Nebraska's Response to Substance Abusing Parents in Child Welfare

A Review of Cases that Opened in 2009

COURT IMPROVEMENT PROJECT

2011

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Purpose

This report summarizes some of the major findings of a study undertaken by the Nebraska Court Improvement Project in conjunction with the National Center on Substance Abuse and Child Welfare (NCSACW) In Depth Technical Assistance (IDTA) effort. The NCSACW IDTA project seeks to improve systems and practice for families with substance use disorders (SUD) who are involved in the child welfare and family judicial systems and includes the participation of several divisions of the Nebraska Department of Health and Human Services (DHHS) and the Nebraska Judicial Branch.

Throughout this report commentary from Nebraska's IDTA Consultant, Pamela Baston, will appear in these orange boxes.

Summary of Findings from the Nebraska Study

1. **Majority of Child Welfare Cases have Substance Abuse Related Problems:** 56% of child welfare cases had substance abuse (SA) identified as a problem in the case record.

Nebraska's percentage is in line with data from national studies that report a range of 33%-66%.[1] The finding of 56% is also in range, albeit on the low side, of the results from a survey of NE judges in June of 2010 that reflected estimates that 50-85% of NE's child welfare cases that come before their courts have parental substance abuse as a factor in the maltreatment. Early identification and treatment of families with substance use as a factor in the parental maltreatment of children is essential to successful outcomes for these affected families.

2. **Majority of Cases have Children Removed:** Children were removed from their parents at some point in 84% of all cases.

This percentage is a bit higher than the national estimates of 66%-70% of out of home placements with substance use as a factor.[2] Importantly, this represents an important area of potential practice change and cost savings for Nebraska if less costly and more innovative solutions are explored. Many other states have experienced success and realized cost savings by using more in-home therapeutic service models as well as innovative housing models for substance affected families that provide intensive family services at rates lower than out of home placement or traditional residential treatment.

3. **Most SA Parents also have Mental Health Problems:** 85% of parents with SA identified also had a mental health problem identified.

> *Substance abuse and child maltreatment often co-occur with other problems, including mental illness, domestic violence, poverty, health problems, and prior child maltreatment.* [3] *These co-occurring problems produce extremely complex situations that can be difficult to resolve without timely and effective treatment. Nebraska's integrated system of behavioral health sets the stage for the delivery of effective treatment as long as these families are identified early and referred to treatment and it is evidence-based and delivered by sufficiently qualified and trained professionals.*

4. **Many SA Parents also have Domestic Violence Issues:** 40% of parents with SA identified also had domestic violence issues identified.

> *This finding is not surprising and appears to be lower than national averages. The US Department of Justice found that 61% of domestic violence offenders also have substance abuse problems.* [4]

5. **SA Parents Face Long Delays to Start Treatment:** A large majority of the SA problems were identified at or close to the time of entry into the legal system….but the median time to the start of treatment is over four months after the filing of the original petition. There were significant delays to treatment start in both the urban (Separate Juvenile Courts) and rural (County Courts) parts of the state.

> *While the data reflected these concerning delays, they do not provide the reasons behind the delays (whether the client was in jail, uncooperative or if the delay was due to a system lag). Either way, it will be important to conduct follow up focus groups and further data collection to better understand how this important issue can be addressed.*

6. **Many SA Parents Get a Lower Level of Treatment than they Need:** Approximately 1/3 of mothers and 1/4 of fathers are provided outpatient treatment (not intensive outpatient). Mothers in rural areas were twice as likely to get a more intensive level of treatment (intensive outpatient instead of regular outpatient) than mothers in the urban areas. There were insignificant rural-urban differences for fathers.

> *It will be important to take a closer look at the actual dosage of treatment that is being provided in the non-intensive level of outpatient treatment to ensure that it is sufficient to address the extent of treatment need that is typically associated with someone whose substance use has risen to the level of contributing to the maltreatment of their own children.*

7. **Entry into SA Treatment System is Inconsistent:** Some cases began with a generic pre-treatment assessment that is followed by an SA assessment and some began with a more specified SA assessment /evaluation.

These data combined with testimony received through follow up meetings held in several venues throughout Nebraska suggest that a great deal of confusion exists as to if and when a pre-treatment assessment is needed. It was reported to be a barrier for families that readily acknowledged having a substance abuse problem and wanted treatment but experienced delays in scheduling and participating in a screening process. In such cases it may make sense for such parents to bypass a screening process and go straight to assessment so that entry to needed treatment can be expedited. Policy and practice clarification may be needed to address this potential barrier, particularly in rural areas where screening appointments were reported to take several weeks to effectuate.

8. **Many Substance Abusing Parents "Drop Off" the Treatment Trajectory:** A drop off analyses illustrates that 25% of parents with identified SA are never referred for an assessment or evaluation and that there is further attrition from the trajectory to treatment as the cases progress.

