



A Transformative  
and Evidence-  
based System  
Response for  
Parents With  
Opioid Misuse and  
Their Children:

Challenges and  
Opportunities In  
Your Community



FLORIDA DEPARTMENT  
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# COLLABORATIVE GROUPS?

- Are there existing collaborative groups currently working on opioid or other substance abuse/child welfare families in your jurisdiction?



# LEARNING OBJECTIVES

- Identify the critical components of an effective community system response to parental opioid misuse, including: screening; assessment; medication-assisted treatment (MAT); recovery support; continuing care; and workforce development and collaboration.
- Identify local barriers to an effective local community system response to parental opioid misuse.

# LEARNING OBJECTIVES

- Identify the critical components of an effective community system response for children of parents with opioid misuse.
- Participate in an interactive process to collaborate with local community partners to identify challenges and opportunities to inform continued development of a transformative and effective local system response to parents and children affected by opioid misuse.

# TERMS<sup>1</sup>

- **Opioids:** Opioids are drugs that reduce the intensity of pain signals from pain associated with conditions such as cancer, arthritis, and other degenerative conditions. They are also used to alleviate short-term pain related to injuries, surgery, or dental work. Opioids can include prescribed medications, counterfeit substances (including fentanyl) made to trick the user into thinking they are real, and heroin.
- **Opioid misuse:** In this context, misuse involves the intentional or unintentional use of opioid medication in a way other than prescribed, or for the experience or feeling it causes.

# TERMS

- **Medication-Assisted Treatment (MAT):** MAT, also referred to as pharmacotherapy, is the use of Food and Drug Administration (FDA)-approved medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders (SUDs).<sup>2</sup>
- **Medically supervised withdrawal or tapering** (formerly called detoxification): Using slowly decreasing doses of medications to help a patient discontinue illicit or prescription opioids.<sup>3</sup>

# TERMS<sup>4</sup>

- **Methadone** – clinic-based opioid medication that does not block other narcotics but prevents withdrawal while taking it; daily liquid dispensed only in specialty regulated clinics
- **Naltrexone** – office-based non-addictive opioid medication that blocks the effects of other narcotics; daily pill or monthly injection
- **Buprenorphine** – office-based opioid medication that blocks other narcotics while reducing withdrawal risk; daily dissolving tablet, cheek film, or 6-month implant under the skin



# TERMS<sup>5</sup>

- **Relapse (opioid use disorder [OUD] context):** A process in which a person with OUD who has been in **remission** experiences a return of symptoms or loss of remission. A relapse is different from a **return to opioid use** in that it involves more than a single incident of use. Relapses occur over a period of time and can be interrupted. Relapse need not be long lasting.
- **Return to opioid use:** One or more instances of **opioid misuse** without a return of symptoms of OUD. A return to opioid use may lead to **relapse**.
- **Remission:** A medical term meaning a disappearance of signs and symptoms of the disease. People who previously met OUD criteria but no longer meet any OUD criteria (with the possible exception of craving) are considered to be in remission. Remission is an essential element of recovery.

# CRITICAL COMPONENTS: EVIDENCE-BASED AND PROMISING PRACTICES

- Screening; Assessment; Medication-Assisted Treatment; Recovery Support; Continuing Care; and Workforce Development and Collaboration



## SYSTEM COMPONENT: SCREENING

# SUBSTANCE USE AS A FACTOR?

- What percent of parents involved in the child welfare system do YOU think have substance use as a factor in the child maltreatment?



# PREVALENCE OF SUD AMONG CHILD WELFARE FAMILIES

- Answer: Many, if not most children under the jurisdiction of child welfare agencies and the courts come from families with SUDs.<sup>6</sup>
- Estimates range from 40% to 80% of families involved with child welfare having substance use problems.<sup>7</sup>
- How did your estimate align?



# CONTRIBUTING FACTOR

- Child welfare workers report that **most** children in child welfare and the overwhelming majority of children placed in out-of-home care have a parent with an alcohol or other SUD.<sup>8</sup>

Prevalence of Parental Alcohol or Other Drug Use as a Contributing Factor for Reason for Removal in the United States, 2000 to 2016



Child welfare workers report that most children in child welfare, and the overwhelming majority of children placed in out-of-home care, have a parent with an alcohol or other substance use disorder. Parental alcohol or other drug use as a contributing factor for reason for removal increased from 18% to over 35% in the last 16 years.

Note: Estimates based on all children in out-of-home care at some point during Fiscal Year

Source: AFCARS Data, 2000-2016

# CHILD REMOVALS<sup>9</sup>

- In Florida, as in many other states, the number of children removed from their homes is steadily increasing.
- In February 2018, nearly 50% of removed children (632) in Florida were removed because of parental drug abuse and 20% (263) were removed because of inadequate supervision.

