Targeted Assessment Program
Opioid Use Disorder Project (TAP OUD)

Partnering with Parents to Begin and Sustain Recovery

Presenters and Contributors

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Today's Objectives

- Understand the need for holistic, trauma-informed, strength-based, and person-centered engagement.
- Identify strategies to partner with parents in developing their recovery plan.
- Identify strategies to develop mutually supportive community partnerships.
- Identify strategies to support treatment engagement and retention.

TAP OUD Development

- The Targeted Assessment Program (TAP) is a partnership between the Kentucky Cabinet for Health and Family Services, Department for Community Based Services (DCBS), and the University of Kentucky
- Initiated as a pilot project in FY 2000 with Temporary Assistance to Needy Families (TANF) funds, and expanded 8 times
- Currently co-locates 57 Targeted Assessment Specialists (clinically trained, University employees) full-time at DCBS offices in 35 Kentucky counties selected by DCBS
- The TAP Opioid Use Disorder Project (TAP OUD)* was initiated by DCBS in FY 2019; at the request of DCBS, TAP applied for and was awarded a State Opioid Response (SOR) Grant with funding from the Substance Abuse and Mental Health Services Administration (SAMSHA) to expand TAP in selected high-risk counties impacted by the opioid epidemic
- TAP OUD co-locates 15 Targeted Assessment Specialists in 12 counties; 9 of the 12 counties are new sites

