

Panelists:

Donna Caldwell

Jean Twomey

Please note: The following is a direct transcription and has not been edited.

Jean Twomey: I'm not sure what letter we are but I am sure that this is the Collaborative Interventions to Promote Permanency for Substance-Exposed Infants workshop. And we're a small group, so Donna and I were saying to rather than wait till the end to bring up questions or discussion, I think as we go along, I mean, this is I think a very nice setting, it's, you know, again small enough that we can be informal. And if that – does that sound okay to folks.

Donna Caldwell: Okay.

Jean Twomey: So, I'm Jean Twomey, I'm at the Brown Center for the Study of Children at Risk. And this is Donna Caldwell, who is at the National Perinatal Information Center. And both of us are also at Women and Infants Hospital.

Here is an overview of what we're going to be discussing this afternoon. Perinatal Substance Abuse and Child Welfare Involvement, now that of course is a very large topic that would easily take the hour and half that we have allotted to us. But what I would like to focus on are what are the implications for parents, infants and social service systems, and particularly as those implications relate to the collaborative interventions which Donna and I have been involved in.

And Donna is going to tell you about the Vulnerable Infants Program of Rhode Island. And then, I'd like to tell you about our Rhode Island Family Treatment Drug Court. And then, Donna will be ending up by talking about how do we achieve long-term success looking at some of the lessons that we've learned from the VIP and the Rhode Island Family Treatment Drug Court as well as what are the challenges to achieving long-term success.

Perinatal Substance Abuse and Child Welfare Involvement, we all know that substance use during pregnancy is a major public health and social problem. It's estimated that about 5% of pregnant women illicit drugs. And we can see the extent of concern about this public health problem reflected in the number of social service systems that become involved with families who are affected by Perinatal Substance Abuse. And that of course sets the stage for some very complicated interactions among the different players who are working with families who have been affected by drug use during pregnancy.

We know now of course that drug use during pregnancy is not an issue that we can compartmentalize. And rather that it serves as a marker for a number of risk factors in a women's life. And those risk factors increase concerns about a women's ability to

provide parenting functions to a child that are going to promote the child's emotional and developmental progress.

And some of those risk factors include co-occurring psychiatric disorders, domestic violence, lack of social support, trauma, unaddressed medical needs and limited vocational and educational experiences. Often women who use drugs during pregnancy have many adverse life experiences, and they have not had role models in their own lives for how to be a nurturing parent.

These concerns of course lead to concerns about the safety of substance exposed infants and that in turn often leads to babies being placed in out of home placement. Substance exposed infants are associated with large numbers with a large number of infants that are in the Child Welfare System. Infants who are in out of Home Placement are usually in care for longer period of time are less likely to be reunited. And if they are reunited, they're more likely to be re-reported.

We know of course that when there are disruptions in attachment which happens when there are changes in primary care givers that children are at risk for psychological, developmental, behavioral and physical problems.

Now, I'm sure you're all familiar with the Adoption and Safe Families Act. But I think that as we talk about families affected by Perinatal Substance Abuse, it's important to review what ASFA is. And this was – ASFA is Federal Legislation that was enacted in 1997. And its purpose was to expedite permanency and reduce foster care drift. And foster care drift refers to children who have been in placement for extended periods of time or have been in and out of placement and really have been, we have found that children in those situations have been significantly adversely affected by those type of life events.

So, ASFA is trying to make the health and safety of children or priority, and in terms of the policy it's a shift from prioritizing reunification – reunifying families on almost all circumstances. ASFA mandates the permanency hearings are held within 12 months of Out of Home Placement that termination of parental rights is initiated when the child is in Out of Home Care for 15 of the prior 22 months. And ASFA mandates concurrent planning. So, that even if the goal is for reunification, the Child Welfare worker also has to have a plan if in fact reunification does not come to fruition.

Now there is a lot of discussion in the literature about the pros and cons of ASFA and certainly this little short slide does not purport to cover this very complicated discussion. But the implications of ASFA are that there is a need for timely and appropriate services because the clock starts ticking right away. And in terms of all that families need to achieve, it's a relatively short period of time.

Also as we said at the beginning, there are a number of different social services that are going to be involved with families and there needs to be enhanced collaboration among

the agencies who are working with a particular family if they want to facilitate the family, optimizing their opportunity for unification.

The potentials of ASFA are that there would be more affective service delivery and in terms of parents, that there may be, that it may help to motivate them that they realize how important it is obtaining help and making major life changes. And that that needs to occur in a quick way that they need to get, start getting services as soon as they possibly can.

Now, some of the pitfalls of the act are that parents may feel that there is so much to do in so little time that they're overwhelmed and they're discouraged. Also, when we have services that are compartmentalized, confusing and conflicting, this further contributes to difficulties that a family may encounter in terms of working towards reunification.

ASFA, also has been criticized because there is no additional funding that went along with the act to improve the quality of services by addressing long-standing Child Welfare problems such as burn-out, staff turnover and high case loads. And others particularly, people who are interested in infant mental health have argued that the timeframes that are specified in ASFA are not sensitive to an infant's need.

So, then, when we're talking about 12 to 15 months in an older child's life, that is a very different proportion of the child's life than when we're looking at an infant, who that could be in infant's entire life. And that during that time, the infant may have become attached to their primary care givers and those people have in fact become their emotional parent and what is it like for that infant then to be placed with a biological parent.

Social service systems play a major role in how treatment and permanency outcomes will progress. Social service systems have gained an increased awareness of complex parental need as we were talking about earlier the number of risk factors that families face. And there is immediate and long-term concerns about substance exposed infants. So, social service agencies are having more global expectations and increased accountability placed on them within the context of the work being done with budget and staff reductions.

Permanency decisions that are made without adequate changes in the home environment to which infants, return increase the potential for re-involvement in the Child Welfare System. And so, it's those factors that really got us thinking about how could we help families who were involved in Child Welfare because of drug use during pregnancy and the social service system that we're working with them to not only achieve timely permanency decisions but also thoughtful ones. And this led to the creation of the Vulnerable Infant's Program of Rhode Island which Donna is going to tell you about.