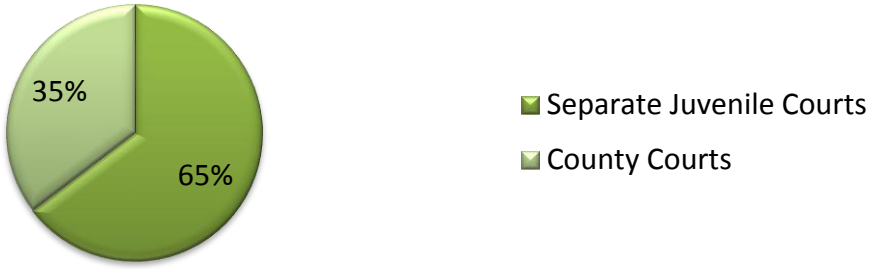
While "drop-off" is expected in any system, a more in-depth follow up is needed to better understand the reasons behind the drop off so that relevant solutions can be planned and implemented. One thing is certain, parents with substance use disorders may drop off the path to treatment but their substance use problems and the associated effects on parenting do not drop off along with them.

9. **Drug Testing is Frequently Used without Treatment:** Over a third of the cases had parents who never received treatment participate in urinalyses (UAs). There were a small number of cases where parents participated in UAs without any evidence of SA in the record.

Drug testing is an important tool to assist in the identification of SUDs and simply identifies the level of alcohol and/or drugs in a parent's system at a single point in time. It does not alone provide enough information to determine the need for treatment, the effect on safe parenting or the level and type of services needed by the affected family. Nor does drug testing equate with treatment. More study is needed on this issue to understand the implications of these data and to identify and implement possible solutions.

Overview of Cases Reviewed – 379 Cases Total

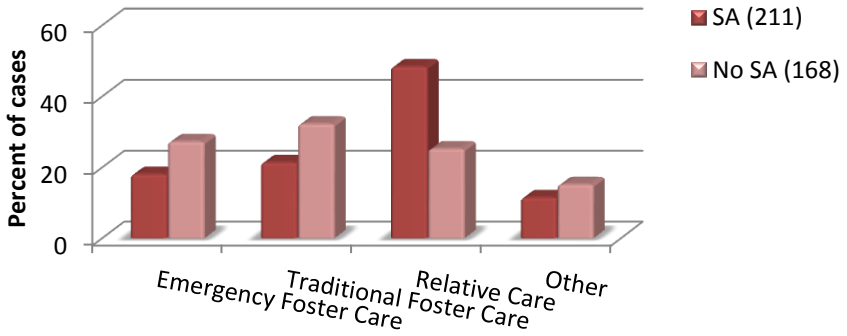
LOCATION OF CASES REVIEWED



- 45% of cases reviewed had closed by the date of case file review
- In 84% of cases children were at some point removed from the home during the pendency of the case
- Median number of children per family: 2

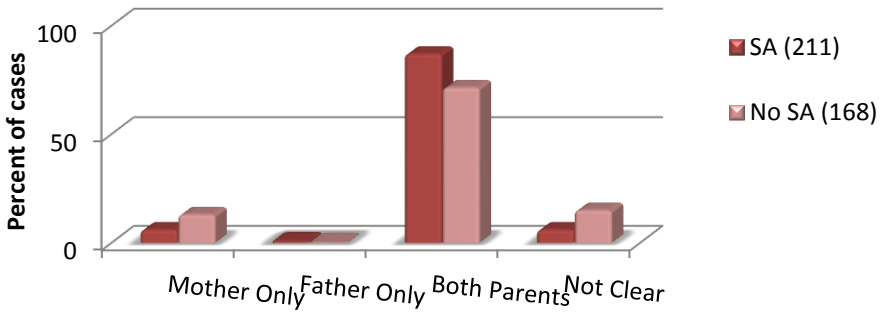
Out-of-Home Placement

PLACEMENT TYPE FOR FIRST PLACEMENT OF CHILD



The use of relative care placement for out of home care is substantially greater for Nebraska families with SUD than for those with no documented SUD. These relatives are likely to play an ongoing role in assisting the substance-involved parents in maintaining their recovery during and after treatment. This presents a tremendous opportunity to include these relatives, as appropriate and with proper consent, in the SUD treatment planning and recovery support provided to these parents and their children.

