

The Family Engagement Program

A Product of the Massachusetts Family Recovery Collaborative

Concept Paper – Draft

Introduction:

The Massachusetts Family Recovery Collaborative, a partnership between child welfare, substance abuse, juvenile court, and tribal systems, addresses systems linkage and services integration related to families involved in the child welfare system who have identified substance abuse problems that contribute to child safety and neglect. The Family Engagement Work Group, a component of the Family Recovery Collaborative, has developed a family engagement program to improve access, referral, and retention into substance abuse treatment and other community services, with the ultimate outcome of improving child safety and permanency. This concept paper outlines the purpose for this model as well as the program elements, cost estimates, and implementation strategies.

Purpose and Desired Outcomes:

The primary purpose of the Family Engagement Program is to improve access, referral, and retention into substance abuse treatment and other community services for Massachusetts' families involved in the child welfare system. Substance abuse plays a critical role in families referred to the child welfare system; nationally, an estimated 60-90% of families in the child welfare system have been identified as needing substance abuse treatment. The federal timelines enforced in the Adoption and Safe Families Act require children who are removed from the home to either be reunified with their families or have an alternate permanent plan in place within 12 months of removal. These families often have difficulty initially engaging in traditional treatment or other services required as part of their child welfare services plan. In FY 2004, Bureau of Substance Abuse Services data showed that only 4% of approximately 49,000 treatment admissions self-reported as being involved in the child welfare system. However, on average, DSS drug tests 1000 women a month across the state, and of these, approximately, one third are positive. Clearly, more integration and collaboration is needed related to client engagement and retention in care. The primary objective of the Family Engagement Program is to aggressively engage these families and facilitate their access, enrollment, and retention in substance abuse treatment, which is viewed as fundamental to their child welfare service plan compliance.

Specifically, the desired outcomes of the Family Engagement Program are:

1. To reduce the amount of time required to gain access to treatment.
2. To increase the number of child welfare families who remain in treatment beyond 90 days.
3. To reduce the number of families that require children to be removed.
4. To reduce the length of time a child remains in out-of-home placement.

Focus of the Family Engagement Program and Referral Process:

The Family Engagement Program focuses on families involved in the child welfare system who have been identified as having substance abuse problems. Due to the permanency mandates of the Adoptions and Safe Families Act, families whose children are removed from the family, and who have

a goal of reunification, will receive priority. The next priority will be those families who are at imminent risk of having their children removed.

All referrals will come from DSS. Referrals will include families in the child welfare system with unaddressed substance abuse issues who are not engaged in treatment services. Priority will be given to child-welfare, court-involved families.

The standard for the Family Engagement Program is to make direct contact with the family within 24 business hours of referral.

Program Description:

Program Philosophy

The Family Engagement Program utilizes a values-based model emphasizing the “culture of recovery” to engage families referred. Use of professionals and peer mentors will operate within the Stages of Change model and employ motivational interviewing techniques. Service delivery will be family-centered, child-driven, strengths-based, and community-based within the home or neighborhood. Services will be delivered free of judgment and provided with kindness, responsibility, consideration, and respect. This is important for several reasons:

- 1) Values-based services will ensure the greatest level of accessibility to difficult-to-engage individuals. Those with severely impaired self esteem simply will not access and utilize a service that does not heighten their sense of self worth and their sense that someone “cares”.
- 2) Values-based services are necessary for the creation of a “recovery culture” within a service facility, since the traditional recovery culture is based on the acquisition of a positive, healthy values system. The staff should be able to model these qualities in order for the clients to begin to learn appropriate behavior and attitudes.
- 3) Values-based service delivery enhances the client’s ability to go through the necessary shift in belief system, behaviors, and appreciation of one’s relationships and interactions with others, which generally occurs if the recovery process is successful.

The family is seen as central to the team and can express their voice in determining their needs and goals. The family describes what they want their life to look like and how they think they can get there or make it happen, and what they need from others. DSS professionals, families, providers, and court personnel, including probation and counsel for parents and children as appropriate, must be a part of a team working to achieve shared outcomes and participate in case coordination meetings.