Donna Caldwell: Thank you, Jean. I wanted to do just a little bit of an introduction of who I am. So, you'll get some sense of where I'm coming from so in my comments. I was the evaluator for the VIP Program, so I apologize I'm not a program staff member

who would be best – the person to describe that program. So, I'm the evaluator with the program, we had two consecutive years of funding from through abandoned infants grants that actually lasted us nine years, it was a great program.

But even more to the point, sort of who I am, I started out as a Substance Abuse Treatment provider way back when and actually worked in a program that has a residential co-ed facility, long-term and in our patient component. And then I worked with pregnant and parenting teenagers before I went and got my PHD in Program Evaluation. And so, I always stressed to that I'm an Evaluator, not a researcher.

The other thing that's important to know about me is that when I was working with Pregnant and Parenting Teens towards the end of that job, I met a mom that I remembered partly because she had a very singular name. And I met her and tried to engage her in services and she refused. I had an opportunity to meet her again when her second child – her baby, she was still a teen at the time was hospitalized, this was in Massachusetts. And she refused again. It was a voluntary program, as you can tell.

I did a home visit after that to try to engage her and found out that she had left the state. And then, 18 months later, my husband and I, when I was in Grad School pursued adoption, and at that point I became the parent of her two little girls. So, I always say to my daughters, I was meant to be in your life one way or another. I was either going to help your birth mom or become mom. And unfortunately they experienced some very severe abuse in that, 18 months. So, unfortunately I was not able to help her. But that tells you a little bit about me in terms of my personal passion for this work as well as my professional experience.

So, VIP, we started in 2001, and the important thing to realize about VIP is that its hospital based so Jean shared that we each work for Women and Infants Hospital, it's a very large perinatal care center in Rhode Island, over 9,000 deliveries. It has a clinic that serves most of the poor women in the providence and greater providence area. So, it does bring in a lot of women who have behavioral health issues. And the hospital is, I would say very aggressive and identifying pre-natally women who have health issues and putting a red flag on those cases and trying to help them access care.

So, all of the VIP staff are actually women and infants employees and they're Masters' level clinicians. And it was a great team. They had experience in substance abuse treatment, mental healthcare and Child Welfare, among them they had many, many years of experience. And I didn't put that on the slide but I thought about it because I worked with a number of programs that due care coordination and I know that the skill level, you know, of care coordinators vary. So, it's important to realize that these care coordinators were all Masters' level clinicians. And they worked with the Rhode Island Family Treatment Drug Court which started about a year after VIP started and Jean will talk about that some more.

And so the goal was really to – the key was to try to help these families negotiate all of these service systems, it says vulnerable infants program but they're actually vulnerable

families. The number of services that the women were referred to and for themselves, the families their children were numerous. So, the care coordinator was really there to kind of work with the Child Welfare in the very beginning to frontload those services and help the women access and navigate all those complex systems.

Okay, so, you had to be a Rhode Island resident. And again, there had to be some substance use during pregnancy. So, all of our mum's were involved with Child Welfare. And the goal had to be reunification. So, if a mom had a severe abuse history, she was not likely to be involved with VIP.

And again, voluntary program so, the referrals in the beginning came primarily from Women and Infants Hospital, and what would happen is that the infant would be born and the social workers we had again, where Women and Infants, they were Women and Infants employees, so they were able to coordinate their services very closely with the social work at the hospital at Women and Infants Hospital. And the social workers would call a VIP care coordinator while the – following the birth of the child and the identification of substance exposure during pregnancy in coordination with Child Welfare coming in the VIP care coordinator would come in as well.

And so, it's a very – it's a wonderful opportunity for intervention following the birth of the child. But of course it's also a very emotional time if the woman has not previously lost the child or if she has, you know, to have a Child Welfare worker come in and say, we're investigating you. You may not be able to go home with your baby. Sometimes the hospital medical staff are not always that sympathetic, although they did a lot of work to work with attitudes of nurses and doctors. We still had a lot of reports from patients that they had a lot of negative attitudes towards them and, you know, reluctance to let them see their baby and etcetera.

So, into that very emotional context stepped are VIP care coordinators and described this program that they were going to offer. And hopefully again, voluntarily but engage them in services. And the key again, is to engage them right at the hospital and engage the women but also hopefully her partner if her partner wasn't involved with the family.

And as it says here too, the Child Welfare of course, the Child Welfare worker had the primary responsibility for developing the case plan for the family. But VIP worked very closely with that Child Welfare worker to identify the service needs of the family and sort of tailor the interventions to what the family needed.

So, as services went on, it was the role of the VIP care coordinator to really closely monitor that parent's progress and any kind of barriers to service delivery and work out a plan for overcoming those, you know, transportation, childcare etcetera. You know, as simple as that to as complicated as a bad treatment match and maybe referral to another set of services.

Rhode Island was very lucky to have a number of programs that were actually had other kinds of federal grants using evidence based treatment protocols and really specialized

for pregnant and parenting women. So, we were very lucky to have those resources in our community. So, the VIP care coordinator, I think one of their key roles was to attend the court hearings, and that would be either the specialty of family treatment drug court once that was established or prior to that they went to the standard family court. And that key role they would play in advocating for their participant sharing the progress that the participant was making any system barriers that needed to be overcome.

And Jean will talk a little bit more about the Family Treatment Drug Court and how that worked. But I think that was a key role in kind of solidifying the relationship between the participant and the care coordinator. And as it says, make sure that the infant's needs we're taking care of as well. So, we had close relationships with early intervention services, infant mental health services other kinds of care that infant or the women or the children might need.

So, these are some of the surveys that we used. We did the SASSI at enrollment only, the others were done at multiple time points, typically enrollment in six months with some were done at discharge as well. So, the SASSI was used to try to identify the level of substance abuse dependence. Because, as you can imagine, you've just given birth and child welfare is involved and you're not as forthcoming about the full extent of drug use that you did during pregnancy. So, the SASSI was helpful in helping us identify people who had a more severe substance use problem.