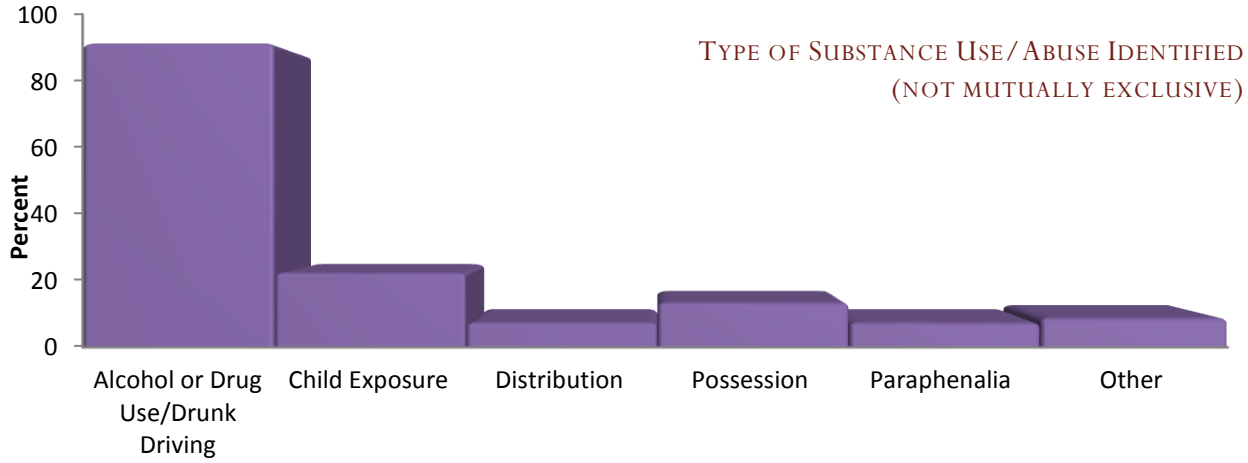
Parent Involvement:



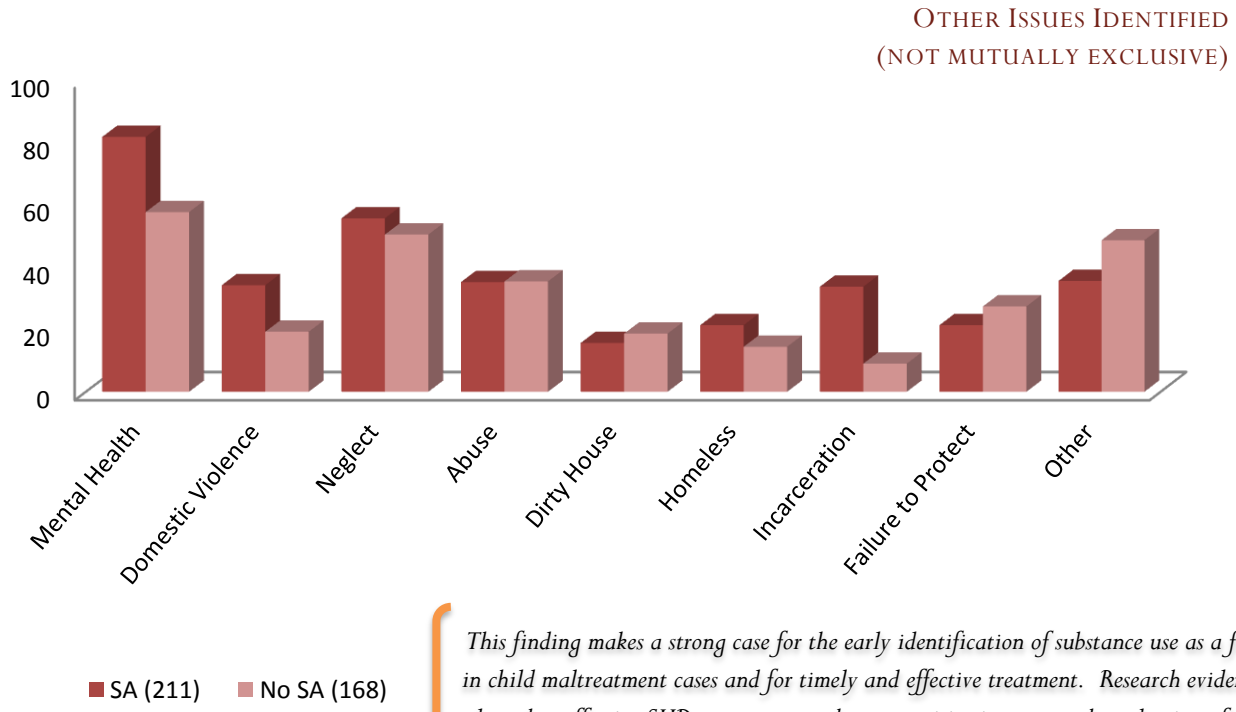
This finding makes a strong case for the delivery of comprehensive family treatment as an untreated partner is a major contributor to the relapse of the other partner. [5]

How Prevalent is Substance Abuse in Child Welfare?

To examine the prevalence of substance abuse in child welfare, cases were reviewed, and any indication of substance abuse noted in the file at any point in the case was captured. A total of 211 cases were found where there was some indication of substance abuse for at least one parent. **This accounts for 56% of cases.** Substance abuse was identified in **58%** of the 3a cases in the Separate Juvenile Court and in **51%** of the cases in the County Courts with juvenile jurisdiction.



