STRATEGY BRIEF

STRONG FAMILIES

What is Connecticut's **Family-Based Recovery Program?**

In 2006, substance use by parents was a factor in half of the Connecticut Department of Children and Families' (DCF) out-of-home care placements for children under age 3.[1] In reviewing data, the agency learned that children who had a parent struggling with substance use disorders were more likely to remain in foster care longer and had lower reunification rates than their peers whose parents did not have a current substance use problem.[2] DCF leaders sought to understand why parents were struggling in spite of the agency's best efforts to provide substance use disorder treatment. Rather than ask why parents weren't succeeding in the programs, they flipped the question on its head and asked: "*Why are the treatment programs failing our parents?*"

DCF learned that parents who sought treatment for substance use disorders were often unable to find programs that addressed the twin struggles of both parenting and recovery, as most programs required they complete treatment outside their home and without their children in tow. These challenges created barriers to accessing and completing treatment, increased the likelihood of child welfare interventions and removals, and negated the motivation that parenting could provide in the recovery process.

To better address the needs of families impacted by parental substance use, in 2006, DCF collaborated with the Yale University Child Study Center (YCSC) and Johns Hopkins University to develop the Family-Based Recovery Program

casey family programs

(FBR). In 2007, DCF awarded contracts to implement the FBR model to YCSC and five community agencies throughout Connecticut, expanding that number to 11 in 2016.

What is FBR?

FBR is an intensive, in-home treatment program that provides substance use treatment, individual and group psychotherapy, parent-child support and developmental guidance, and comprehensive case management.[2] Acknowledging the close relationship between substance use and parenting struggles, and to more effectively and efficiently provide dual treatment for parental recovery and healthy parent-child attachment, the FBR program combines Johns Hopkins' Reinforcement-Based Treatment (RBT) for substance use disorders and YCSC's home-based parent-child program, which is grounded in attachment theory.[3] DCF developed and refined the FBR model for 10 years before initiating the Connecticut Family Stability-Pay for Success (PFS) project, which is an expansion of FBR (described in the accompanying brief, *How did Connecticut expand Family-Based Recovery using a social impact bond?*).

The main goals of the FBR program are to recover from substance use as evidenced by decreases in positive toxicology screenings, reduce repeat maltreatment, and reduce entries into out-of-home care. These goals are guided by the following principles:

- The ability to join together substance use treatment with attachment-focused therapy amplifies the circuitous nature of parenting and recovery.
- The pleasure of bonding with a baby and the satisfaction of competently parenting reinforce abstinence.
- Substance use recovery reinforces the ability to competently parent.

THE FBR APPROACH:[4]

SUPPORTS BEHAVIORS SUCH AS...	AVOIDS BEHAVIORS SUCH AS...
Listening	Arguing
Reflecting	Challenging/confronting
Affirming	Criticizing
Expressing empathy	Confronting with authority
Supporting self-efficacy	Rushing
Remaining objective	Judging and using critical words to describe parents, such as manipulative or resistant
Remaining open and curious about observations	Disagreeing
Reflecting observations to parent	Persuading with logic or evidence

A bold approach to treating families

Historically, child protective services (CPS) has responded to issues around substance use by removing children from their homes while their parents undergo treatment. However, DCF used FBR as an alternative response to substance use, adhering to two basic tenets: 1) parents can achieve recovery while parenting, and 2) bonding with a child and competently parenting can reinforce abstinence. Under FBR, DCF provides families with intensive, in-home treatment focused on both treating substance use, and understanding and responding to their child's unique developmental needs.

Keeping children at home while their parent receives treatment represents an innovative approach that requires treatment providers and the child protection agency to share not only the same philosophy, but also the inherent risks and responsibilities. While some worried about the possibility of a child fatality, the agency determined that such a risk exists where any system-involved child remains in the home, but that with the right set of interventions and supports, families can receive better and more timely services, and ultimately have more successful outcomes.[5]

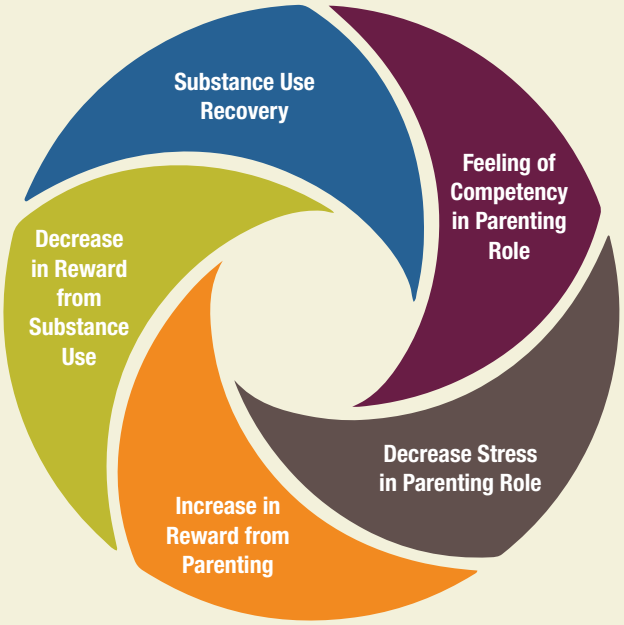
Core components

The treatment-specific goals of FBR are to help parents recover and succeed beyond abstinence, and to prevent future adverse experiences that may affect a child's overall development. To do this, clinicians work collaboratively with parents to:[2]

- Understand substance use patterns.
- Develop personalized recovery goals.
- Learn coping strategies to manage substance-use triggers.
- Increase recovery supporting behaviors.
- Address any mental health issues that may contribute to substance use.