The brief symptom inventory was useful for identifying the need for malnutrition treatment. The AAPI we used to identify high risk parents and child growing attitudes and I'll show you some of the data in a minute. The CaPRA survey, if anyone has had a SAMHSA grant, that's our requirement of SAMHSA Funding, our Family Treatment Drug Court was funded through the Center for Substance Abuse Treatment. And so, the CaPRA survey has a lot of detractors but it was a requirement of that grant.

So, and I think even more to the point there is also a very expensive psycho social history that the care coordinator would complete with the participants shortly after enrollment. And again, that was part of the basis for working with child welfare and identifying the service needs of the family.

Okay, so, this describes our sample, the people who enrolled. We had 235 moms and only 50 dads, so that's about 20% fathers that enrolled. We did have some fathers that we did work with they didn't enroll. But by and large, that was a very – that was a very difficult issue for us, our Child Welfare in Rhode Island actually was deemed in their federal review for not doing enough services for dads and doing enough to engage fathers.

And some of the reasons the dads weren't engaged is that women didn't identify the dad or the dad's in prison or the dad didn't you know, was still actively using substances, perpetuate domestic violence, so they were not really a safe person to engage. And some of those dads we referred to other services and didn't work with that family. But that was

certainly one of our lessons learned. I was picking up material earlier in the day about how to engage dads. If we get to do this again, hopefully we will do a better job.

And you see from court involved kids that we had 411, so women had – most of the women had two to three children, one woman had nine. You know, we had arranged a number of children. And again, in understanding the women, you know, that many of these women had prominently lost custody of older children, so that was an influence for them as well, yeah.

Speaker: Well, the enrolled only the children who were kids that were involved from the – or just?

Donna Caldwell: No, they just had to be Child Welfare involved. So, you'll see in a later slide that some of the infants did stay in the home and it was just an open case. So, we did have you know, children that were x-party that were removed and children that were not.

I mean, you can see the age and race ethnicity information. And so, you can see that that's a little staggered there, sorry, that slide. But you can see that our minority sample is over-representative, if you know Rhode Island demographics which I'm sure you don't. But about 90% of the women of child bearing age in Rhode Island are white. And you can see that they only make up 61% of this service sample. So, I think other speakers today have talked about disproportionate representation of minorities in the child welfare system and that certainly was true in this case as well.

And this describes our infants at birth. And you can see, I think in particular the percent that are very low birth rate or low birth rate. And the percent that are pre-term. If you look on the very bottom, you'll see that the Rhode Island rates, this is 2006 which is roughly the time that these data were collected. So, only 8% of all babies in Rhode Island were low or very low birth rate and you can see our sample there has got 32%. And then, our pre-term birth is about 12.6% of babies in Rhode Island and we had 28%. So, in that way as well, they are vulnerable infants right from the very start.

And here is our parent substance abuse data. And you can see some of the information too from the SASSI that about 68% of the moms and 73% of the dads had a high probability for substance abuse disorder. You can see that from the next point, previous substance abuse treatment, mother is 79%, father 64%, so there were multiple treatment episodes in the past and including some successful completion of treatment and relapse and need to return to treatment.

So, previous mental health treatment, mother is 55%, father is 32%. Those were low statistics in part because it was very difficult to access mental health treatment or more difficult than to access substance abuse treatment.

The other issue that we found a lot was really the stigma of mental health treatment that women would be willing to enter substance abuse treatment, but if you were talking to

them about mental health treatment, they would refuse. Even though in many cases, the substance abuse, the drug use was really self-medicating mental health issues that the stigma of having a mental health issue was stronger than the stigma associated with having a substance abuse issue.

Speaker: I find it surprising that the percent of alcohol abuse was so low?

Donna Caldwell: Oh, that's a good point. I meant to actually say something about that. If you look women in general, in Rhode Island seeking treatment, the alcohol percent is actually much higher, it's more like 30%. I think in this sample, it's low because this is what was identified at birth through, you know, screening efforts. And I don't think they were as good at identifying women with primarily alcohol problems. So, I think we missed those women in this sample because we know in Rhode Island that's a much higher percent. Good question, thank you.

All right, so this is the history of traumatic events for the women in our – participating in VIP. And you can see that very, very high rates, both of violent trauma and non-violent trauma. And certainly with some of the information that people were talking about today about adverse childhood experiences, you can see that many of these women, 76% witnessed by answer as a child but also you know, half sexual assault or rape as a child so, just one of the ways that this was a very vulnerable population of parents as well.

And I think one of the most compelling arguments for this program is when you look at the percent in this population that had been separated from their mother and/or their father as a child, if especially women, reporting 60% had been removed from the home as a child. So, you see that cycle repeating here, with your own children. And so, hopefully the VIP program can step in and stop the cycle.

So, we had worked very hard to keep the data meaningful and keep the data really integrated into the day-to-day program operations. So, I should recall self-correcting model of evaluation, meaning, just constantly looking at what are we doing, what's working, what's not working. How can we tweak the program to make it more effective?

So, I attended VIP staff meetings. We also had family treatment drug court meetings every month that included the magistrate that heard the cases. And we talked about the problematic cases and why they were problematic and what we needed to do to improve that. And we also had a team member that went to all of the family treatment drug court hearings to report the outcomes so we're collecting the tug screen data.

All of the service plans, all the service providers I mean, had to give reports to the family treatment drug court and also to be key. So, we had all of that information about how well were they doing in substance abuse treatment, parenting classes, etcetera. So, a lot of information coming in that again we were working very hard to feedback and to try to understand why, some people were being more successful than others.

So, to get to some of our outcomes, successful completion, 46% of our participants in the average length of stay, was 14 months. So, I put here how we had to define successful completion under our grant. So, it did mean that the case was closed and that the child was placed in the home. And my staff colleagues would always argue that if someone had made the decision to voluntarily place a child for adoption, that was also a very successful outcome because they were thinking about the best interest of the child and I certainly would concur. But this was our definition of successful for the grant.

So, one of the first things we looked at and again, we were working in the Women and Infants Hospital context, so one of the first things we looked at was trying to decrease the length of stay, the amount of time that a baby would board. So, this would be a baby that had been medically cleared for discharge but did not have a setting to which they could go either a foster home or back to home or some other type of congregate care setting.