How often do other factors co-occur in substance abuse cases compared to cases without substance abuse?



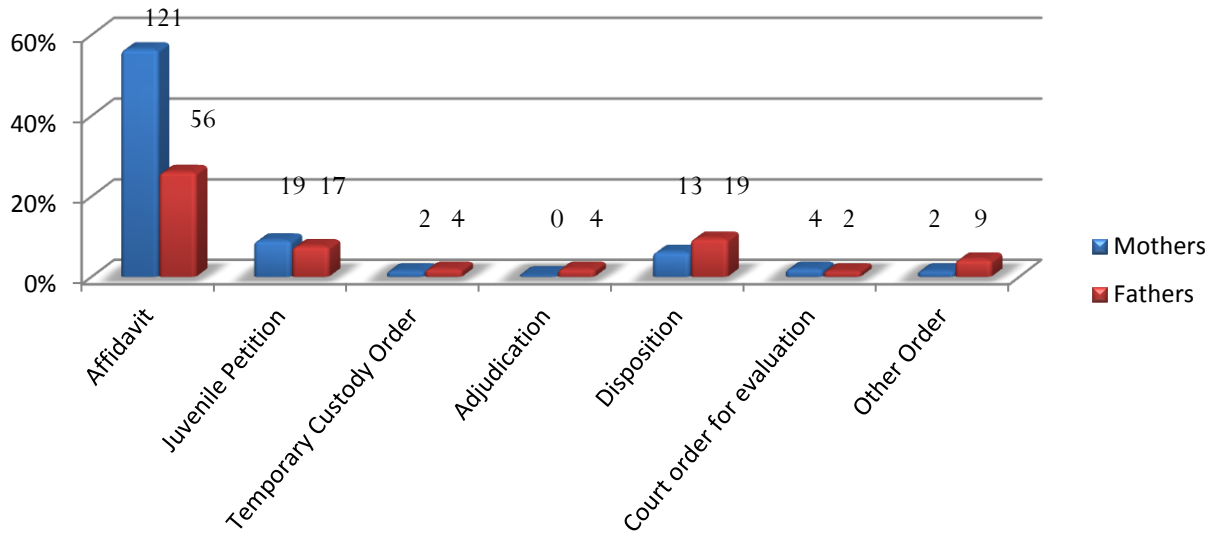
This finding makes a strong case for the early identification of substance use as a factor in child maltreatment cases and for timely and effective treatment. Research evidence is clear that effective SUD treatment can have a positive impact on the reduction of other health and human service problems and associated costs.

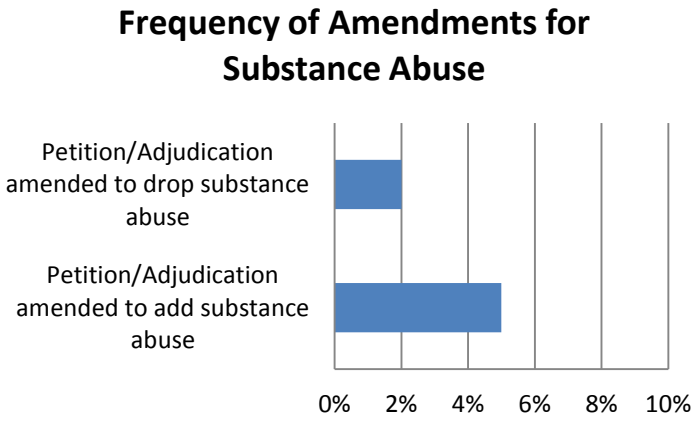
How early are we Identifying Substance Abuse?

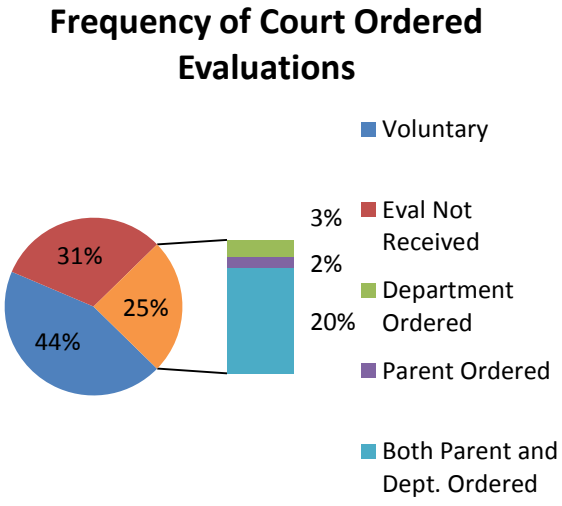
Legal Progression Overview

	SA Cases (211)	Non- SA Cases (168)
Median Days from Affidavit for Removal to Juvenile Petition:	1 day	1 day
Median Days from Petition to Temporary Custody Order:	8 days	11 days
Median Days from Temporary Custody Order to Adjudication:	49 days	59 days
Median Days from Adjudication to Disposition:	47 days	47 days
Median Days from Juvenile Petition to Court Ordered Evaluation	40 days	NA