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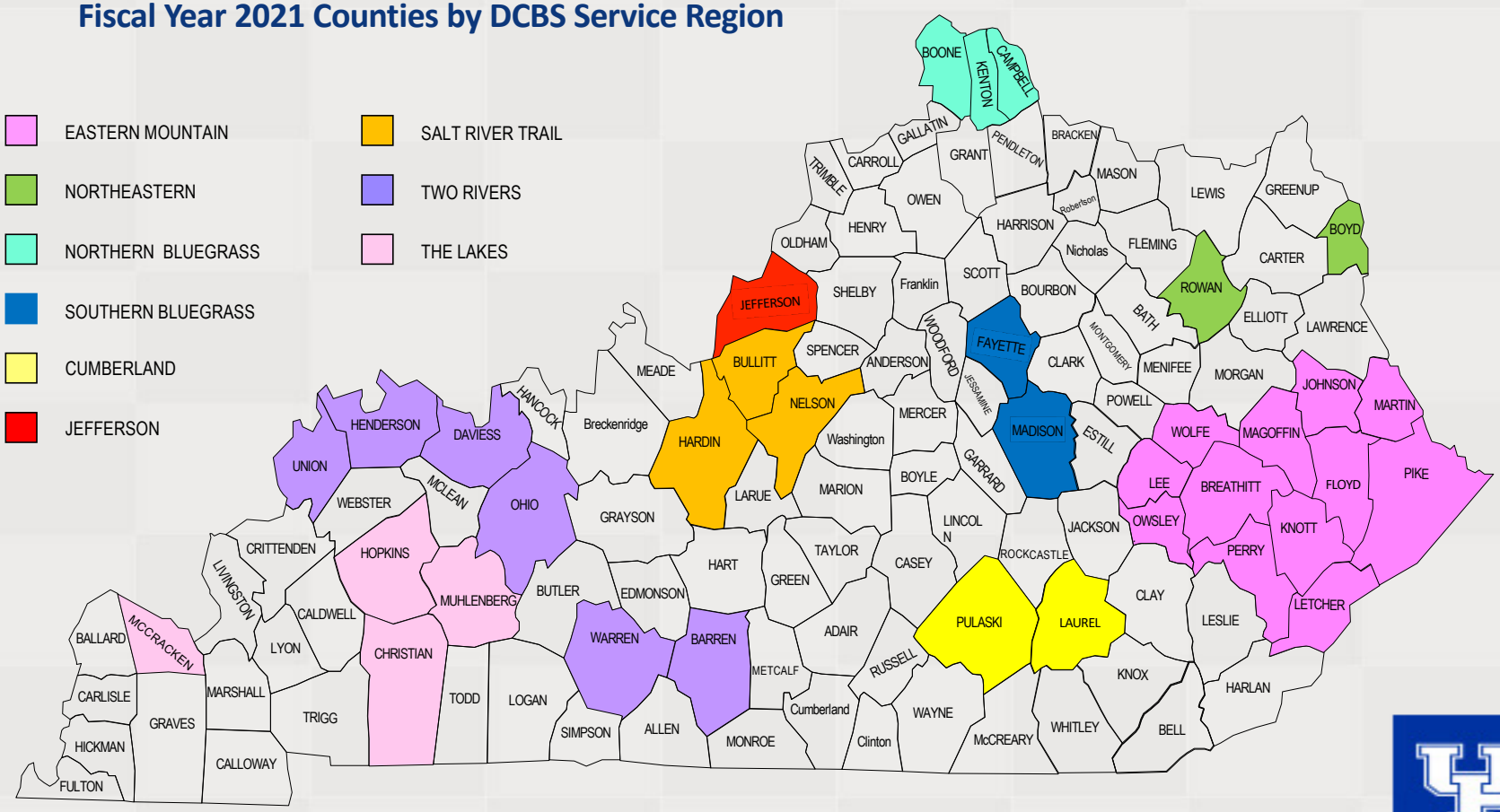
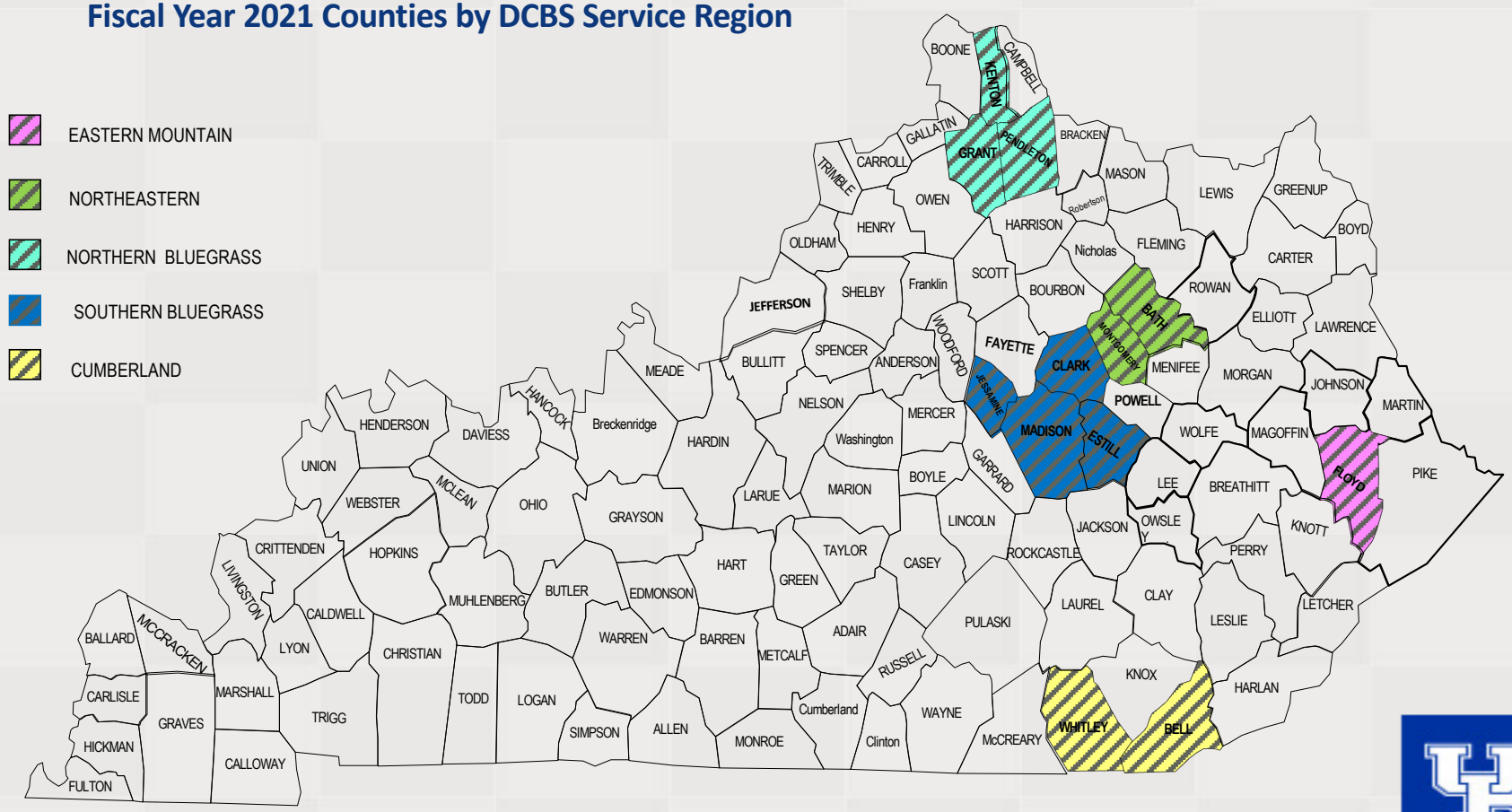
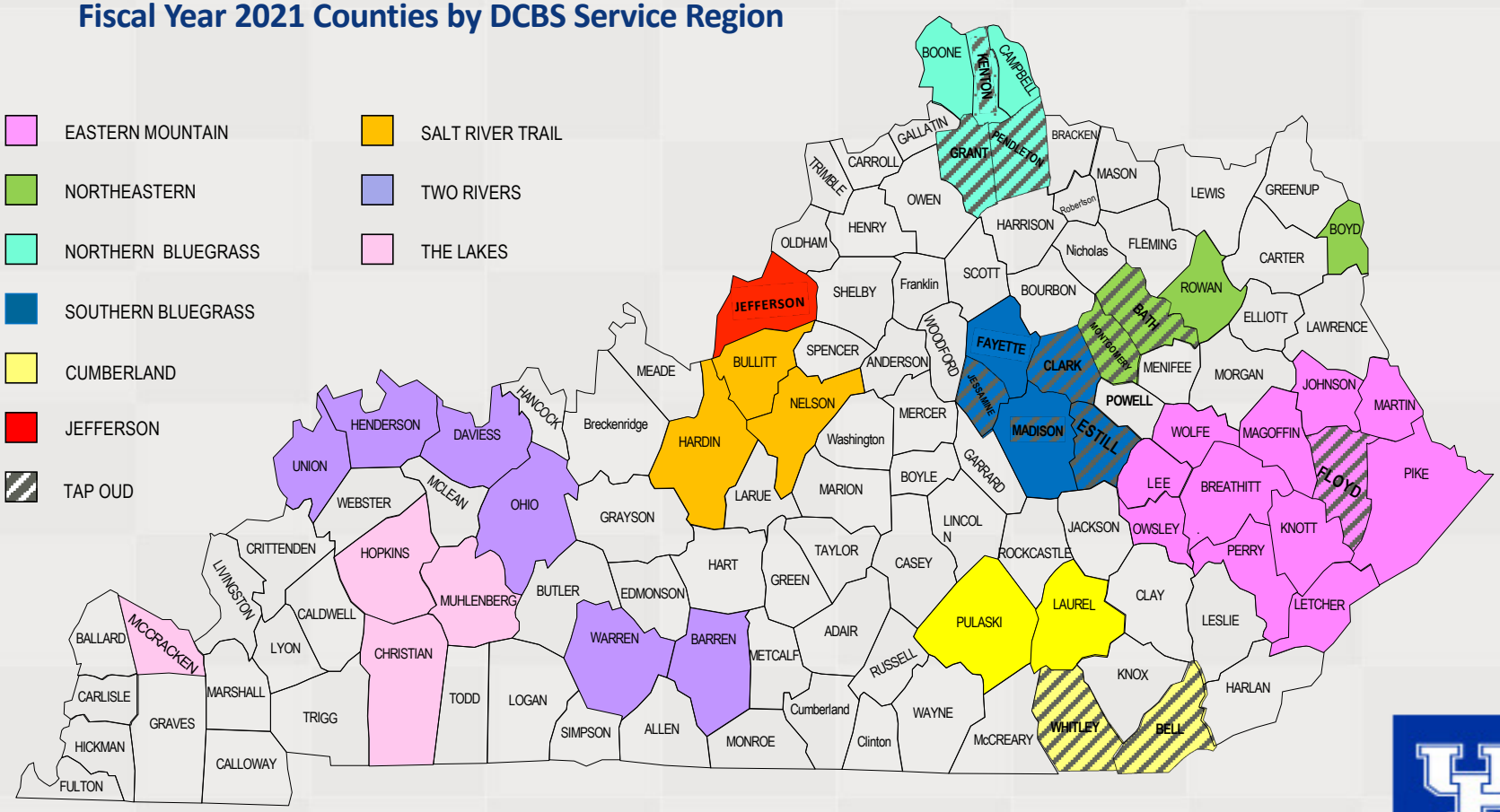
UK Targeted Assessment Program (TAP)
Fiscal Year 2021 Counties by DCBS Service Region