So, one of the first things we were very invested in doing was really getting in there, helping Child Welfare identify alternative placements. Rhode Island has a very high rate of placing children in kinship care. So, the VIP care coordinator would work very closely with Child Welfare hoping to identify suitable kin that the child could go to and again trying to decrease the amount of time that a baby would be in the hospital, when it was medically cleared for discharge. And so, you can see pretty much right off the bat the VIP care coordinators were very successful in reducing the amount of time that babies were boarding. Nice cost saving for the hospital, doesn't help to – I mean, does it help to have cost savings when you're trying to do sustainability.

Okay. So, this was parents with no reported drug or alcohol used enrollment in six months. And this is self-report and also tug-screen data from our courts, our Family Treatment Drug Court, every court appearance they had to do a tug screen. But we also had service provider data about tug-screen. So, we weren't able to see a dramatic increase in the percent that were able to abstain.

And if you're a member, describe the brief symptom inventory which was screen from mental health issues. This is – it has nine dimension symptoms dimension and the global severity score is a combination of those nine. And so, you can see that the symptom severity for our participants did significantly decrease by six months. And that of course was associated with getting appropriate behavioral healthcare.

And, sorry, this is a lot of follow, got a little thrown off. But this is our high-risk scores. So, there are with the AAPI, there is five domains, expectations as appropriate developmental expectations for children. Empathy is having appropriate empathy for kids, understanding their stage and what is appropriate to expect from them. Punishment is essentially how much deemed or supportable punishment.

Rules, is having an appropriate sense of what you should expect from a child or a lot of children were really parentified. So, some of the older kids, you know, even four and five expected to do some of the care giving for some of the younger kids. So, we wanted

to address appropriate rules for children and then also just the extent to which the parent felt a need for power in control.

So, at enrollment, we had 50% that had at least one high risk court in one of those domains and we were able by six months to see that reduce to 39%, a nice improvement especially in empathy which of course is a byproduct of substance abuse treatment, you're developing empathy for others, your peers and also for your children.

I apologize for that, the slide there. And here is, it goes back to the question about children's placement. So, this is essentially placement from the hospital or enrollment. And you can see that about a third did go home with a parent at enrollment. And by final placement, we had almost two thirds going home. So, we were able to dramatically increase the number of children that were home with the parent.

And you can see here too that relative care giver, 26%, we did have as I said before pretty high rate of kinship care placements and then 14% of those relatives adopted those children. Okay.

So, participant satisfaction data, this just shows some of the variables I think, I'm trying to remember when the, I heard one of the earlier sessions I was talking about satisfaction data. And we did actually do interviews as well because I find a lot of a times people fill out surveys and unless they're having a really bad day they pretty much say positive things about programs. But we really use that data to try to inform again our service design.

And the last one is they stood by me and believed in me even when I didn't essentially, that I think one of the key things they did was really instill hope in this population. You are going to be able to reunify with your child. You're going to be able to maintain custody of your child. You're going to be able to be done with Child Welfare at some point.

One of the nicest things I learnt through the satisfaction interview is actually, was that a lot of participants came to have a very positive attitude towards their Child Welfare worker. Let's start it out as they would stay in their life, actually came to be a positive relationship. And they said that external motivation of losing custody or the threat of losing custody actually helped them especially early on staying in care in services so.

So, any questions, about VIP before we switch a little more to Family Treatment Drug Court?

Jean Twomey: I think Donna gave a good – I did give you a good idea of how closely VIP was working with our standard, with our family court. And we were working so closely with them and we were, we both shared similar concerns and similar goals that one of the early achievements of VIP was to establish the Rhode Island Family Treatment Drug Court. That was specifically designed for perinatal substance users.

And I think we're one of the few drug courts in the country that is specifically focused on this population. So, that having rather quickly beginning in September of 2002, and we were all very concerned by the high number of infants that were being placed in Out of Home Care. Rhode Island, even though we're the smallest state, we have proportionately a very, very high number of Out of Home placements. And I want to say at one time we were second in the nation. We wouldn't think of Rhode Island that would not be the state I think that comes to mind. But we were very concerned.

And again, as we were talking about with ASFA, we also were quite concerned because we were seeing that families with very complicated problems were having less time to meet their case playing goals to reunify.

So, the structure of the Rhode Island Family Treatment Drug Court, like other treatment drug courts is, that it's an interactive and therapeutic approach. So, it's not adversarial. There is intensive case monitoring. And there are frequent court reviews, you know, overtime, hearings become less frequent as participant's progress.

But one of the things that and it's a small intimate setting that the judge really gets to know the families that can't be for her. So, it's an intimate setting. The families are familiar with their judge who remains constant. And the judge is well aware of the families and what their needs are and how they're progressing. So, our hope was that that would lead to more informed judicial decisions regarding child placement and permanency.

And the other thing that we were very interested in doing was supporting the workers in our Child Welfare System. Because you know, as you all know, those are very difficult jobs people have very high case loads. And the amount of time that an individual worker maybe can devote a case, can be very variable as well as all of the work that goes into coordinating with the many different services who are getting involved with the family.

So, VIP really, I have one of the fathers of VIP describe it and I always say this because he has summed it up so very nicely, he was – VIP sort of served this clearing house function where we could really get the information from all the treatment providers – the services, VIP was often initiating referrals, keeping in touch. So, that when a family who was involved in Family Treatment Drug Court went to court, there was – they had their Child Welfare worker. But they also had their VIP care coordinator who was also providing input to the judge.

And again, I think, you know, as Donna was saying, think one of the unique features of VIP was we had a very strong substance use – understanding of substance use as well as infant mental health and infant development. So, we're very much interested in Infancy and early childhood mental health. And I think that that really served families well in terms of going to the courts and reporting. And I think it's fair to say that the courts relied very heavily information that VIP was providing.

The court, you know, played a pivotal role in coordinating provision of services. And again, with well-established partnerships with all these community agencies and services, people in the court really were prioritized in terms of having access to services. And the court used incentives and sanctions to move people along in the process. Now, when the Family Treatment Drug Court started we thought it was an opportune time to start looking at how did participants in the Family Treatment Drug Court compared to families who remained in standard family court.