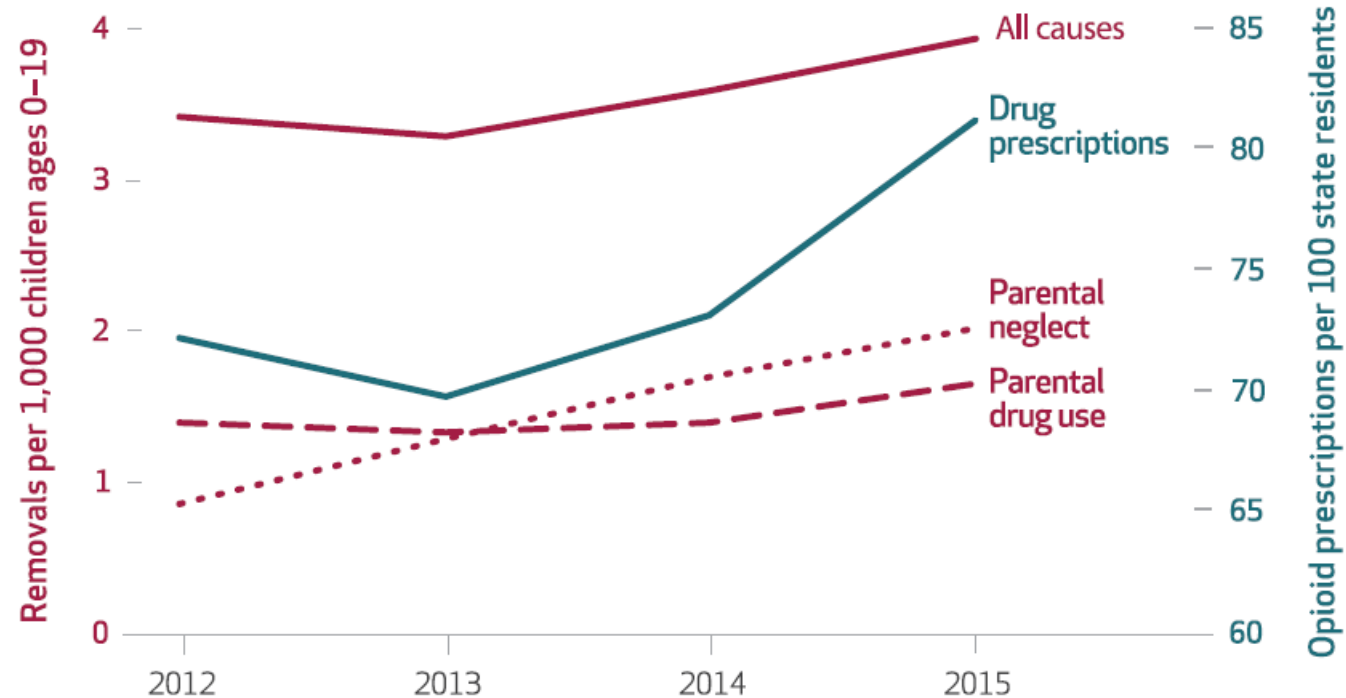
## SUBSTANCE ABUSE

By Troy Quast, Eric A. Storch, and Svetlana Yampolskaya

# Opioid Prescription Rates And Child Removals: Evidence From Florida<sup>10</sup>

## EXHIBIT 1

Annual statewide rates of child removal and drug prescription in Florida, 2012-15





# EVIDENCE-BASED/BEST PRACTICE: SCREENING<sup>11</sup>

- Screenings are brief, rapidly administered tools that determine whether a problem or condition exists and if there is a need for an assessment.
- Screening parents and children involved in the child welfare system for the effects of SUDs and other co-occurring risk factors is an essential part of determining risk and safety.

# EVIDENCE-BASED/BEST PRACTICE: SCREENING<sup>12</sup>



- Although families may not reply honestly to screenings conducted as part of initial investigations, it is likely that indications of SUDs will emerge as workers become more familiar with family histories.
- It is essential for workers to approach screening as an **ongoing** and routine part of their work, and not as a one-time event confined to initial and early investigations. Staff should combine screening results with information gathered from other sources.

# WHY OPIOID SCREENING IS IMPORTANT



- The opioid epidemic differs from previous surges in substance abuse (crack cocaine in the 1980s and methamphetamines in the 2000s) because of the higher risk of death from overdose. Another difference is the role of prescription medication in treatment (methadone, buprenorphine, or naltrexone) which can prevent cravings and ease withdrawal symptoms.<sup>13</sup>

## CHALLENGE: YET...MOST PARENTAL SUD IS MISSED

- In the only study which collected data (from a nationally representative sample of 5,504 families who had not been investigated by child welfare) on caregiver substance dependence, the workers did not identify a substance use problem in 61% of the caregivers who actually met criteria for alcohol or drug dependence. Child welfare workers were even more likely to miss potential alcohol or drug problems among caregivers who used but were not dependent on a substance.<sup>14</sup>
- Case record reviews consistently found higher rates than parent self-reports or caseworker reports.<sup>15</sup>

# DISCUSSION OF YOUR LOCAL SUD SCREENING PROCESS FOR CHILD WELFARE- INVOLVED PARENTS WITH SUD

- What, if any, screening barriers are present?