UK Targeted Assessment Program Opioid Use Disorder Project (TAP OUD)
Fiscal Year 2021 Counties by DCBS Service Region



UK Targeted Assessment Program (TAP) and TAP Opioid Use Disorder Project
Fiscal Year 2021 Counties by DCBS Service Region



Eligibility

- Parent or caretaker is receiving Kentucky Transitional Assistance Program (KTAP) benefits or is Temporary Assistance to Needy Families (TANF) eligible
  - Family income at or below 200% of the federal poverty level
- At least one dependent child in the home
- If the child(ren) have been removed from the home, there must be a plan for reunification (can be concurrent with another permanency goal)
- In TAP OUD counties, priority is given to participants with, or at risk for, an opioid use disorder

Who Benefits from Referral

- Parents/caretakers
  - with suspected problems in one or more of TAP OUD's targeted areas (mental health, substance use disorders, intimate partner violence victimization, and learning problems)
  - with/at-risk for opioid use disorders (OUD)
  - dealing with complex multiple barriers and basic needs
  - with learning deficits who need extra help in navigating systems & accessing services
  - in need of crisis consultation & emergency referrals for help
  - who lack sufficient support to address problems or accomplish goals on case plan
  - facing removal or who have had children recently removed
  - who have previously attempted to engage in services but have made little or no progress

TAP OUD Key Practices

- Co-location of TAP OUD with DCBS
- Strong collaboration and communication with DCBS and other community partners
- Persistent outreach to make/maintain contact with participants
- Holistic assessment of barriers and strengths
- Individualized service plan created with each participant in consultation with the referring case worker
- Trauma informed and strengths-based interventions
- Evidence-based practices:
  - Motivational Interviewing
  - Supports trauma-focused cognitive behavioral therapy
  - Pretreatment to resolve internal barriers to service engagement and provide ongoing education & support
- Intensive case management and supportive services to resolve external barriers & encourage progress

Common Barriers

Studies examining the hardships of individuals living in poverty confirm that they have significantly more barriers to self-sufficiency, including

- mental health
- substance abuse
- intimate partner violence victimization
- learning problems
- physical health
- adverse child experiences, such as neglect, child physical, sexual, or emotional abuse, and placement in foster care
- unmet basic needs