So, I think what's important for you to realize is in either court VIP performed the same functions. And so, truly what was different was the structure of the court. And so, in those first two years, we looked at the 79 families who participated in Family Treatment Drug Court compared to the 58 who were in our Standard Family Court. And what we found was that the time to initial reunification was significantly quickly for those families who participated in Family Treatment Drug Court.

Within the first three months 73% of Family Treatment Drug Court participants were reunified compared to 39% of Standard Family Court participants and this slide illustrates that with the blue beam, the Rhode Island Family Treatment Drug Court participants.

So, we were very pleased with these preliminary findings which indicated that the Family Treatment Drug Court did in fact promote recovery and abstinence, did increase for unification with the biological parents and did so in a quicker way. So, we felt gee, that looks very promising for the Family Treatment Drug Court.

But we thought, that is really a snapshot of what is happening to families who are at a point in their lives where they are getting a tremendous amount of help. They have the vulnerable Infant's Program, they have the Family Treatment Drug Court, they have their Child Welfare Worker, as well as all the ancillary services that are with them. So, we're looking at them when they've probably got the most amount of help that they're going to get.

And so, we were very interested in as we are as we are at the Brown Center in longitudinal outcomes. And if I could digress for a minute, we have, I have to say, we have just run out of funding for our maternal lifestyle study which followed the substance exposed infants from zero to 16 years old so on. So, that was really quite an epic for us.

But here we applied for a small grant from Robert Wood Johnson, and we said, we want to look at how families do overtime. So, we followed 54 substance exposed infants whose mothers participated in Family Treatment Drug Court. And we did assessments at six month intervals, and we want to start when the babies were 12 months old and follow them until 30 months of age.

And what we were interested in was what we thought were areas that really would reflect child developmental outcomes in a meaningful way. So, thinking about that, we thought well how a child's mother functioning is a huge factor in a child's developmental and emotional trajectory. Of course we're interested in permanency. And we also wanted to

look at the children and their developmental outcomes. And I do think that this is a factor that sets this study apart because we were looking at Child Development outcomes as well. So, it wasn't just abstinence, yes, no, permanency yes, no. We'd like to think it was a much more complex examination of what was going on in family's lives.

And you can see we took many of the assessments that Donna mentioned that VIP had used. And VIP was using those assessments to collect data but more importantly to determine what were the services that families needed. We built on the base that VIP had provided by saying, we're now going to use these assessments for this research project that we have.

And as Donna was saying, we wanted to screen for the potential for substance dependence, mental health symptoms, high risk parenting and child wearing attitudes. So, by 12 and 24 months, we administered those measure, those of course are standardized measures to the child's biological mother. And at 12 and 30 months, we administered the child abuse potential inventory which assesses for the risk for child abuse and the parenting stress index which measures the levels of parental stress that could adversely affect parenting.

Looking at the Child Developmental Outcomes measures, at 18 and months, we ask the child's primary care giver to complete a child behavior checklist, and that identifies child behavior problems. And at 30 months, we use the Bayley to measure the child's cognitive, abilities, the dial R to look at motor conceptual and language skills. And we also wanted to see how the quality of the child's attachment. And so, we used the attachment Q-Sort to do that.

So, these are what the mothers in our study look like. You're going to see, there is a discrepancy in the number of mothers and the number of infants because in this study, we had two sets of twins. So, the mother's average age was 29 with a range from 19 to 45. The number of children less than 18, the average was 2.6 with a range from one to six. 54% of the mothers had children other than the study child who did not live with them.

The education, 40% had a high school degree or equivalent such as a GED. But I do want to point out none of the mothers in this study had four year college degrees. So, what that means is I think it was about another 40% have less than a high school diploma and the remainder had some education beyond college. But as I said, no one had a four year degree.

And if you look over at household income, you're also going to see that this was a sample where families had low income about a third of the sample, had household incomes, less than \$10,000.

You can see looking at race and ethnicity, that this was a diverse sample. And for primary substances, we had 38% whose primary substance was poly-substance use. 29% cocaine was the primary drug of choice, 23% marijuana and 10% opium. Now I would imagine that for many of you who come from different parts of the country, you may be

struck that there is no Methamphetamine as a primary drug of choice which speaks to the fact that it really is not and I'm sure, this is going to be surprising for some people but Methamphetamine is not a widely used drug in Rhode Island. So, that's reflected here that really there was no meth-use in this study.

The infants, 56% were male, about three quarters were – and that should be greater than or equal to 37 weeks. So, most of the infants in the study were full term. And again, in terms of speaking to families with socio economics status, you can see that the vast majority of infants were receiving government supported health insurance.

I think too, I have to say that this does speak to Rhode Island, does do a very nice job of covering children. It would be very unusual for a child to not have health insurance in Rhode Island. I do see that sometimes but it's mostly when the parents are kind of just above that threshold that they don't qualify for state supported insurance.

So, again, I think at some ways this is one of the goods that things about the state is the way that health insurance is provided to the children. I will say this though, that one of the problems we are constantly faced with is that when a child is removed, the mother loses her health insurance. And that of course is problematic and concerning although there has been a great deal of advocacy and work done to remedy that situation. I believe it has been remedied but I don't know, I think there may be a lag time in terms of actually getting that implemented.

So, what we found was that 81% of the mothers did graduate from Family Treatment Drug Court. However, 7% of the graduates did relapse. Mothers who did not graduate were significantly more likely to relapse. What we found was that between 12 and 24 months using the SASSI, the probability of substance dependence increased as did the psychiatric symptoms at 24 months and parenting stress increased at 30 months.

In this study, the changes in the high-risk parenting attitudes, there was one domain where there was improvement and that was in the role reversal domain. And then, age appropriate expectations and promoting child independence worsened between 12 and 24 months.

The CaPi scores, again, I want to show you these scores using different cut off points. The 215 is a more conservative cut-off point. And so, not surprisingly, we have lower numbers. Although I think those are still pretty, you know, that's over a quarter of the sample, meaning that these mothers scored in a way that was comparable to parents who had physically abused their children. When we use a lower cut-off point, you can see that those percentages are even higher, 40% at 12 months and 46% at 30 months.