Figure 5. Frequency of First Substance Use Identification across Legal Orders



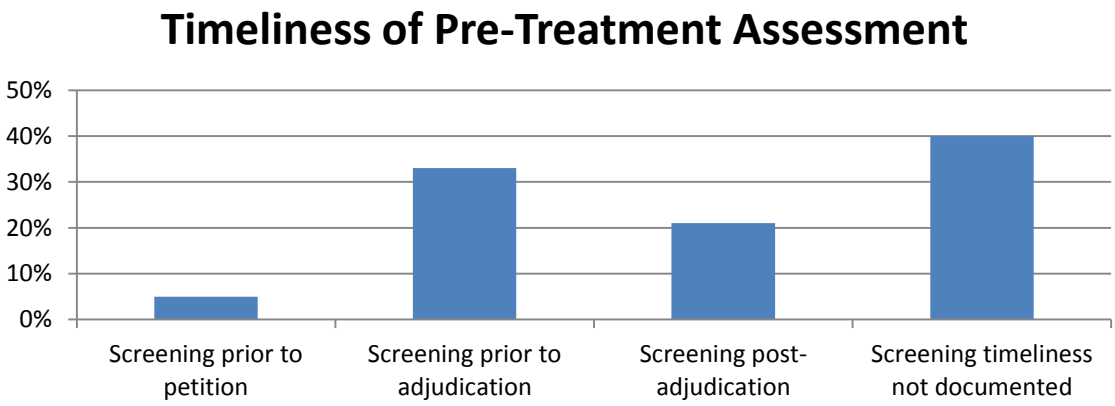




Identification of Substance Abuse

The charts presented thus far indicate that, especially for mothers, substance abuse is generally identified fairly early in the case. Identification of substance abuse by fathers occurs somewhat later which may be due to a delayed identification of the involvement of fathers in the child welfare cases altogether. Petitions and amendments were rarely amended to either drop or add substance abuse as a factor in the case. This finding suggests a potential missed opportunity to promote maximum recovery among substance affected families in Nebraska's child welfare system. Most cases had voluntary evaluations, suggesting that they were arranged early in the case, well before the disposition.

How long are the Steps to Treatment?



Timeliness to Substance Abuse Screening

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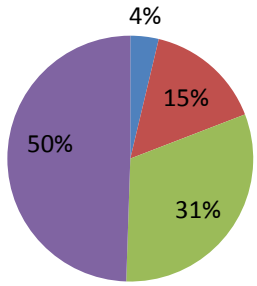
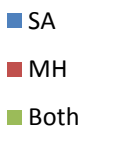
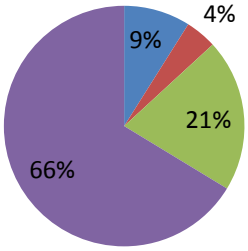
	Mothers	Fathers
Among cases where substance use or abuse was identified (211 cases) –		
Frequency of **referral** for pre-treatment assessment:	117 (60.3%)	79 (44.4%)

196 of 379 (51%) of the child welfare parents included in the study sample received a referral for a pre-treatment assessment. An area that may be worthy of additional exploration is a more in-depth look at whether this pre-treatment assessment process serves as a barrier to treatment access by creating an additional step before a full-blown assessment is conducted or whether these efforts are (or can be) combined into one step to lessen the burden on the client.

Identified in screening:







Mothers (101 received a PTA)

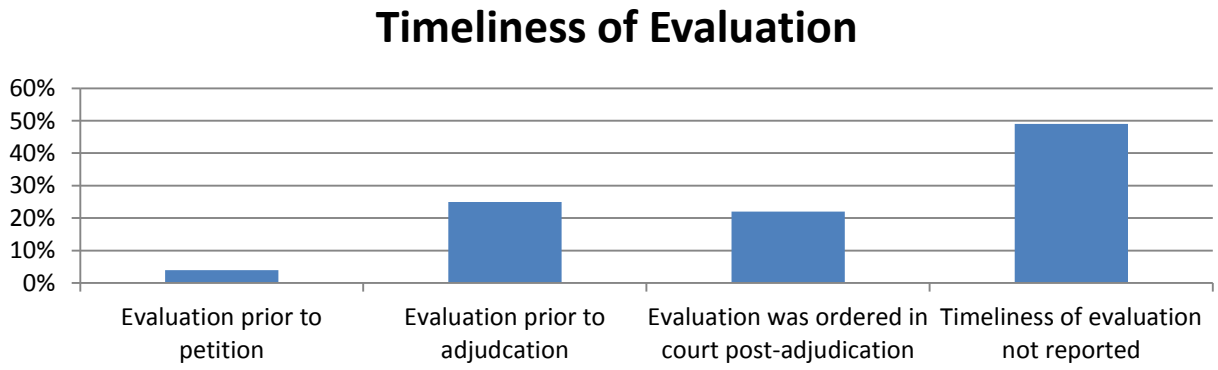
Fathers (68 received a PTA)

Median time from juvenile petition to PTA: 47 days for mothers, 87.5 days for fathers

Timeliness to Substance Abuse Evaluation

In Nebraska, it appears that some parents receive a pre-treatment screening followed by a substance abuse evaluation, where others receive the evaluation directly. The rates below use the 211 cases where substance abuse was ever identified.