PARENTING AS A COMPETING REINFORCER TO SUBSTANCE USE[4]

Joining substance use treatment with attachment-focused therapy addresses the interrelatedness of parenting and recovery.



> There was a deliberate effort to look at our mandates, cross-cutting themes, expectations that guided how we were going to do the work — how we were going to engage families differently — and then, operationalize that at the direct-service level all the way through to administrative supports.
>
> — CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES

Clinicians provide: individual psychotherapy; contingency management[6] substance use treatment; parent-child therapy; developmental screenings; group therapy; linkages to community resources; and on-call services. FBR clinicians use positive reinforcement as an effective means of producing behavior change, given that the best way to eliminate an individual's substance use is to offer *competing reinforcers*[4] that can take the place of substance use, such as an individual's child.

With regards to parenting, clinicians work to:[2]

- Increase parent's ability to read child's cues.
- Encourage warmth, sensitivity, and synchronicity in parent-child interactions.
- Use naturally occurring parent-child interactions to identify and support areas of change.
- Educate parents regarding child development and attachment.
- Utilize positive parent-child interactions as a primary reinforcement for parental recovery.

Model logistics

To qualify for the FBR program, parents report substance use in the 45 days prior to referral, and have a child under the age of 3 who either resides with the parent, is in foster care with a plan of imminent reunification, or is at-risk for removal from the home.[7] DCF policy requires FBR to operate with a "no waitlist" policy because it considers the families served by the program to be too high-risk to wait for services.[2]

Once enrolled, a family is assigned a team that consists of two master's-level clinicians and one bachelor's-level family support specialist for up to one year, with the average duration of treatment being 5.59 months.[8] The family can also access a clinical supervisor and a psychiatrist, as needed, and a clinical team member for around-the-clock crisis services.[2] During the first six months, the family has three 60-minute in-home sessions per week, with two sessions focusing on parental sobriety and mental health using John Hopkins' RBT model, and the third focusing on strengthening the parent-child bond and promoting healthy development through parent-child dyadic psychotherapy. After six months, the number of sessions decreases gradually to one visit per week. Staff also facilitate non-mandatory weekly group meetings, also known as a social club, where parents and children can access group therapy and peer support. FBR defines success as completing approximately six months of treatment and achieving at least three of five personal treatment goals.[2]

Engaging staff, providers, and the judiciary

While this new approach required a philosophical shift for DCF staff and partners, the agency was committed to generating widespread support for the model while also adhering to its key components. DCF created many different opportunities to bring stakeholders together for candid discussions designed to unpack misconceptions about FBR. DCF also adjusted its practices to facilitate a working relationship with FBR staff. Based on the FBR principle that strong

> The family thought they wouldn't have an opportunity and that their trajectory would look grim. Instead, they were met with an agency like ours and a provider that really joined with them in a proactive, non-adversarial partnership so they could remain intact and continue to be the parents they always hoped they could be for their children.
>
> — CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES

collaboration between DCF and FBR will support parents in maintaining custody of their children while working towards abstinence, DCF and FBR staff began conducting joint intake and home-visiting sessions, maintaining regular communication regarding participants, coordinating bi-monthly/monthly case reviews, and jointly developing safety plans for children in case a parent uses substances while enrolled in the program.

Additionally, DCF specifically engaged judicial partners early on to gain their support. DCF invested in building better relationships with parents' attorneys, with the aim of helping them to see how the agency was offering different supports to parents. The agency also worked to help judges understand the circumstances in which DCF might bring a case to court but not seek an order of temporary custody to remove a child, despite concerns for parental substance use. A key strategy to engaging the judicial partners was to illuminate the benefits of keeping children with their families, as well as the benefits of reducing long stays for those currently in out-of-home care.