# SYSTEM COMPONENT: SUD ASSESSMENT

# EVIDENCE-BASED/BEST PRACTICE: ASSESSMENT<sup>16</sup>

- Assessments are typically multidimensional and involve the use of standardized questions in an interview to identify whether substance use (which may have been identified in screening) has reached the level of a mild, moderate, or severe SUD.
- Assessments are performed by trained substance use or behavioral health staff that provide information regarding a person's functioning, needs, and strengths and that leads to a determination of level of care and needed services.

# EVIDENCE-BASED/BEST PRACTICE: ASSESSMENT<sup>17</sup>

- The more that SUD treatment and child welfare staff communicate with each other systematically, the more complete and beneficial the SUD assessment process will be.
- Information garnered from assessments should be shared with dependency courts for situations in which families are under court jurisdiction so that needed services can be included in court-ordered case plans.



## EVIDENCE-BASED/BEST PRACTICE: ASSESSMENT FOR OUD<sup>18</sup>

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends assessing individuals for OUD if:

- They screen positive for opioid misuse.
- They disclose opioid misuse.
- Signs or symptoms of opioid misuse are present.

**If a provider does not offer pharmacotherapy, the focus should be on medical assessment, making a diagnosis of OUD, and patient safety.** This allows the provider to refer patients to the appropriate level of treatment. Either way, the SAMHSA Opioid TIP 63 provides detailed guidance on opioid assessment.

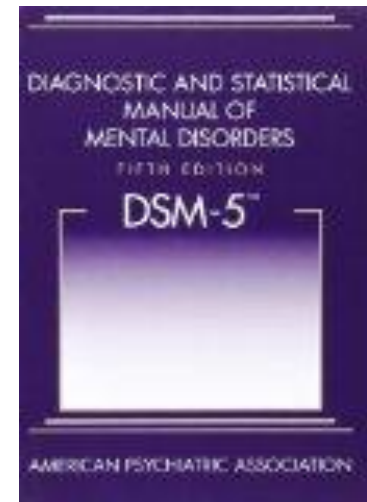
## EVIDENCE-BASED/BEST PRACTICE: ASSESSMENT FOR OUD

- Parents identified by the child welfare system are often reluctant to disclose their opioid or other substance use out of fear their children may be taken away from them.
- Motivational interviewing strategies, such as asking open-ended questions, foster successful assessment. The assessment setting should create a welcoming environment that is nonjudgmental, respectful, and empathetic.<sup>19</sup>
- SUDs are highly variable in their course, complexity, severity, and impact on an individual's health, well-being and in their connection to the safety and wellbeing of an individual's children.

# DSM-5: SUD SEVERITY<sup>20</sup>

The SUD assessor will have to determine severity as follows:

- 0-1 = No diagnosis
- 2-3 = Mild SUD
- 4-5 = Moderate SUD
- 6-11 = Severe SUD



# DSM-5: SUD ASSESSMENTS<sup>21</sup>

Comprehensive assessment of nature and complexity of the individual's problems as well as strengths. The SUD assessor will have to determine:

1. Use in larger amounts or longer than intended
2. Desire or unsuccessful effort to cut down
3. Great deal of time using or recovering
4. Craving or strong urge to use

## CRITERIA 1-4 RELATE TO USE

1. Report observations of drugs, paraphernalia, parent appearance
2. Family and collateral reports/observations
3. Current and past substance allegations

# DSM-5: SUD ASSESSMENTS<sup>22</sup>

- 5. Role obligation failure
- 6. Continued use despite social/interpersonal problems
- 7. Sacrificing activities to use or because of use
- 8. Use in situations where it is hazardous

## CRITERIA 5-8 RELATE TO BEHAVIORAL ISSUES

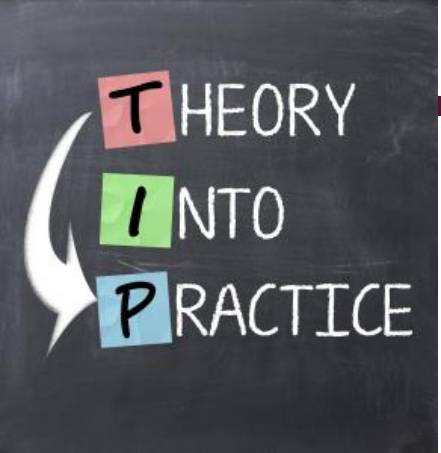
- 1. Inactive **parenting roles**
- 2. No age-appropriate activities with child
- 3. **Interpersonal** problems (social isolation, strained relationships)
- 4. Inability to retain **employment**
- 5. ER visits, DUIs, drug criminal hx