	Mothers	Fathers
Frequency of referral for substance evaluation:	96 (49.5%)	60 (33.0%)



Frequency of cases where substance evaluation was conducted: 99 (51%) 56 (32%)

Median time from juvenile petition to evaluation: 58 days for mothers and 97 for fathers

Any Treatment recommendations:

How do Substance Abuse Cases Progress Through Treatment?

There were 85 mothers and 54 fathers where treatment was recommended after an evaluation

	Mothers	Fathers
Of those cases –		
Frequency of recommendation for substance abuse treatment:	83 (98%)	52 (96%)

Median time from juvenile petition to treatment referral: 69.5 days for mothers and 122 days for fathers

In 68.3% of mothers and 24.8% of fathers, treatment was ordered in court

How Successful are Parents in Substance Abuse Treatment?

Of the 83 mothers and 52 fathers who received a referral for substance abuse treatment –

	Mothers	Fathers
Frequency of cases where inpatient or outpatient treatment was ever started:	73(88%)	33 (63%)
Frequency of cases where inpatient or outpatient treatment was completed (when tx started):	46 (63%)	20 (61%)
Frequency of cases where inpatient or outpatient treatment was ongoing (when tx started):	19 (26%)	8 (24%)

These findings are quite good and exceed engagement and completion rates common in many other states. One caution here, however, is the actual treatment dosage received is not documented meaning that it is possible that there are high treatment engagement and completion rates because little is being expected of the client in terms of attendance or length of stay. These data also do not speak to the quality of the treatment being provided, for example, whether it is evidence-based. We have heard anecdotal reports by some Nebraska professionals that many clients receive about six weeks of outpatient services which are often more educational rather than therapeutic in nature. While a large body of research documents that SA is a treatable public health problem with a wide range of cost-effective treatment solutions, success depends on a number of factors which include sufficient dosage, appropriate level of care and the relative effectiveness of the treatment approaches utilized.