We had about a quarter of the infants in our study who were never removed from their biological mother. And at 30 months which was the end point in our study, 79% of the infants were living with their biological mother. And 90% were in homes that were identified as their permanent placement. So, for those infants, for that 10% of infants who were not in a home identified as a permanent placement those have been situations

where they had been reunited and then removed because the mother had relapse. So, that as you can see and I think as you probably all can appreciate, that then extends what the time to permanency for a particular child.

Let me show you some of the child developmental outcomes. These are the results from the CBCL at 18 months in blue and kind of the yellowish color is 30 months. And you can see here that none of the children are scoring in the critical range or the board of line clinical range for behavior problems.

In terms of cognitive scores, we have the cognitive composite and the language composite. And again, you can see that the scores are a little bit lower than a normative sample but those scores are less than one standard deviation. So, again, they're not considered in a clinical range.

The dial-R, this again I want to show you how the results can vary pretty dramatically depending on what you're using as your cut-off. So, if we use a 1.5 standard deviation, it looks like the potential problems for the infants really are not that high, whereas if we use a 1.0 standard deviation, you can see it tells a much different story, where there are potential problems in for over 50% of the sample in three of those domains.

Now, the infant attachment we did Q-Sort and what the Q-Sort does is it compares the infant attachment behavior as a particular sample like our sample to a secure ideal prototype. And what happens is a score is derived for each child. And how we get that is we observe the mother and the child interacting and we have 90 cards that describe attachment seeking behavior or non-attachment seeking behavior.

And what you do is, you have 10 piles that go from least characteristics to most characteristics, and you literally sort your pile, your 90 cards into these categories. It's fairly labor intensive but not as labor intensive as doing the strange situation. So, each attachment score per child is correlated with this secure ideal prototype.

And the correlation, there is a range from negative one to plus one. Higher correlations are indicative that the child is similar to a secure ideal prototype. And in our study, 41% of the sample is comparable to a secure ideal prototype of a non-clinical sample. I just want to say, in terms of the strange situation paradigm, people who are examining attachment using that, 60% of a normal population is going to come out securely attached. So, again, I would say that the 41% in our sample is not a particularly high number. And when we look at the attachment scores of the entire sample, we see and if you look on that grid there, our study sample really mimics this secure ideal prototype of a clinical sample.

So, what do these findings tell us? Well, certainly there are strengths and that the infants are not exhibiting behavioral problems or cognitive delays. Concerns are that when we looked at the Bayley language scores more closely, we found that 22% of the children has scoring falling, that did in fact fall below the clinical cut-off. And we also looking at that dial our results a little bit more closely, the normal curve of the general population is

going to have 16% using a one-point standard deviation and 6% using the 1.5 standard deviation to identify potential problems. In our study sample, 60% show potential problems in at least one area using the 1.0 standard deviation so that gives you a sense of that their learning assessments are really not what we would like them to be. And that attachment may be affected even by minimal disruptions in placement and of course what the quality of the relationship with the mother is.

So, you know what does this mean? Well, I think the important thing is are these findings indicators of incipient difficulties in learning or in the infant caregiver relationship that will depend on many factors such as appropriate developmental stimulation, nurturing homes that remain constant, how mothers are functioning over time so again thinking about what kind of support women need over time to help them in their efforts to parent their children once they've been reunited and of course adequate resources so that we don't want to overlook as you remember when we were describing our study sample this is a poor sample they don't have many resources and how can we help families with young children in terms of meeting their basic needs so they can focus on their children's emotional and developmental growth so that we can assure that children are going to high quality schools that are going to promote the strengths that we're finding in this sample.

And that I think is a good stopping point for me and Donna is now going to talk about how do we achieve long term success.

Donna Caldwell: Oh sure. Well, basically talking about what we've learned, so we certainly did see especially with the Family Treatment Drug Court when we had the family, the magistrate that heard the cases, the child welfare attorneys and social workers and supervisors and our VIP team as well as invited other service providers to come in and really did great case reviews, talked about again frontloading those services and getting everybody on the same page, the same case plan, which as Jean showed you with a slide really facilitated more timely reunification.

And that reunification of course had a reinforcing effect for the women very hard when your child is removed you know there is a lot of anxiety and depression with that so being able to get into services, get your kid back was a nice reinforcer for maintaining treatment. So having that great team working together was certainly a benefit and we did a lot of cross training and really worked to get everybody on the same page and the magistrate and also the Chief of the Family Court in general played a great role in really getting that to function.

And of course with limited time to meet case plan goals that the more you can work together as a team and get those services in there, all of the services that families need the more likely you are to meet with success with that family. So, lessons learned intervene early as I said this has a great role instilling hope and keeping connected to those families, keeping them connected to their services and being that ongoing presence in the person's life the VIP program I'm speaking of now really played a key role in helping

families achieve success or deciding that they were not going to continue to be parents which was also true for some of our families.

So, one of the things of course that I think you see with Jean's study recognizing changing family circumstances, one of the things that happens when moms are done with the VIP or have finished Family Treatment Drug Court with some of those supports and I think we especially any of us who are parents can acknowledge that parenting an infant is very different from parenting a two-year old. So, as these children get older and it will obviously the supervision needs increase you know just placing them in a crib or a play thing, the child's you know mobile now getting in trouble and also being our positional, so for our moms who may have faired very well with a baby as the child gets older and a little more willful or just a little more independent, the mom may not be up to that challenge and may not be as successful in parenting.

One of the things that I always like to remind people and you probably all know this very well, but when a woman comes into the court and into care, if she is addressing multiple issues so you know substance abuse I need to become abstinent, I need to start mental healthcare maybe some medication, I need to find a home, I need to get a JED, I need to get a job, and often that we found that one of the last priorities was really doing some kind of parenting skills programming. There were just a lot of survival skills and obviously the priority to become abstinent that those needs, those services would be provided and then the parenting skills often came a little bit later and may not have been a successfully implemented. So that was another lesson we learned. You are asking a lot of moms and dads who are very vulnerable themselves.