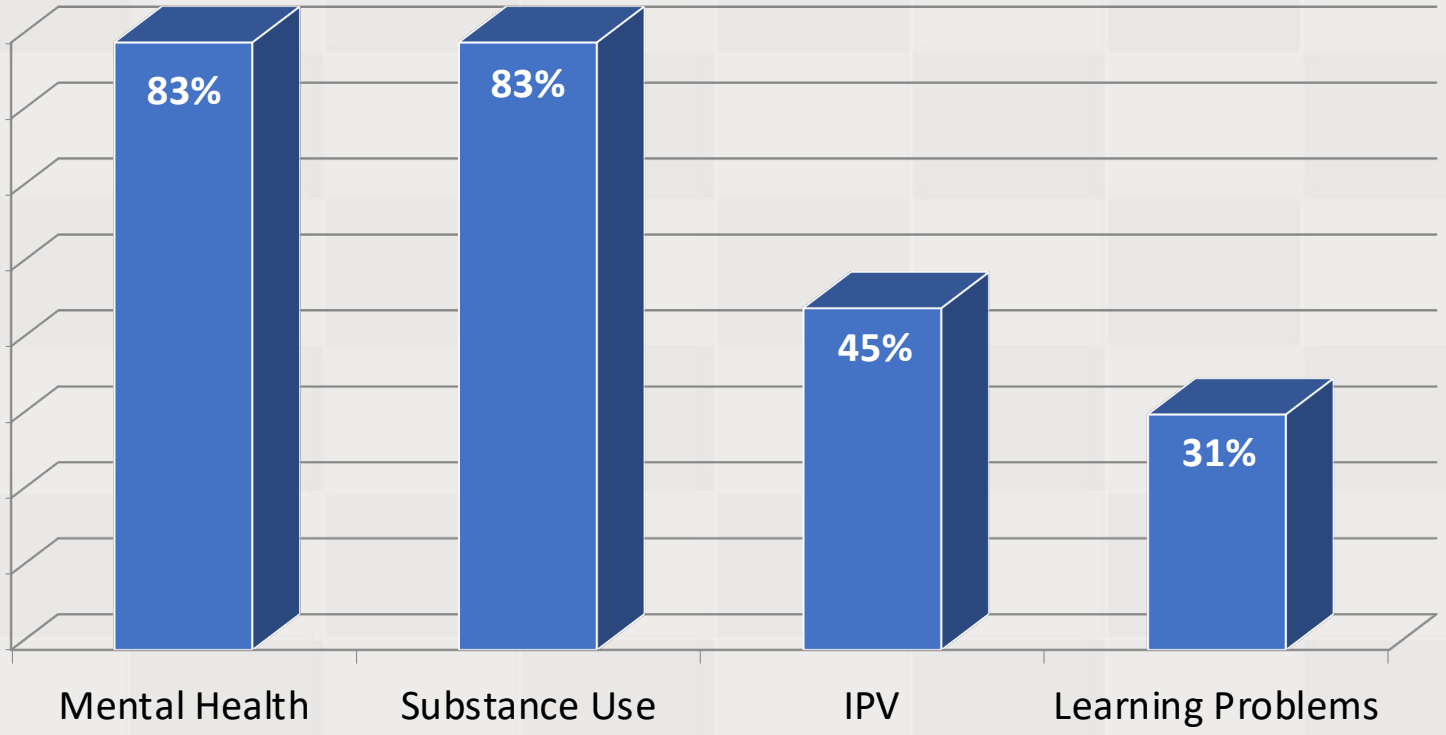
Participant Demographics

Table 1: TAP OUD Participant Demographics (n=356; July 1, 2020 – March 31, 2021).

	TAP OUD Participants
Demographics	
Age (mean)	31 years
Gender (female)	88%
Race (white)	96%
Marital Status (married)	13%
Number of children (mean)	2.4
Education (less than a high school diploma)	29%
Work Hours (mean) per week	11.4 hours

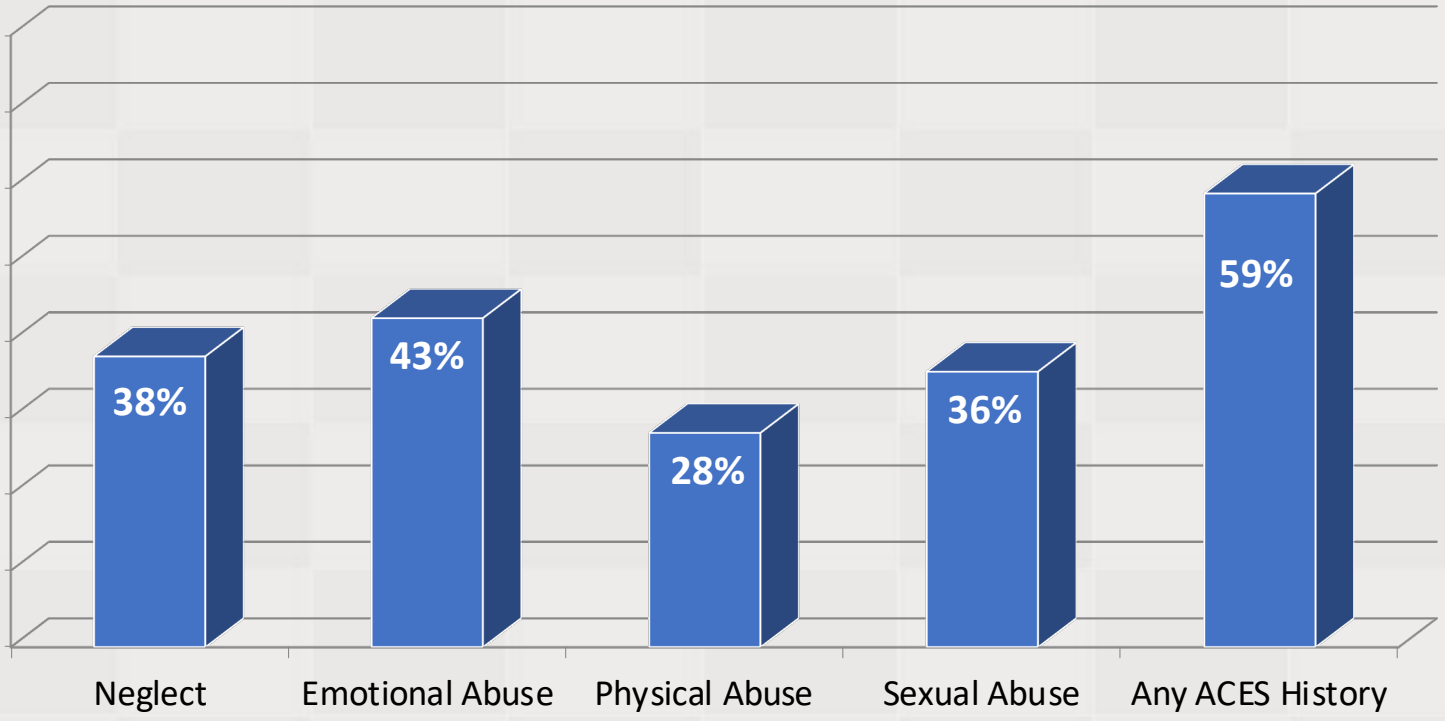
Participant Barriers

Figure 1. Percent of participants assessed with mental health, substance use, intimate partner violence victimization (IPV), and learning problems (n=356; July 1, 2020 – March 31, 2021).



Participant History of Trauma

Figure 2. Percent of participants reporting childhood trauma (n=356; July 1, 2020 - March 31, 2021).



