) for substance abuse (parents)
  - Clarification of the abuse
  - CPS involvement in sessions and natural ecology interventions

- As warranted, families also receive:
  - Parent training interventions
  - Family/couple communication and problem-solving training
  - RBT for substance-abusing partners
  - Trauma treatment (TF-CBT for children, Prolonged Exposure for adults)
  - Evidence-based psychiatric care (20% dedicated time)
  - CBT for anger management
  - CBT for depression and generalized anxiety
Reinforcement-Based Treatment for Parental Substance Abuse

- Linkages to detox, medication management services, (e.g., suboxone), and recovery housing as warranted
- Functional assessment of substance use
- Functional assessment of periods of sobriety
- Drug testing multiple times/week and vouchers for clean screens
- Feedback session and other motivational interviewing techniques
- Behavioral contracting and behavioral graphing
- Cognitive-behavioral skill development (e.g., coping with cravings, drug refusal skills)
- Emphasis on employment and recreation as competing behaviors
- Weekly relapse prevention group
- Ecology member involvement
MST-BSF Pilot Study Design

- First 25 families served by MST-BSF (2005-2008)
  - Referred parent: 100% mothers
  - Self-report measures at pre/post treatment
- An additional 18 families who received Comprehensive Community Treatment (CCT) similar on key variables:
  - Mothers: age, ethnicity, number of previous CPS reports
  - Youth: age, gender, ethnicity, number of previous out of home placements
- Compared MST-BSF to CCT over a 2-year follow-up period
MST-BSF Pilot Study Participants

- Representative of cases served by DCF in New Britain, CT
- Mothers:
  - 79% Caucasian, 16% Hispanic, 5% African-American
  - Age $X = 38.9$ ($SD = 6.3$)
  - Primary substance abused:
    - Cocaine
    - Marijuana
    - Heroin
    - Alcohol
  - 91% had a prior CPS report; $X = 2.6$ reports ($SD = 2.6$)
- Children:
  - 44% female (target youth)
  - Age $X = 11.9$ ($SD = 3.7$)
  - 16% had experienced a previous out-of-home placement ($X = 0.44$ prior placements)
MST-BSF Pilot Study Results

• Strong preliminary support for the effectiveness of MST-BSF in addressing co-occurring child maltreatment and parental substance abuse
  ▫ Reductions in alcohol and drug use during treatment
  ▫ Improved mental health functioning
  ▫ Improved parent-child interactions
  ▫ Mothers 3 times less likely to have another incident of maltreatment
  ▫ Youth 2 times less likely to experience another incident (though not statistically significant)

• Medium to large effect sizes on clinically significant outcomes

• NIDA-funded Randomized Clinical Trial underway

Schaeffer, Swenson, Tuerk, & Henggeler (2013)
Model Developer Perspectives

- A facts-based universe
  - Real-world systems that care about science
  - Researchers that care about the real world
- Designing for “effectiveness” from the beginning
  - Accelerates the development and implementation of evidence-based treatment
  - Researcher “street cred” for dissemination efforts
- Consistent with Community Participatory Action Research principles
  - Home-grown, but scientifically-based
Partnering to Address Challenges for Child Protective Services
Substance Abuse and the Child Protection System

- Traditionally, families with substance abusing parents have poorest outcomes among all CPS cases
  - 2.5 times more likely to result in foster care placement

- As many as 10 providers may be called into the picture to help resolve the problem
  - Difficult for parents to meet CPS goals
  - Process alone may be iatrogenic
Traditional Treatments for Adult Substance Abuse are Incompatible with Parent Needs

- Inpatient detoxification facilities and recovery housing remove parents from children
- Treatment models focus on individual needs using individual and group treatments, rather than on family needs using family-based treatments
- Prevailing attitude is that “you can’t take care of anyone else until you take care of yourself”
  - Not an option for parents
BSF
Provider & CPS Team Approach:

- Builds trust
- Shared risk management
- Creates increased support network for therapist, DCF worker and family
Implications for Child Welfare, Treatment Systems, and Families

- “Culture shift” within child welfare system
  - Broader/deeper view of substance abuse and interventions to address it
  - Increased compassion for people in recovery
  - Wider range of options available
  - Shared risk model
  - Improved staff morale and retention

- “Culture shift” within treatment systems
  - Fully sharing the responsibility for risk and protection of children
  - Working partnerships with child welfare
  - Increased flexibility in treatment provision (e.g., recovery houses)
Implications for Child Welfare, Treatment Systems, and Families

- “Culture Shift” for families: increased trust and partnership with child protection, less adversarial

- Consistent with current state and federal child welfare focus and initiatives – e.g., child and family well-being, differential response, reduction in foster care placements, child and family teaming community partnerships
Contact information:

Cindy Schaeffer, Ph.D.,
Model Developer MST-Building Stronger Families
Medical University of South Carolina
schaeffc@musc.edu; tel. 410-970-6451

Elisabeth Cannata, Ph.D.,
Vice President Community-Based Family Services and Practice Innovation,
Wheeler Clinic, 91 Northwest Drive, Plainville, 06062 CT
ecannata@wheelerclinic.org, tel. 860 793-3547

Christine Lau, MSW Regional Administrator
Connecticut Department of Children and Families;
250 Hamilton Street, Hartford, CT 06105; christine.lau@ct.gov;
tel. 860 418-8312