Conceptualized permanency is an ongoing state and I think you know they spoke well to descent the plenary that it isn't just good, get a permanent placement close, close the case everything is happy ever after. We all know that's not true. And I think especially now Jean and I were talking about especially now with the economy you know and some of the -- in Rhode Island we're seeing some of the safety net services being cut, so families that were making it and were perhaps a little bit marginal are now falling down so. And that there should be ongoing access to treatment again for the parenting, you know parenting the infant different from parenting the older child, try to prevent the reentry into the child welfare system and to maintain the child in the home.

Okay. So, challenges, providing comprehensive multi-generational family centered system of care within the current service systems, I worked on, I've been working on a couple of programs trying to implement this multi-generational family centered system of care so really trying to work with beyond the mom and her children, the mom, the dad and the children, you want to work with any relative family member that is important and can be a source of support. So, it becomes very complicated as different people have different needs and the way they interact, so it's a huge challenge. It's certainly the way to go, but I don't think at least I haven't seen in Rhode Island the adequate staffing up to that, so we want to do that and certainly with some of our women that relapse a lot of times the relapse is associated with returning to a partner or getting a new partner that is substance using. So, you really need to engage the dads or the significant others in the

woman's life, but that remains a huge challenge especially where some of our programs are concerned about women's safety and how do you work with the dad, bringing the dad into the system when he may not be abstinent and may be abusive.

And sustaining services especially in times of economic strain, competition among providers and other sectors for resources, one of the things that our programs have been successful at is really demonstrating some cost savings, so we have been able to sustain some services at women and infants hospital and they have sustained a care coordinator at the Family Treatment Drug Court despite the ending of all sorts of federal funding that we had. So, that's been great to see and a lot of times it's because you can see we're saving money for foster care because we're getting the kids back in sooner et cetera.

And I think one of the biggest things is the stigma associated with parents with substance abuse issues and also mental health issues any kind of behavioral health issue and of course the extent to which the men and women have internalized those as well. You know we called our program the vulnerable infants program for a reason. People can support. We need to take care of those vulnerable infants. We're not calling at the vulnerable families program. That's what we're really dealing with, but we have a long way to go in addressing stigma, so yeah.

Female Speaker 1: Do you have any challenges and then you're trying to make that collaboration I know that you already you had a collaboration with the Drug Court, but what about with collaborating with the child welfare agencies and mental health agencies and substance abuse treatment centers...

Donna Caldwell: Yeah.

Female Speaker 1: How -- were there any challenges there or anything that you learned that you can share with us in terms of going into something similar?

Donna Caldwell: Sure. Yeah, I think to talk about just starting with the child welfare actually, the grand work was really laid by our Chief Judge for the Family Treatment Drug Court and the Vulnerable Infants Program working together and so he was very strong in encouraging child welfare workers to become engage with that. One of the things that worked for us was just again kind of showing the partnership that where the VIP were implementing the child welfare workers case plan and one of the benefits actually for our child welfare workers is that the Family Treatment Drug Court calendar was just two afternoons and it was a very short calendar.

So, instead of what would happen on our standard calendar the child welfare worker would come in the morning and maybe not heard until 3 o'clock in the afternoon excuse me and you know so they are spending the whole day at court. So that was just sort of an extra little benefit for the child welfare worker if you engage with this, your clients in this on this calendar then you're not going to spend in their courts, so some of those things really did help get the child welfare staff on board.

The substance abuse treatment providers I think what really sold them was that they would often provide letters to the court; they did not have the time to send a worker to family court to advocate for their participant, but they would feel like these letters went into some black hole and what's actually at the big mystery of what's actually happening in the family courts in setting, so the VIP worker was that bridge. The substance abuse treatment provider would give that information to VIP. They get it back from VIP. This is what happened in court today.

So, there was that nice collaboration where they felt like the service providers could feel like I have a voice in the court and again did a lot of education about what is the role of the VIP care coordinator because not everybody necessarily understands what's a care coordinator and how is that different from what I do and we're not doing the same thing are we and just making sure there wasn't any splitting. You know I'll get my care coordinator to say. I don't need to make sure treatment program you know so there was a lot of work by the care coordinators to really partner with those service providers and be their voice in court and also give them the feedback there, so okay.

Jean Twomey: And I just like to add, can you hear me? Can you hear me? I just like to add to that because I think that's a very, very important question and I remember when we were first partnering on the VIP grant we had to get letters of support you know from all of those again to go back to all of the social service systems that are involved. And so, you know I often think how is it possible for parents to deal with all these agencies when I as a professional know how incredibly frustrated and knowing that I don't have the effective involvement of something so critically important in my life involved.

So, we had to get letters of support from you know all sorts of, you know all the places that you mentioned and more. And initially when we were introducing VIP, there was confusion about what are you doing, because in a very kind of pure way, VIP was not a treatment, it was not a treatment program and so that was a little bit unclear what it was going to be doing although I do think you know when I think as Donna has suggested in her presentation it certainly had a therapeutic component to it, but it was a care coordination program. Now, you can imagine people might be a little defensive when you're going and saying you're going to have this care coordination program, because it might amplify that the system is not working as seamlessly as it should be.

I mean in an ideal world you could say why do you need this kind of a program because everyone is talking to each other and coordinating. Now, we all know the reality of that is people are so busy, the most well intention people, you know how long it takes to even connect with someone and so what I think became a big selling point of VIP was first of all to recognize we had a number of high quality programs in Rhode Island and to really convey that in a very genuine way and that we did not want to duplicate services, but we wanted to hook people in by saying what's in it for you.

You know kind of the bottom line often can be or what's in it for me and so as VIP took shape, people could start to see that having a parent, a family and infant in the program helped them and so they started to see that the positive outcomes, the way to end, and so

then it became a plus. It was and VIP would in fact be referring to agencies they were not competing and as -- and then the pieces started falling in place. I would say in an analogous way to getting the drug court started, you know to kind of be explaining to lawyers why it may be advantageous to go this route instead of the route and the mindset. So, it's a very good question because it's at the heart of so much.