Partnering with parents

System of Care

How TAP OUD supports the system of care for low-income families

- Works with the parent to reduce risk factors in the home by strengthening parental protective factors
- Reduces the negative impact of barriers on children and mitigates risk
- Decreases the risk for removal or re-entry into foster care
- Supports DPP to facilitate reunification as soon as possible if the children are removed
- Helps ensure reasonable efforts have been made when reunification isn't possible
- Participates in local and regional groups
- Participates in Plan of Safe Care; PIP subcommittees; Agency for Substance Abuse Policy Boards; RIACs; Child Fatality Review groups (Mapping Meetings)
- Participates in regular TAP implementation meetings with regional and local DCBS management
- Collaborates with other DCBS partners such as START, KSTEP, KVC, Audubon Area, SAFY
- Participates in Trusted Community Partners and other statewide advisory groups

System of Care

TAP OUD's roles in the system of care

- Conducts a holistic, comprehensive assessment of barriers and strengths to identify barriers – *1 stop assessment*
- Partners with DCBS and the participant to establish goals
- Provides pretreatment to encourage participant engagement in recommended services
- Provides a "warm hand-off" into recommended services
- Provides updates and verifies participants' engagement in recommended services

"It's wonderful to see how this level of intensity can help. And frankly, if a parent can't 'make it' with TAP's help, that really says something."

~ Family Court Judge

System of Care

For TAP OUD, communication and collaboration is a KEY ingredient in the system of care

- TAP OUD provides updates to DCBS on the parent/family's progress
  - Written update once a month, minimum, in addition to updates via phone, email, or 1:1 contact throughout the month
  - Preliminary assessment recommendations immediately after the interview, followed by a written assessment summary
  - Verification of participation in recommended services
- TAP OUD workers are accessible, available and responsive to DCBS and Community Partners
  - Provides consultation on both TAP OUD and non-TAP OUD cases, providing the parent and/or worker with resources and information
  - Responds quickly to phone and email
  - Provides training on a variety of topics, such as the dynamics of addiction and secondary trauma
  - Schedules and participates in Family Team Meetings (FTMs)
  - Accompanies the caseworker on home visits when requested

Sally's Story

- At the time of referral, Sally was a 27-year-old, single Caucasian mother of 2 children, a 4-year-old son and a newborn daughter. She was referred after both she and her daughter tested positive for heroin, fentanyl, and methamphetamine at the hospital. The referral form stated she had a history of substance use, intimate partner violence, and was at risk for becoming homeless. She had prior DPP involvement after the birth of her eldest child four years ago; she successfully completed her case plan, and the case was closed.

Sally's System of Care at Referral

- At time of referral to TAP OUD
  - Medicaid and SNAP
  - DPP who had referred her to
    - HANDS
    - Local Community Mental Health Center for a SUD assessment
    - Parenting Classes
    - TAP OUD

Person-Centered Approach: A Recipe for Change

40% Client Factors

30% Helping Relationship

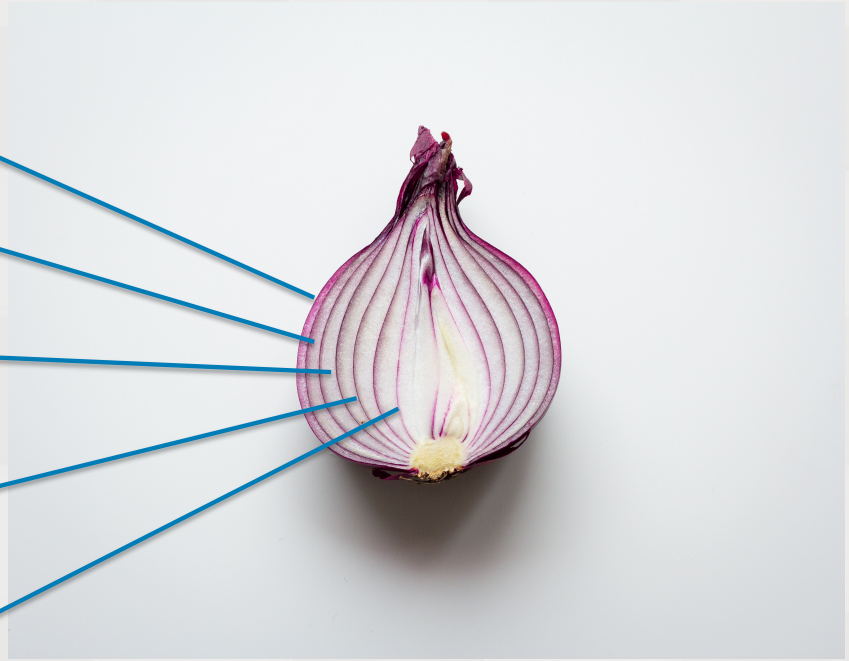
15% Hope/Expectancy

15% Modality

(Thomas, 2006)

Client Factors

- PHYSIOLOGICAL: food, water, oxygen, rest, etc.
- SAFETY: security, stability and freedom from fear, anxiety, threats and chaos.
- BELONGING AND LOVE: intimacy and affection provided by friends, family and lover.
- SELF-ESTEEM: self-respect, respect of others, achievement, attention and appreciation.
- SELF-ACTUALIZATION: the sense that one is fulfilling one's potential.