# DSM-5: SUD ASSESSMENTS<sup>23</sup>

- 9. Continued use despite knowledge of having a physical or psychological problem caused or exacerbated by use
- 10. Tolerance
- 11. Withdrawal

## CRITERIA 9-11 RELATE TO PHYSICAL/EMOTIONAL ISSUES

- 1. Observed withdrawal symptoms (e.g., profuse sweating, trembling, goose flesh, and vomiting)
- 2. Drug test results and Blood Alcohol Level (BAL)



## CW-5 DETERMINING NEED FOR ASSESSMENT

### TOTALITY OF INFORMATION

1. Substance Misuse Priors (Child Welfare Hx)
2. Drug-related Criminal Hx
3. Family Arranged Out of Home Placements
4. PRIOR TREATMENT ADMISSIONS and COMPLETIONS
5. Lack of Current Engagement

# OTHER PERTINENT INFORMATION



- The presence or absence of support by family (immediate or extended), faith community, or close friends
- The extent to which the caregiver has stable housing
- Any treatment barriers (e.g., domestic violence, financial, transportation, cultural, other barriers)

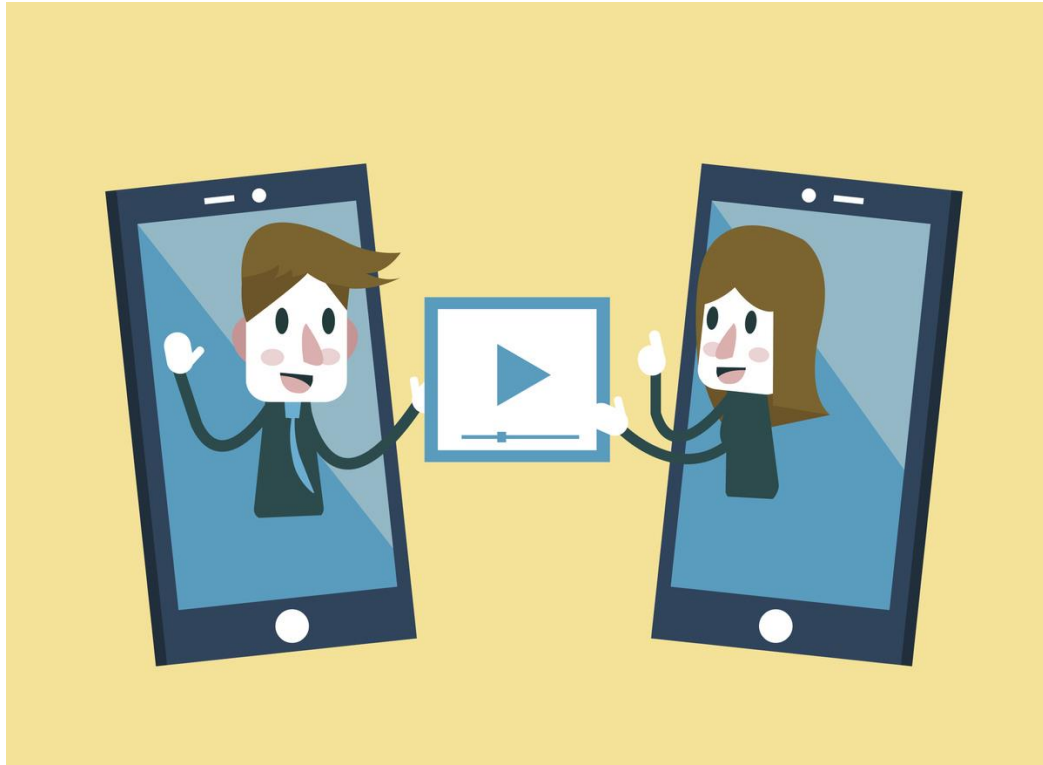


# IMPORTANT ASSESSMENT CONSIDERATIONS

- Without supporting SUD-related information from the child welfare system staff, an SUD assessor may only have the parent's word (self-report) on which to base an assessment.



# EVIDENCE-BASED/BEST PRACTICES: ASSESSMENT



- Assessments that are done separately by either child welfare or substance abuse staff, in parallel but not coordinated processes, run the risk of overlooking factors critical to recovery and family stability, thereby depriving families of needed services and reducing the likelihood that they will achieve their goals.<sup>24</sup>

## EVIDENCE-BASED/BEST PRACTICE: ASSESSMENT<sup>25</sup>

- The point at which families are referred from one system (e.g., child welfare system) to another system (e.g., SUD system) for assessment is a critical one in setting the stage for whether families engage and remain in services.
- If the transition across systems is seamless and timely, families are more likely to feel that service plans will be realistic, feasible, and targeted to their needs.
- If the transition is marked by delays, complications, and passive referrals that are not coordinated and that lack follow-up by either system, families are likely to feel disconnected from their service providers and are more likely to fall through the cracks as they attempt to create the linkages they expect from their service providers.