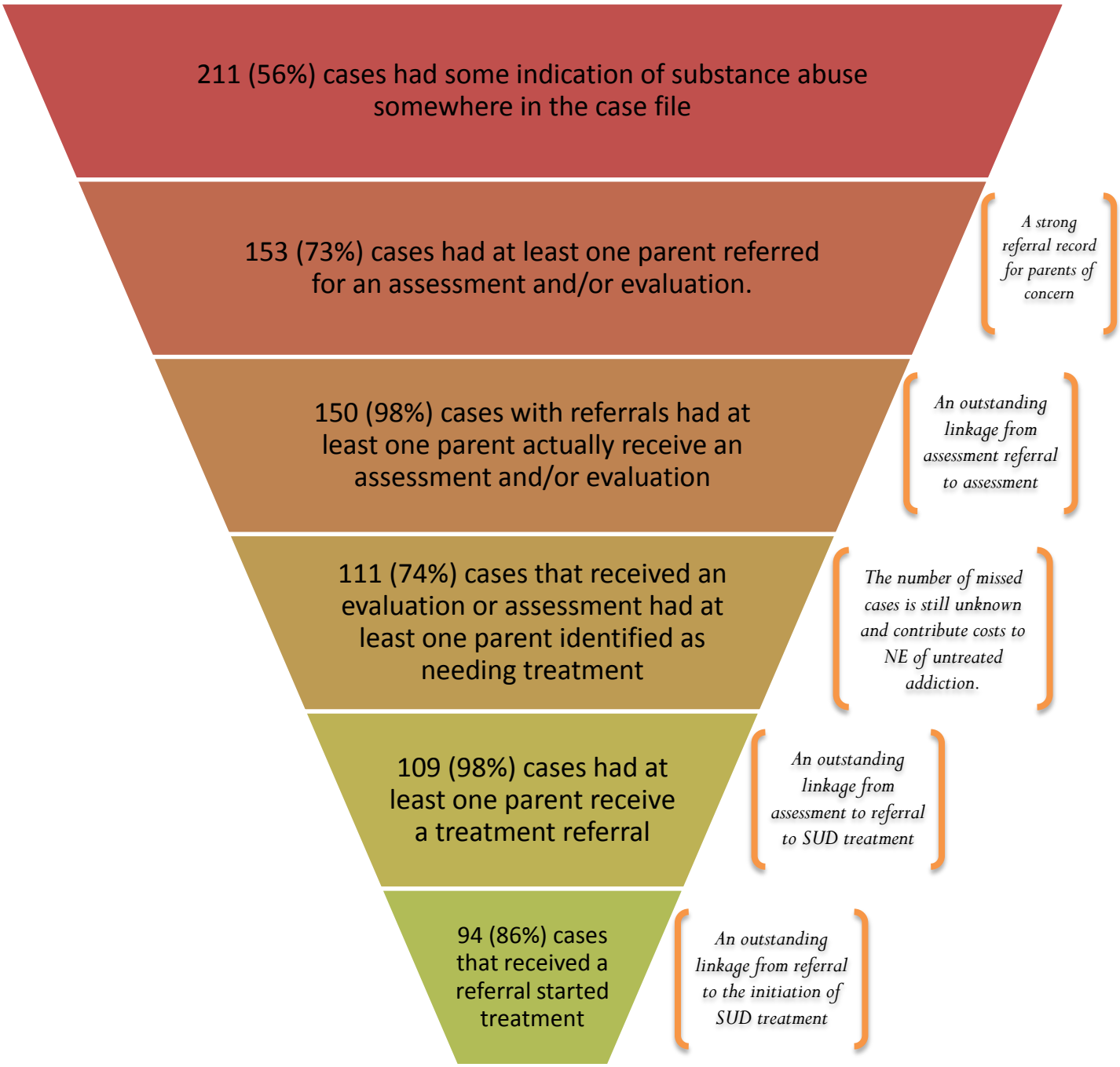
Timeline to Treatment

47 days for mothers	11 days for mothers	12 days for mothers	76 days for mothers: (35 cases with start date)	146 days
			Separate Juvenile Courts-	138 days
			County Courts-	178 days
88 days for fathers	9 days for fathers	25 days for fathers	1 day for fathers: (25 with start date)	123 days
			Separate Juvenile Courts-	219 days
			County Courts-	112 days

Timeliness:

The median time for parents to begin treatment is more than four months after the original petition that brought them into court. Half of the cases take longer than four months. As noted in the earlier section, substance abuse problems are identified within the first week of entry into the system for most parents, especially mothers.

Drop-Off Analysis



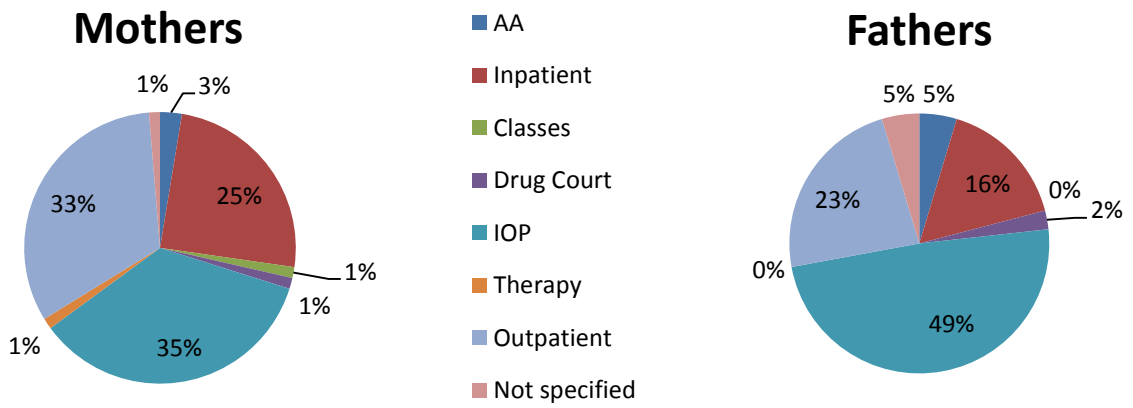
57 (61%) cases had at least one parent that successfully finished treatment

25 (27%) cases have at least one parent still in treatment, and no parents that have finished treatment

Are Nebraska's Parents getting the Right Treatment Services?

Type of Primary Treatment-Related Service

The following charts show that approximately 1/3 of mothers and 1/4 of fathers are provided outpatient treatment (not intensive outpatient). Mothers in rural (county courts) areas were twice as likely to get a more intensive level of treatment (intensive outpatient instead of regular outpatient) than mothers in the urban (separate juvenile courts) areas. There were insignificant rural-urban differences for fathers.