Client Factors

The Johari Window

- Named after the founders in 1955: Joseph Luft and Harry Ingham
- Illustrates the ‘known’ & ‘unknown’ - what you know and don’t know about yourself and how much others know (or don’t know) about you
- The window contains four panes

(Luft & Ingham, 1955)

Client Factors

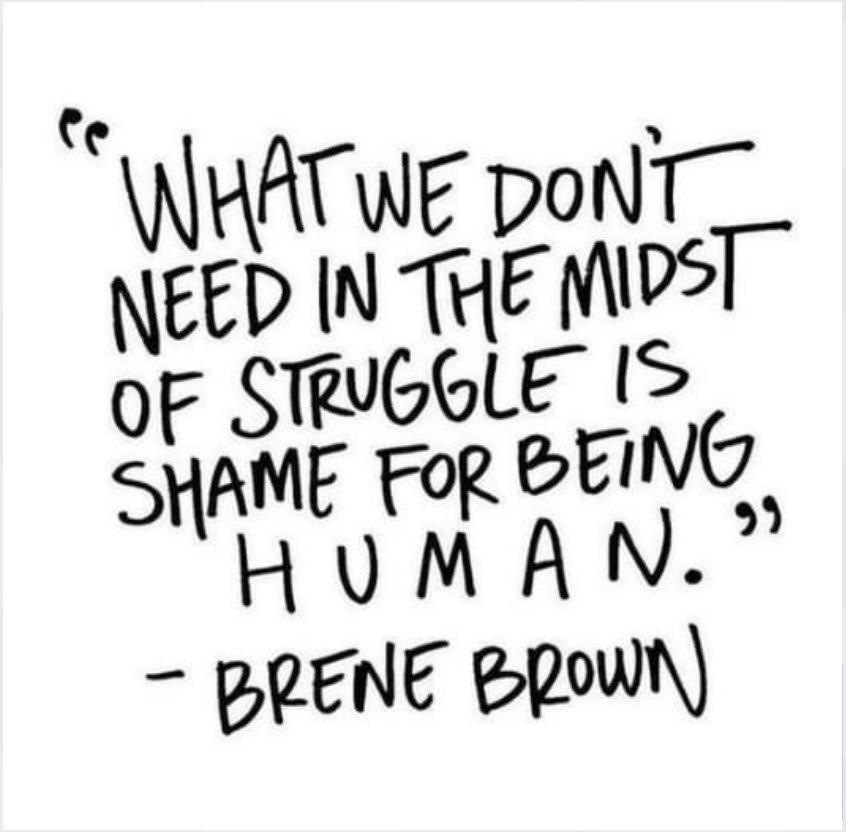
Open Pane Information such as hair color, occupation, and physical appearance. Known to self / Known to others.	**Blind Pane** Includes information that others can see in you, but you cannot see in yourself. You might think you are poor leader, but others think you exhibit strong leadership skills. Blind to self / Seen by others.
Hidden Pane Contains information you wish to keep private, such as dreams or ambitions. Open to self / Hidden from others.	**Unknown Pane** Includes everything that you and others do not know about yourself. You may have hidden talents, for example, that you have not explored. Unknown to self and others.

Sally's Window

Open Pane Young single mother of two small children. Positive drug screens for heroin, fentanyl and meth. Barriers that make it difficult to work and maintain housing, limited income, transportation, and support. Second DPP case. Has a high school diploma. Consistent work history until a year ago when she met and moved in with her infant's father. Gave up her income-based apartment at the time. Known to self/ Known to others.	**Blind Pane** Limited insight into how her barriers impact her and her children. History of trauma that underlies her self-esteem and self-worth but has made her resilient and a survivor. Past success completing her DPP case plan. Had over three years of drug abstinence prior to meeting her infant's father. Demonstrates a deep love for her children and knowledge of parenting and child development. Honest and open to suggestion. A good listener. Self-motivated. Not easily broken. Blind to self/ Seen by others.
Hidden Pane A history of IPV with her newborn's father and a fear of what he will eventually do to harm her. Her partner is also her drug dealer and leaving him may cut her off from drugs and she is fearful of going through withdrawal. Experienced post-partum depression after her 4-year-old was born. Survivor of childhood sexual abuse. Witnessed IPV as a child. Limited family support, no relationship with her father who abandoned the family when she was 12. Open to self/ Hidden from others.	**Unknown Pane** Could be a strong student should she be interested in furthering her education. She may be able to concentrate more on her daily activities if her post-partum depression is treated properly. May flourish in a support group for survivors of IPV and make long term supports within the group. Participation in MAT could increase her likelihood for long-term recovery. Unknown to self and others.

Relationship Factors

- The Importance of Trust
- ***NOT EVERYONE DESERVES TO HEAR OUR STORY***



Relationship Building

TAP OUD

- Builds a trusting relationship
  - Hears them; helps reduce their anger/confusion, sense of shame
  - Provides respect
  - TAP OUD is as accountable to the participant as they are to the DCBS case worker
- Facilitates communication between DCBS and the participant
  - Go between with DCBS
  - Helps the parent understand the DCBS and court process
  - Helps the parent develop a realistic sense of timelines

"Some of my clients have been too afraid to reach out to me so they talk to TAP first and ask them to be present when meeting with me." ~ Samantha Campbell, DPP Supervisor, Breathitt and Wolfe County

Outreach & Engagement

- Persistent outreach to make/maintain contact with participants
  - TAP OUD goes to great lengths to locate DCBS clients referred to the program. We use an intensive outreach process to find them and offer services.
  - TAP OUD continues to offer services no matter what. TAP OUD doesn't "fire" participants, takes former participants back when they no-show and/or don't follow recommendations, etc.
  - TAP OUD makes referrals and front-loads services, following up with case management to ensure participant is engaged in services. Case workers need to make only one referral. Parents only need to start with one provider (TAP OUD). This saves the case worker many steps and prevents the parent from becoming overwhelmed.

Relationship Factors

Rogers' Person-Centered Theory

- Empathy
- Genuineness
- Positive Regard

(Cherry, 2017)

TAP OUD and Sally

- Began with first contact
- Continued with a holistic assessment
- Utilized pretreatment education on identified barriers and asked for her input into recommendations for services
- Provided service coordination to assist her engagement into recommended services

Relationship Factors

EMPATHY

- Accurately sensing the client's world; being able to see things the way they do
- Verbally sharing your understanding with the client

Relationship Factors

Visual	Auditory	Kinesthetic
• It seems like • It appears as though • From my perspective • As I see it • It looks • From my point of view • My picture of it is	• Sounds like • As I hear it • What you're saying is • I hear you saying • Something tells you • You're telling me that • I can tune into this	• You feel • From my standpoint • I sense that • I have the feeling that • I can grasp

Relationship Factors

"It is a paradox … we push harder to get someone to do something, and yet we will get less of what we want because their brain will stop working in the ways we need.