# TIMELY ASSESSMENT

- The first 24 hours after a client's initial phone contact is a critical period in initiating assessment and treatment. One possible reason may be that clients are often in crisis when contacting the agency. Another possibility is that clients may have only temporarily overcome internal or external barriers to treatment.<sup>26</sup>



# TIMELY APPOINTMENT

- Offering an appointment date immediately and reminding clients of their initial scheduled appointment usually improves the rate at which clients will begin treatment.<sup>27</sup>



## QUICK ACCESS TO TREATMENT<sup>28</sup>



- Because individuals with SUDs may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical.
- Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.



# DRUG TESTING

Drug testing (urine or oral fluid) will need to be initiated before patients start OUD medication (pharmacotherapy) and during treatment for monitoring. During ongoing pharmacotherapy with buprenorphine or methadone, drug testing can confirm medication adherence.<sup>29</sup>



# SPECTRUM OF SUDS



**A Problem for Child Welfare and Court Officers:  
A drug use admission or drug test does not tell you anything about the individual's  
place on the spectrum**

***Experiment  
and  
Use***



***Abuse***

***Disorder***



## DRUG TESTING: DURING ASSESSMENT AND BEYOND <sup>30</sup>

- Drug tests tell you whether a particular substance or panel of substances were present in a person's body at sufficient levels to register at a point in time.
- Drug tests alone **do not** provide information about whether a person has a SUD (or in fact where they are on the substance use spectrum - see prior slide).
- Drug testing by itself is not an effective gauge of progress, and drug testing results should always be considered in light of other circumstances, actions, and observations.

# DISCUSSION OF YOUR LOCAL ASSESSMENT PROCESS FOR CHILD WELFARE- INVOLVED PARENTS WITH SUD

- What, if any, assessment barriers are present?





What opportunities do YOU see for making progress addressing local screening and assessment barriers and challenges?



SYSTEM  
COMPONENT:  
TREATMENT,  
INCLUDING  
MAT

## Components of Comprehensive Drug Addiction Treatment <sup>31</sup>



*The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.*

## WHY MEDICATION?<sup>32</sup>

- Typically, the changes in the brain caused by opioid dependence will not correct themselves right away, even though the opioid use has stopped.
- These changes can trigger cravings for the drug months and even years after a patient has stopped using opioids.
- Overcoming opioid dependence is not simply a matter of eliminating opioid substances from the body.
- Unless restorative, rebalancing treatment is provided, these functional brain imbalances can result in worsening or sabotage of recovery attempts.



# THE FDA-APPROVED MEDICATIONS<sup>33</sup>



- Methadone may be provided only through opioid treatment programs (OTPs) that are regulated, certified, and accredited through SAMHSA and the Drug Enforcement Administration (DEA).



## THE FDA-APPROVED MEDICATIONS<sup>34</sup>

- Buprenorphine can be provided either by an opioid treatment program or by office-based providers, who may be primary care providers (physicians, nurse practitioners, and physician assistants) who have received training on the medication as well as a waiver issued by SAMHSA in coordination with the DEA.
- These waivers are called DATA waivers after the Drug Abuse Treatment Act of 2000, which permits qualified practitioners to treat OUD with certain narcotic controlled substances that have been approved by the Food and Drug Administration (FDA) for that purpose.

## THE FDA-APPROVED MEDICATIONS<sup>35</sup>

- Naltrexone can be provided by any physician or health care provider who has the authority to issue prescriptions and who is operating within their scope of practice, without special certification or training.
- In addition to these pharmacotherapy medications, naloxone is a medication that rapidly reverses opioid overdose. It is used to treat overdose but does not address the underlying substance use disorder.

## MAT BENEFITS<sup>36</sup>

**The three FDA-approved medications used to treat OUD improve patients' health and wellness by:**

- Reducing or eliminating withdrawal symptoms: methadone and buprenorphine.
- Blunting or blocking the effects of illicit opioids: methadone, naltrexone, and buprenorphine.
- Reducing or eliminating cravings to use opioids: methadone, naltrexone, and buprenorphine.
- Re-establishing normal brain functioning, as long-term drug use results in significant changes in brain function that can persist long after the individual stops using drugs.

## MAT BENEFITS<sup>37</sup>

- Methadone and buprenorphine (which are themselves opioids) both reduce the patient's cravings and suppress symptoms of withdrawal, essentially by tricking the brain into thinking it is still getting the abused drug but without the euphoric effects of most commonly abused opioids.
- Naltrexone blocks the euphoria as well as other effects (including pain relief) by preventing the opioids from attaching to the opioid receptors in the brain. The result is that even if a person relapses and uses an opioid, its euphoric effects are limited, which may help motivate the patient to reengage in treatment.