Donna Caldwell: And I think really just taking that team approach, because you know in an old fashioned traditional model you had a child welfare worker focusing on the child, the substance abuse treatment provider may be focusing just on the mom and this was an approach that really brought everybody together to focus on the family which again very challenging but there really was the relationship with the providers so that there was the understanding that we're working in the best interest of the family and that that sometimes meant you know termination.

Jean Twomey: The other thing I want to say about VIP was it really signaled to everyone who was working with an adult that this person is a parent and taking that I mean that may seem obvious to people in this room, but to really take into account that you're not just dealing with the individual in front of you whether it's at substance abuse treatment or criminal you know some sort of criminal, but that this person is a parent and that you know what are the implications for that and how do we, how are we constantly bringing that parenting function into the work that's going on no matter who is doing it as Donna said just even when you're working. And I think I like to think this is less true now, but so it's so often that part gets pushed to the back inadvertently or but...

Donna Caldwell: So, thank you for your attention and we'd be happy to entertain any questions.

Jean Twomey: And it's just to recognize our funding source and also our collaborators that...

Donna Caldwell: Oh.

Jean Twomey: To also to mention...

Donna Caldwell: Sorry.

Jean Twomey: Our collaborators as well that I would say particularly Barry Lester who has been instrumental in getting this grand funding and supporting our work in many different ways. So, any other questions? We still we have a little bit of time.

Female Speaker 2: I was just thinking about some of the outcomes that you are showing and thinking about what you know what could you refer -- you know what is that tell you that could be done I'm sure it would contain the same things like when you're seeing in the outcomes the strength of the improvement in rollover in parental attitude but the decreasing appropriate expectations and supporting the child dependence along with attachment problems, language delays, and high child abuse potential regulatory supports

type, it's going to be something in action among all of that you know and I'm thinking you know so I just wondered what your thoughts were what directions you think if you have the opportunity forward?

Jean Twomey: Well, you know this is a very small study sample, so and I was my own research assistant. So, I got to know these families very well. And you know I think that the mothers in the study were clearly trying very hard overcoming a great deal of adversity in their life. I think they had limited understanding of child developmental needs. And I think you know that's their no fault of their own in the sense of you know if we look at those histories which Donna's slide on trauma is very telling I think but you know the again situations where basic needs are not taken for granted and one of the things too at the 30-month visit particularly because a lot of the assessments involved the parents and the child together if not like the assessment just kind of seeing them together.

And I also I didn't present this data this afternoon, but we also did a home at 18 months. One of the things that really struck me was the mother's inability to play. That to me is so telling and profound on a number of different levels, so one in a very concrete way, the kind of not sure what to do, really not sure what to do with this child, how to entertain, how to interact with her. In a more and in a more profoundly in the sense there is just not that exchange. There is kind of that give and take that the fun of whatever you're doing you know to always put a little spin on that quality of playfulness and that was surely lacking.

And so I think as the children and again what I found so striking about this study was that as the children were getting older, you know we're leaving the families at that point we're then saying hey, reunification, good job, bye, goodbye, and again a two-year old has the -- you know understanding the ongoing emotional developmental needs is very different when you carry around an infant than when you're dealing with a two-year old who is able to express themselves more, who is and a three-year-old or four-year who is relying on you more to help them with self-regulation, emotional regulation, looking I think a lot of mothers in the study and our VIP work really were not comfortable with emotional regulation themselves and in terms of teaching that to their child, teaching them coping mechanisms, the idea of again we think of attachment that the warmth, the nurturing that goes along a lot of these women have difficulty with trust, with relationships again drawing on what their experiences with relationships what relationships are like are not things that they're wanting to pass on to their children.

And so in some ways there really, it's like you're trying, you're asking them to build a house without the blueprint. You know they're really having to do so much on their own and at a time when we're removing services from them. Again what I hope to emphasize with the study was we're not just looking at abstinence versus you know there is so much more that go as you all know that goes into parenting. And I think where, I mean the good news I think is that we're not looking we've come a long way in terms of working with perinatal substance users recognizing the importance of promoting their parenting skills and recognizing the importance that parenting skills are not just about behaviors, about this is when you do a timeout or this is set limits that it's much people you know

people are just doing fantastic work and are now saying we should look at promoting parenting skills in substance using women as a way to help them with the recovery rather than that what we used to do which was they need to focus on their recovery and then they can look at parenting. You know we're really recognizing the importance of parenting and substance using limits like how much they want. I think certainly the motivation and the desire is there and I think in many ways we fail them.

Donna Caldwell: You know I would just add to I think that beyond the substance abusing community there really needs to be more parenting resources for parents in general. You know that these women kind of get identified because at first you know there was the positive talks, but there is plenty of parents that really could benefit from developmental outcomes just even you know agents and stages information they didn't get that through their own childhood and you know just that that basic level what can I expect at the two-year-old, but then also the interaction, how do you enjoy your child, how do you form a relationship, just parenting in general and it's unfortunate that I've been involved with a lot of programs that I've tried to engage parents and there is such stigma for idea and maybe I need some help with parenting skills you know whether you're a substance user or not, it's very hard to engage families in the parenting skills programming or parent child interaction services, so if there is some way to open that up as a resource just in general that will help our substance abusing moms and dads as well, so.

Jean Twomey: Keeps little.

Female Speaker 3: I was wondering if you have any collaboration with any of the education piece you know that the children when they went to child care or you know being there in day care or in the schools or another piece to it you know being there is a big movement of changing the way teachers staying and listen them in the classrooms and using that as a way to help the family so also kind of building the circle around that as put the background not just...

Jean Twomey: Right.

Female Speaker 3: You know you're not just getting services outside but even your children in their school right then by those families that may also need the initial support in teaching that?

Donna Caldwell: Right. Well, VIP did work very closely with early intervention that would help the transition to school or you know pre-school you know special ed services, but not so much with the older kids that were in school. I mean they did try to do that, but the resources were a little limited for them, but that's a great point. That's a great point.

Jean Twomey: Well, thank you. Thanks for your questions and thanks for coming.