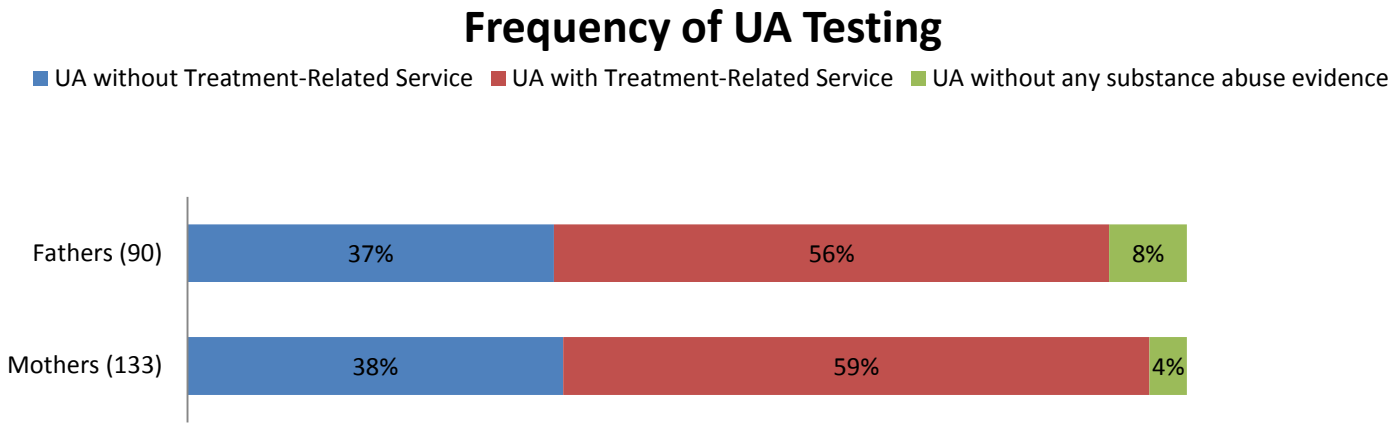


Separate Juvenile/County Court Comparisons

	Mothers SJC	Mothers CC	Fathers SJC	Fathers CC
AA	4%	0%	7%	0%
Inpatient	26%	21%	11%	25%
Classes	2%	0%	0%	0%
Drug Court	0%	4%	0%	6%
IOP	28%	50%	48%	50%
Therapy	0%	0%	0%	0%
Outpatient	38%	21%	26%	19%
Unspecified	2%	0%	7%	0%

Urinary Analysis

Of the 379 cases, there were 133 (39%) mothers and 90 (31%) fathers participating in urinary analysis (UA). The following chart shows the relationship between being tested and being in treatment at any time. As can be seen, over a third of both mothers and fathers get UA testing (many times very frequently) without getting treatment. A small number are getting UA testing in the absence of any evidence that they have a SA problem.



Nebraska leaders may want to weigh the relative value of UA testing (and costs) as a standalone treatment in view of the research evidence that suggests it is ineffective. Experts convened by the National Quality Forum (NQF) endorsed the research and practice evidence that suggests that acupuncture, relaxation therapy, didactic group education, or biological monitoring of substance use as a standalone treatment is generally ineffective and should not be provided.[6] *Moreover, it is well-documented that misuse or abuse of alcohol is, as great or greater, a contributor to child maltreatment as misuse of legal drugs or use of illegal drugs.*

Endnotes

1. Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection, April 1999, Chapter 4
2. Jaudes, P. K., Ekwo, E., & Van Voorhis, J. (1995). Association of drug abuse and child abuse. *Child Abuse and Neglect, 19*(9), 1065-1075
3. U.S. Department of Health and Human Services. (1999).
4. Collins, James J. and Donna L. Spencer. (2002) "Linkage of Domestic Violence and Substance Abuse Services, Research in Brief, Executive Summary." U.S. Department of Justice.
5. SAMHSA Treatment Improvement Protocol 51: Addressing the Specific Needs of Women
6. *Evidence-Based Treatment Practices for Substance Use Disorders,* National Quality forum (NQF), p. 8

Study Methodology

Four-hundred cases were randomly selected from 4,616 Nebraska 3a cases that opened between July 1 and December 31 of 2009. Twenty-one cases were excluded because they did not meet study criteria (e.g. had opened prior to July 1, or had status of delinquency offenses). Analyses were conducted on the remaining 379 cases. To maintain consistency across the state, cases were treated on an individual (i.e., one child, one case) rather than a family (i.e., multiple children from the same family, one case) basis. For each case, the presiding judge granted Court Improvement permission to access and review all files.

Three attorneys familiar with juvenile law conducted the structured reviews of both the legal and social/exhibit files. Forty non-study files were used to establish reliability among the raters. Reliability was above 85% for all the raters, ensuring minimal differences in the information gathered. Case reviews began in December of 2010 and were completed in April of 2011.

Most of the data provided is statewide because the random sample was of the state, not of individual counties. However, there is some data that is broken down into Separate Juvenile Court and County Courts because of perceptions of large differences in services between the urban and rural parts of the state.

Acknowledgements

Study Design, Analysis, and Report Preparation
Victoria Weisz, Ph.D., M.L.S. *Court Improvement Project Director, UNL Center on Children, Families, and the Law*
Pamela Baston, MPA *Consultant Liaison for the National Center on Substance Abuse and Child Welfare (NCSACW)*
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