# MAT BENEFITS AND SUBSTITUTION MYTH<sup>38</sup>

- **Methadone and buprenorphine DO NOT substitute one addiction for another.** When someone is treated for an opioid addiction, the dosage of medication used does not get them high—it helps reduce opioid cravings and withdrawal. These medications restore balance to the brain circuits affected by addiction, allowing the patient's brain to heal while working toward long-term recovery.



## MAT BENEFITS: MAT IS EVIDENCE-BASED<sup>39</sup>

- MAT is a well-studied, effective, evidence-based treatment that significantly improves treatment outcomes. Patients taking medication for OUD are considered to be in recovery. MAT increases social functioning and retention in treatment. Numerous studies have documented that patients treated with medication are more likely to remain in therapy compared to patients receiving treatment that did not include medication.

# MAT BENEFITS: MAT IS EVIDENCE-BASED



- Research has documented that the combination of medication with counseling and recovery support is more effective than substance use treatment without medications in treating OUD. Available research evidence indicates that MAT improves treatment adherence, reduces the risk of overdose death, and reduces the risk of contracting associated infectious diseases, such as HIV and hepatitis B and C, among other outcomes.<sup>40</sup>



## MAT AND PREGNANCY

- The transition to parenthood is often a critical opportunity for intervention because parents often experience heightened motivation levels for addressing their addictions at this juncture in their lives.<sup>41</sup>



## MAT AND PREGNANCY<sup>42</sup>

- Caring for a young child can be viewed by a parent as a deeply meaningful opportunity to successfully navigate their addiction recovery.
- Motivation can be harnessed by encouraging parents to take steps they have long been considering and are now ready for, including taking better care of themselves and their family.

# MAT AND PREGNANCY

- Pregnant women with OUD are more likely to seek prenatal care late in pregnancy, miss appointments, experience poor weight gain, or exhibit signs of withdrawal or intoxication.<sup>43</sup>
- MAT is recommended for pregnant women with OUD and is considered the best option for healthy fetal development, despite the risk of neonatal abstinence syndrome (NAS).<sup>44</sup>
- The benefits of pharmacotherapy for OUD during pregnancy outweigh the risks of untreated OUD.<sup>45</sup>

## MAT AND PREGNANCY<sup>46</sup>

- **SAMHSA's guidance is clear:** Pregnant women with OUD should **not** be encouraged to withdraw from pharmacotherapy for OUD during their pregnancy or shortly after delivery. Pharmacotherapy is the recommended standard of care, and it is the best option for a pregnant woman with OUD. Remaining on pharmacotherapy will help her avoid a return to substance use, which has the potential for overdose or death. A decision to withdraw from pharmacotherapy should be made with great care on a case-by-case basis, and additional supports such as close observation should be put in place.

## MAT AND PREGNANCY<sup>47</sup>

- Withdrawal of pharmacotherapy for OUD and tapering during pregnancy have a high failure rate (American Society of Addiction Medicine, 2015; Jones, O'Grady, Malfi, & Tuten, 2008; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; World Health Organization, 2014), and expectant women with OUD often return to opioid misuse and its attendant risks (e.g., Kaltenbach, Berghella, & Finnegan, 1998; Mattick, Breen, Kimber, & Davoli, 2009).

## MAT AND PREGNANCY<sup>48</sup>

- If medically supervised withdrawal is attempted, healthcare professionals should anticipate providing the pregnant woman with intensive behavioral and social supports such as those available in residential treatment centers, which provide close monitoring and support to avoid return to substance use.
- This should be a decision between the woman and her medical team and be an informed decision and not mandated or coerced.



# WITHDRAWAL MANAGEMENT (TAPERING)

- Medically assisted withdrawal management (formerly called detoxification), if appropriate, is only the first stage of treatment.<sup>49</sup>