So, the Bible's principle of "speak the truth in love" is not only a nice thing to do, it is sound brain anatomy and biochemistry. When we do that, we actually are helping someone's brain function in a way that will get to a solution, instead of causing it to react."

(Cloud, 2013)

Relationship Factors

GENUINENESS

- Authenticity
- Open communication
- Be direct and open in the way you communicate
- Do not present as you have all the answers and solutions
- Be yourself as an example
- Encourages openness (stop denying), authenticity (stop pretending), truthfulness (stop concealing thoughts and feelings)

Relationship Factors

UNCONDITIONAL POSITIVE REGARD

- To communicate a willingness to work with the client
- To communicate interest in the client as a person
- To communicate acceptance of the client
- To communicate caring to the client

Advocacy & Empowerment

- TAP OUD empowers participants to advocate for their rights, their needs – gives them a voice when engaging in services and with DCBS
  - Facilitates communication between DCBS and the participant
  - Advocates with community providers and Court
  - Prevents duplication of services
  - Provides continuity of care

TAP OUD and Sally

- Began with first contact
  - Helped her understand why she was being referred
  - Explained why working with TAP helps her with her case plan
  - Explained the DPP process, timelines and expectations
- Continued with a holistic assessment
  - Listened to her story
- Utilized pretreatment education on identified barriers and asked for her input into recommendations for services
  - Asked her what her goals were and where SHE wanted to start with addressing her barriers
  - Provided a list of potential service providers and helped her choose
  - Helped her scheduled her appointments
  - Transported her and stayed with her for her first appointment

Modality

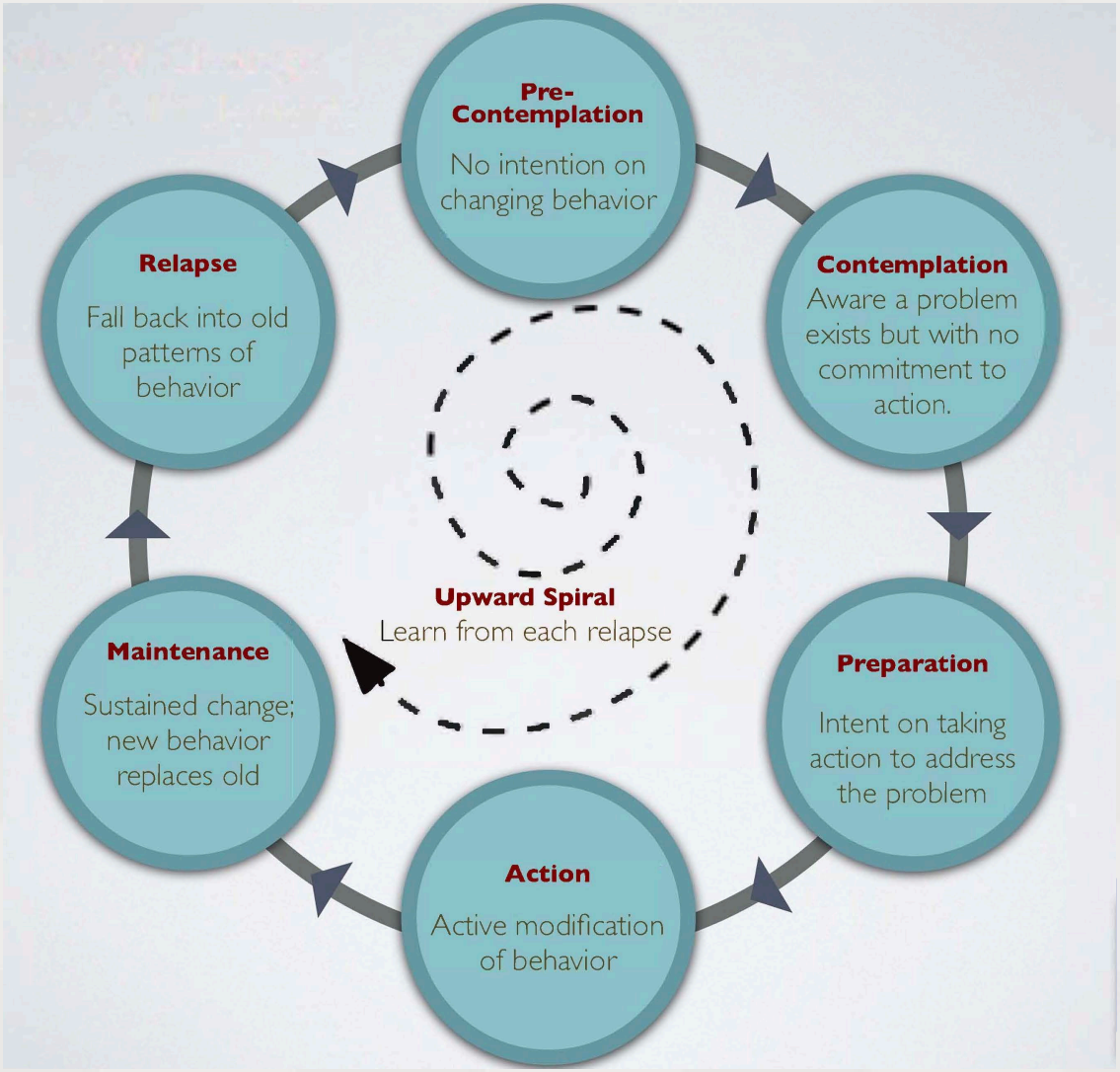
- Strategies used to partner with parents in developing their recovery plan.
- Strategies used to support treatment engagement and retention.