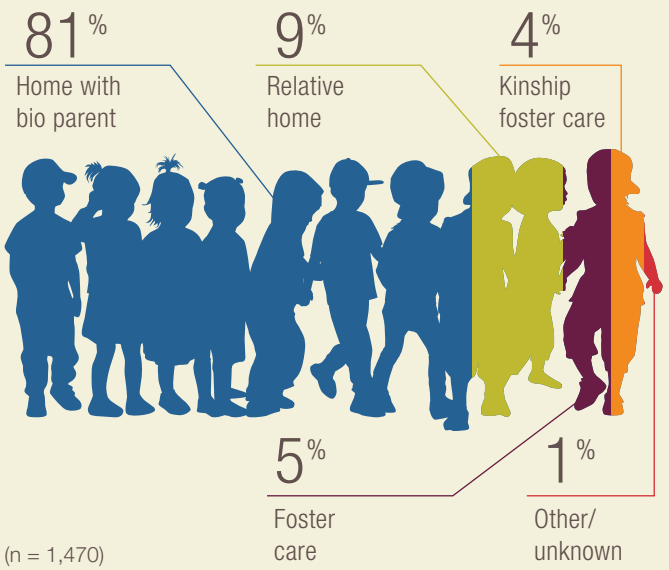
Impact and outcomes

Data collected between 2007 and 2017 showed:[8]

- 85 percent of FBR participants were mothers, 5 percent were fathers, and in 10 percent of cases, both parents participated in the program.
- Most parents were Caucasian, single, and had a high school diploma or lower, and the families earned an average monthly gross income of $661.49.
- Most of the children participating were 0-6 months of age, with a near equal distribution between boys and girls.

Throughout treatment, FBR utilizes a number of assessments to measure critical outcomes of parental abstinence, placement of child at discharge, and parental wellbeing. Information from those assessments is entered into a web-based system and monitored over time. Assessments include:

CHILD'S PLACEMENT AT DISCHARGE[4]



- Specific to parental substance use and mental health, a bio-psycho-social screening is completed during intake, and the Brief Substance Abuse Assessment, Functional Assessment, and Global Appraisal of Individual Needs are completed at intake and discharge.
- Each in-home session includes a urine toxicology screening and breathalyzer test to track sobriety.
- Specific to the parent-child relationship and child development, the parent-child clinician completes three assessments to measure changes in symptoms of parental depression, parental stress, and parent-child bonding: The Edinburgh Postnatal Depression Scale, The Parenting Stress Index-Short Form, and the Postpartum Bonding Questionnaire. All three are administered at intake, 90-day intervals, and discharge.
- The Ages and Stages Questionnaires (also known as ASQ-3) and the Ages and Stages Questionnaires-Social-Emotional are completed quarterly.

FBR has a 93 percent engagement rate. An analysis of data collected between 2007 and 2017, on 1,155 families, provides evidence of the high impact that FBR has on participating families.[8] As an example, there is statistically significant evidence that caregivers in FBR treatment experienced reductions in depression and parental stress, and enhanced parental bonding with their children, as well as decreased levels of substance use over time.[8] Of the active clients whose toxicology screens were analyzed, 50 percent tested positive for substance use in the first week of FBR treatment. However, at week five, only 28 percent tested positive, and at week 20, only 15 percent tested positive.[8] These results have contributed to FBR's ability to **successfully discharge 11 percent more clients than the national average for intensive outpatient treatment programs.**[2]

FBR also has led to statistically significant reductions in the rate at which children are placed in out-of-home care and the rate of re-referrals to DCF compared to children and families not receiving FBR treatment.[2] For example, during the 10-year period studied, **81 percent of children living at home at the beginning of treatment remained in home at the end of their parents' treatment.**[2] **As of July 2017, data showed that 77 percent of 1,155 FBR families had no report of abuse or neglect filed during the course of treatment.**[8]

These findings illustrate the success FBR has had in achieving its main goals of recovery, reduced maltreatment, and reduced entries into out-of-home care.

To learn more, see related resources at casey.org/family-based-recovery.

1 Information for this strategy brief was shared through an interview with the Connecticut Department of Children and Families on April 9, 2018. The interview included Elizabeth Duryea, Chief of Staff, Kristina Stevens, Deputy Commissioner, and Mary Painter, Director of the Office of Intimate Partner Violence and Substance Use Treatment and Recovery.

2 Hanson, K. E., Saul, D. H., Vanderploeg, J. J., Painter, M., & Adnopoz, J. (2015). Family-based recovery: An innovative in-home substance abuse treatment model for families with young children. *Child Welfare, 94*(4), 161-183.

3 Attachment theory purports that a strong emotional and physical attachment to at least one primary caregiver is critical for a child's social and emotional development.

4 Painter, M. (2018). *Family-Based Recovery: An Innovative Model for Integrating Substance Use Disorder Treatment with Infant Mental Health*. Presentation to Casey Family Program's Board of Trustees, November 14, 2018.

5 While a few child fatalities occurred during this period, the state was able to maintain the FBR program and is making program adjustments that focus on safe sleep, given that it was determined to be a leading factor in the fatalities.

6 Contingency management is a behavioral therapy in which individuals are rewarded and their actions are positively reinforced when there is evidence of positive behavioral change. In this case, retaining custody of their child.

7 Yale School of Medicine. (2011). *FBR model overview* [PowerPoint]. Retrieved from http://cmhconference.com/files/2011/conferencepresentations/tuesday/Sessions37-45/44-BuccaneerC/TampaMarch222011forweb.pdf

8 Hanson, K. E., Duryea, E. R., Painter, M., Vanderploeg, J., & Saul, D. H. (2019). Family-based recovery: An innovative collaboration between community mental health agencies and child protective services to treat families impacted by parental substance use. *Child Abuse Review*.

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