# WITHDRAWAL MANAGEMENT (TAPERING)

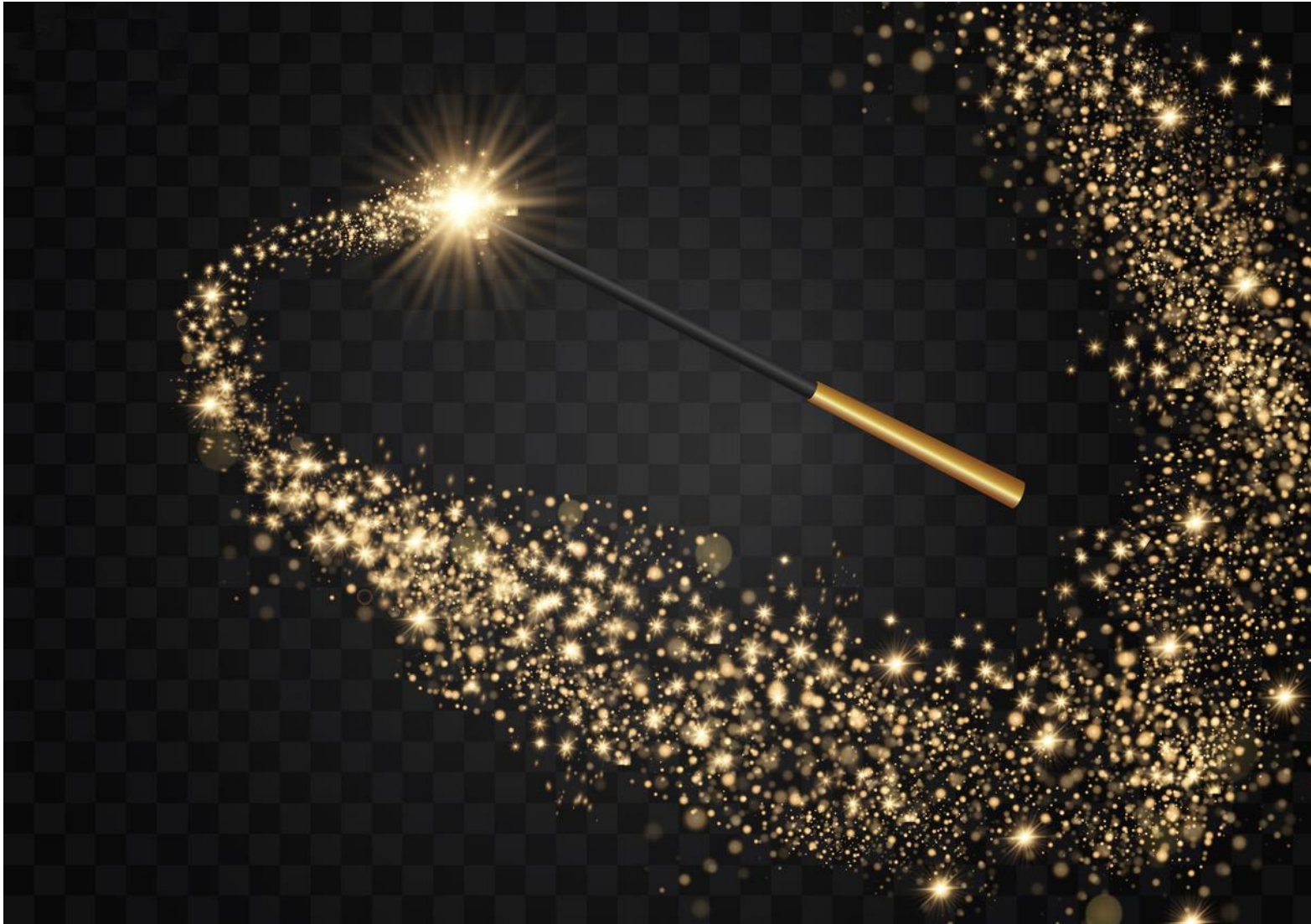


- A Norwegian study of the mortality risk after inpatient medically supervised withdrawal in a nonpregnant population found that the elevated risk of dying from an overdose within the first 4 weeks of discharge was so dramatic that prevention measures should be instituted.<sup>50</sup>

# WITHDRAWAL (NOT MEDICALLY ASSISTED)<sup>51</sup>



- The duration of unmanaged (not medically assisted) withdrawal depends on the specific opioid from which the patient is withdrawing and can last 1 to 4 weeks. After the initial withdrawal phase is complete, many patients experience a prolonged phase of dysphoria, craving, insomnia, and hyperalgesia that can last for weeks or months.<sup>53</sup> This can adversely affect the way a parent interacts with their children (or foster false impressions about parenting capacity).



MAT IS NOT A  
MAGIC WAND  
THAT MAKES  
PROBLEMS  
DISAPPEAR  
FOR OPIOID-  
AFFECTED  
PARENTS OR  
ANYONE ELSE.

# MAT BENEFITS FOR PARENTS IN THE CHILD WELFARE SYSTEM WITH OUD

- While some clients with OUD may be stabilized with medications alone, the parents involved with the child welfare system typically have a range of interrelated problems for which counseling and recovery supports are essential.
- A study that specifically examined the use of MAT with child welfare clients<sup>52</sup> found that MAT treatment improved the likelihood that program participants retained custody of their children.

## CHILD WELFARE STUDY SUPPORTS MAT BENEFITS<sup>53</sup>

- Parents who use opioids and are involved in the child welfare system are less likely to retain custody of their children than parents who use other drugs.
- Of the 596 individuals that were part of a “first of its kind” child welfare study of MAT-utilization and child permanency outcomes for this population, only 9.2% of the parents with a history of opioid use received MAT.
- Compared to parents who received no MAT, a year of MAT increased the odds of parents retaining custody of their children by 120%.
- This outcome is consistent with previous studies showing other positive outcomes that are associated with the increased duration of MAT.