Motivational Interviewing,
Strength-based, and Trauma-informed Interventions

Modality

Transtheoretical Model of Behavior “Stages of Change”

(Prochaska & DiClemente, 1984)



Modality

What does it take to move through the stages?

Motivation

Modality

Definition of Motivation

Motivation can be understood not as something that one has but rather as something one does. It involves recognizing a problem, searching for a way to change, and then beginning and sticking with that change strategy. There are, it turns out, many ways to help people move toward such recognition and action.

Modality

Definition of Motivational Interviewing

"Motivational interviewing is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence."

(Miller & Rollinick, 2013)

Modality

Motivational Interviewing is founded on four basic principles

- Express empathy.
- Develop discrepancy.
- Roll with discordance.
- Support self-efficacy.

(Miller, Zweben, DiClemente, & Rychtarik, 1992, p. 8)

Modality

The Four Tasks of Motivational Interviewing

- **Engage** through having sensitive conversations with clients.
- **Focus** on what's important to the client regarding behavior, health, and welfare.
- **Evoke** the client's personal motivation for change.
- **Negotiate** Plans.

Motivating often means resolving conflicting and ambivalent feelings and thoughts

Modality

"Spirit" of Motivational Interviewing

- Partnership that encourages power sharing
- Evokes what's inside the client – not education, evoking what they already know – perceptions, experiences, goals
- Autonomy (not authority)
- Emphasizes clients are in control and the choice is theirs
- Firmly rooted in compassion and at the need to act in the best interest of the client
- A skill that requires the clinician to practice and master

Sally and the Stages of Change

- Contemplation at time of referral
  - Past treatment and recovery
  - Wants to leave the relationship
- Planning at time of assessment
  - Acknowledges barriers
  - Open to discussing potential services/providers
- Action
  - Accepted referrals
  - Let us make and accompany her to appointments
  - Applied for and obtained income-based housing
  - Filed for an EPO
  - Started work
  - Researching options for further education
- Maintenance after fully engaging in services and supports
  - Negative drug screens
  - Engaged in MAT
  - Attending 12-step meetings and working with a sponsor
  - Engaged in trauma-focused therapy
  - Maintained housing
  - Maintained employment

Modality

Strength-based interventions

- Hallmarks
  - Client-centered goals
  - Systematic assessment of strengths
  - The environment is a rich resource
  - Explicit methods are used for the development of the individual and the environment's strengths towards goal attainment
  - A relationship that is hope-oriented
  - The individual has the autonomy to choose
- Language matters; use person-first language when talking about emotional health and addiction
- Building on strengths instead of focusing on weaknesses
- Looks for what can go right instead of what can go wrong

(Rapp, Saleebey, & Sullivan, 2008)

Useful Websites

- Language Matters in Mental Health: https://hogg.utexas.edu/news-resources/language-matters-in-mental-health
- Podcast: Why Language Matters When it Comes to Addiction: https://www.wnycstudios.org/podcasts/takeaway/segments/stigma-addiction-language
- Addictionary: https://www.recoveryanswers.org/addiction-ary/
- Words Matter: https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction

Modality

Key Principles of Trauma-informed Care

- Trauma Understanding
- Safety & Stability
- Cultural Humility & Responsiveness
- Compassion & Dependability
- Collaboration & Empowerment
- Resilience & Recovery

(SAMHSA, 2014)

Modality

Trauma-informed in Action

Screen

- Routinely screen for trauma exposure and related symptoms;

Use

- Use culturally appropriate assessment and treatment for traumatic stress and associated mental health symptoms;

Consider

- Consider the impact of traumatic stress on mental and physical well-being;

Attempt

- Attempt to strengthen resilience and protective factors;

Address

- Address the trauma that parents, caregivers, and family have experienced

Maintain

- Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience.

Strategies

Employing strategies in each stage

- Motivational Interviewing
- Trauma-informed and Strength-based Interventions

Strategies

- Strategies in the Precontemplation Stage
  - Reflect and listen
    - Establish rapport
    - Approach with empathy not sympathy
    - Unconditional positive regard
  - Develop discrepancies between goals and current behaviors
  - Accept or adjust their discord instead of confronting it
  - Establish safety and stability (elicit trust)
  - Believe their story and identify strengths

Strategies

- Strategies in the Contemplation Stage
  - Explore ambivalence
  - Elicit change talk
  - Explore pros and cons
  - Focus the conversation on choosing change
  - Elicit hope
  - Build on identified strengths
  - Encourage and believe in their ability to change

Strategies

- Strategies in the Planning Stage
  - Create a specific plan
  - Remove obstacles
  - Collaboration and empowerment (the power of choice)
  - Reinforce belief in their ability to change

Strategies

- Strategies in the Action Stage
  - Support and affirm successes
  - Highlight unintended benefits
  - Continue to remove obstacles
  - Begin to talk about relapse
  - Reinforce “safety first”
  - Acknowledge and celebrate progress

Strategies

- Strategies in the Maintenance Stage
  - Support self-efficacy
  - Reevaluate and reinforce plan
  - Develop skills to maintain change
  - Acknowledge new strengths and celebrate progress

Strategies

- Strategies in the Relapse Stage
  - Express unconditional positive regard and empathy
  - Frame relapse as a learning opportunity
  - What have we learned about what did/didn't work
  - Assess current stage of change "Where are we now?"
  - Reinforce partnership "Where do ***we*** go from here?"

Final Thoughts

- Understand the need for a holistic, trauma-informed, strength-based, and person-centered engagement.
- Identify strategies to partner with parents in developing their recovery plan.
- Identify strategies to develop mutually supportive community partnerships.
- Identify strategies to support treatment engagement and retention.

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Questions?

Thank You!