The team would provide on-going feedback into the development of the services provided by the Family Engagement Specialist. At the same time, the Family Engagement Specialist would provide ongoing communication and project education with DSS Area Offices.

Program Components

There are three components to the Family Engagement Program, each designed to support families in the early recovery process while they navigate the demands of the requirements of the child welfare and juvenile court systems. These components are outlined below:

Primary Engagement Service:

The primary goal of this component is to engage families and link them to substance abuse treatment services. Research shows the efficacy of substance abuse treatment improves the longer one stays in treatment. Once these linkages have been established and the families have been enrolled in treatment, the Family Engagement Staff will continue to offer services until the family has engaged in a consistent and appropriate recovery program of at least 90 days duration.

Service activities during the Primary Engagement Phase include initial overview of family needs, including substance abuse, mental health, domestic violence, children's services, housing, health, and other needs, utilizing the Stages of Change model. The Family Engagement Staff will link the family to needed services through resource coordination and advocacy. Families are supported in their relationships with DSS professionals and are provided Family Mentors who train parents how to facilitate positive outcomes to meet mutually developed goals.

Family Engagement staff will focus on initial access to substance abuse treatment, transitioning between treatment programs, and accessing mental health and/or domestic violence services. Family Engagement staff will assist clients by enhancing treatment motivation and follow through for these services, including reducing barriers to treatment, and matching families to appropriate treatment services. Concrete supportive services could include assisting with arrangements for transportation, childcare, after school programs, job training, employment, education, and parenting education and advocacy. These services are coordinated by staff when required as part of the comprehensive case management services provided during this time. The Family Engagement staff will assist in the integration of psychoeducation materials related to family health, parenting, risk reduction, HIV/Hep C and TB risk assessment, drug interactions, self-medication, and medication compliance.

Peer Support Groups:

A key tenet of the culture of recovery is the principle of experiential authority. People who have "walked in the same shoes" can often establish credibility with families who are fearful and distrustful of the "system." Peer-facilitated groups would be established to help support families as they become involved with the treatment system and move into early recovery while being involved with the child welfare system. Staff will offer substance abuse psychoeducational groups to families. These groups will include discussion of what to expect in substance abuse treatment programs, as well as basic substance abuse education. Additional groups will also nurture and support the family's relationship with the child welfare system. "Developing a Relationship with DSS" is a training module that has been developed by the Massachusetts Organization for Addiction Recovery. Both groups will be facilitated by staff and peer facilitators. In the event of waiting lists for treatment or as an aftercare support, these support groups provide the unique element of offering recovery support and guidance for families involved in child welfare.

Follow-up and Retention Services:

Once a parent has achieved a consistent and appropriate recovery program of at least 90 days duration, they enter the Follow-up or Retention Phase of the program. The purpose of follow-up and retention is to continue to support the family after initial treatment engagement has occurred. The literature recognizes the key variable in determining positive outcomes for substance abuse treatment is “length of time in treatment.” The Family Engagement staff continue to follow the parents as they either remain engaged in primary treatment or are transferred to aftercare services and support. Continuing treatment, community-based support, coaching and orientation to the “culture of recovery”, are key objectives of this phase of treatment.

An element of the intensive engagement and case management services provided at all levels of this program is the identification and utilization of community and other resources. Examples of community resources are local substance abuse treatment providers, local and/or regional resources for mental health, domestic violence, housing, employment, and other social services. Equally important, though, are natural resources occurring within the family’s immediate access. These may include supportive family members or neighbors, 12 Step sponsors, churches, or other individuals or organizations the family identifies. The general standard is to utilize family and community resources whenever possible to avoid over-dependency upon formal services and to solidify future support networks for families

Staffing Structure and Cost Estimates:

Primary service delivery is accomplished through a team of staff members comprised of master and non-master leveled staff in the role of Family Engagement Specialists. It is important for some staff to have recovery experience. Training will be a key component of this model. All staff will be trained and supervised regarding adult mental health and trauma issues, and in utilizing a team approach. Staff will be culturally competent, reflecting the racial and ethnic diversity of the population to be served and will be recruited for language capacity.

Each staff person is estimated to be able to serve an average of 15 families at any given time. Flexibility must be maintained to accommodate individual family dynamics and readiness for change. Service estimates are based upon case loads turning over approximately 2.25 times per year. Access to the Family Groups are open-ended and not included in case load estimates.

Each program site will provide services to 3 or 4 DSS area offices, serving approximately 100 families per year.

1.0 Program Manager	\$52,000
.80 FTE Supervisor	(\$50,000 FT); \$40,000
12.0 Family Engagement Staff	512,000
1.0 Support	\$33,000
Total Salaries	\$637,000
Taxes and Fringe (25% salaries)	\$159,250
Program-related expenses (including travel, office supplies, occupancy, etc)	\$46,598
Indirect costs (13% of total)	\$107,152
TOTAL	\$950,000

Cost estimates are based upon actual costs of the Family Engagement Pilot Project conducted by the Institute for Health and Recovery under contract to the Department of Social Services. This pilot Substance Abuse Engagement Project took place in 2004-2005 in three DSS area offices in the Northeast region of Massachusetts. Based on the proposed staffing structure, the cost of serving 13 DSS area offices would be approximately \$950,000/year, serving approximately 400 families in three regions the first year of implementation.

Utilizing the same staffing model and cost estimates, the Family Engagement Project would provide services to the remaining DSS area offices during FY 08.

In developing a funding strategy for this program, certain principles are employed. These principles form the foundation for preliminary funding as well as the subsequent development and sustaining of these services. These principles are shown below:

Implementation:

Implementation of the Family Engagement Program will be accomplished over two years through the regional service areas of DSS. Identified roll out for the program will be accomplished by utilizing target populations served by DSS Regions or Offices. Sites of similar size will be used for comparative evaluation to measure the impact of the Family Engagement Program. As additional sites are added in the second year, comparative data from outside of the service areas will continue to be used as the bench mark for evaluating program progress. The schedule for a two-year implementation strategy is estimated as follows:

1 st Year of Implementation	Total of 13 DSS offices covered (half of state)
--	--

(1 site covers 3 or 4 DSS offices)

2 nd Year of Implementation	Total of 29 DSS offices covered (remainder of state)
--	---

Full implementation is considered when all the service areas of DSS have access to the Family Engagement Program, by the 2nd year of the project.

Evaluation:

Evaluation is prioritized to collect data on the indicators that measure proposed outcomes for the Family Engagement Program. In addition, process indicators can be used to evaluate the effectiveness of program procedures and implementation. In order to evaluate the impact of the Family Engagement Program, data systems will be required statewide. During the first year of the implementation strategy, baseline data will be established in those regions or area offices not served by the Family Engagement Program services, and compared to those target areas that are receiving such services. Sample outcome and process measures will be evaluated as shown below:

Outcome: Reduce the amount of time required to gain access to treatment:

The Family Engagement Program will expedite the process of engaging people into treatment compared to those families who do not receive family engagement services.

Outcome: Increase the number of child welfare families who remain in treatment beyond 90 days:

The number of child welfare families who remain in treatment beyond 90 days will be increased compared to those families who do not receive family engagement services.

Outcome: Reduce the length of time a child remains in out-of-home placement:

The average amount of time a child remains in out-of-home placement will be reduced by an average of three months compared to those families who do not receive family engagement services.

Outcome: Reduce the number of families who have had children removed from the family:

The number of families who need to have children removed will be decreased compared to those families who do not receive family engagement services.

Additional process measures that may be used to evaluate program implementation include: the number of referrals, number of families served, average number of visits during Primary Engagement and Follow-up Phases, average length of time from initial referral to first meeting with Family Engagement staff, average length of time with families in Primary Engagement and Follow-up Phases, the number of families utilizing Peer Support Groups, and the number of negative drug screens during the Follow-up Phase. Collateral information may also include the numbers of referrals to mental health, domestic violence, and community programs, number of ER visits and psychiatric services, and number of families with subsequent child welfare or legal involvement.