## ASPE FINDINGS: MAT SUCCESSES<sup>54</sup>

- A program in Kentucky found that clients with a history of opioid use who received a year of MAT increased the odds of retaining custody of their children by 120%, compared with those who did not receive MAT. However, fewer than 10% of opioid-using clients in the program received MAT, a factor the authors attribute largely to stigma against MAT.



# WHY TREATMENT IS IMPORTANT

- SUD treatment has been successful in improving child welfare outcomes. Research has found that family reunification is more likely when parents complete substance use treatment.<sup>55</sup>
- Two recent reviews of existing evidence found that treatment is more likely to lead to successful family reunification when comprehensive services that are matched to an individual's specific needs are provided and when recovery management and other social and family supports are integrated into the treatment plan.<sup>56</sup>



# OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (ASPE) STUDY<sup>57</sup>

November 2018



## Medication-Assisted Treatment for Opioid Use Disorder in the Child Welfare Context: Challenges and Opportunities

by Laura Radel, Melinda Baldwin, Gilbert Crouse, Robin Ghertner, and Annette Waters

This brief describes four key challenges related to the use of medication-assisted treatment (MAT) in child welfare contexts for parents with opioid use disorder. It draws on results from a mixed methods study examining how substance use affects child welfare systems across the country. Key challenges discussed include the following:

- **Limited availability of appropriate treatment.** Quality treatment programs for parenting women are in short supply in many communities. In addition, limits on insurance coverage, including Medicaid coverage in some locations, often prevent sufficient treatment duration.
- **Misunderstanding of MAT.** MAT is not always well understood by stakeholders, who may encourage tapering of MAT prematurely and do not insist that medications be accompanied by necessary psychosocial and recovery support services, undermining clients' opportunities for success. Divergent understanding and views of MAT also mean that parents with opioid use disorder receive mixed messages about appropriate treatment, which may undermine referral and treatment engagement efforts.
- **Limited interaction between child welfare agencies and MAT providers.** The opioid crisis has prompted new entrants to the substance use disorder treatment community who are not familiar with child welfare agencies, are often unaccustomed to the needs of child welfare system clients, and may be resistant (even with appropriate client consent) to providing the feedback on parents' treatment progress needed for child welfare proceedings.
- **Need for alignment of systems and stakeholders with different perspectives and objectives.** Child welfare outcomes related to safety, permanency, and well-being depend on multiple stakeholders who may have different perspectives on MAT and different objectives regarding client outcomes.

The brief also describes opportunities to address each of the challenges described. Opportunities include new funding to expand MAT for opioid use disorder, funding soon to be available under the Family First Prevention Services Act that states may use to fund evidence-based treatment for substance use disorders to prevent children's entry into foster care, and additional steps that could enhance the availability of MAT and improve outcomes for children and families involved with the child welfare system in part because of parents' opioid use.

- A research team conducted statistical analysis of nationally representative data from demographically diverse urban, suburban, and rural counties study sites that had experienced high levels of drug overdose deaths and drug-related emergency room visits and hospitalizations (including opioids and other illicit substances). The study examined how substance use affects child welfare systems across the country and involved over 180 interviews to understand the observations and experiences of child welfare administrators and practitioners, substance use treatment administrators and practitioners, judges and other legal professionals, law enforcement officials, and other service providers.

## ASPE FINDINGS: MAT BARRIERS<sup>58</sup>



One of the primary barriers to successful family reunification for parents with OUD is the availability of quality MAT. The ASPE study found that few of the MAT providers oriented their services in ways that were well-suited to the child welfare clientele. For instance, most:

- Did not accept Medicaid as a form of payment for office visits (even when the pharmacotherapy drugs were covered by state Medicaid)
- Did not have child care available

## ASPE FINDINGS: MAT BARRIERS<sup>59</sup>

- Put forth little effort to provide psychosocial services in conjunction with the medication
- Did not accept pregnant patients
- Some SUD treatment programs prohibited admission of clients using methadone or buprenorphine.
- None of the communities in the study identified a MAT program with a focus on family counseling and supports.
- Most communities did not have an opioid treatment program that could dispense methadone. This was considered a significant gap by many of those interviewed, especially since methadone treatment is less expensive than buprenorphine.

## ASPE FINDINGS: MAT BARRIERS<sup>60</sup>



- Limited availability of appropriate treatment. Quality treatment programs for parenting women are in short supply in many communities.
- Clients with OUD had to wait weeks before they could have an initial appointment and that the nearest methadone clinic (to which enrolled clients typically must report daily) was hours away.



# ASPE FINDINGS: MAT BARRIERS<sup>61</sup>

- While opioid treatment medications available through opioid treatment programs (OTPs) like methadone clinics are typically covered by Medicaid, physicians prescribing MAT in office settings often did not accept Medicaid for the required office visits, for which they typically charged \$500 to \$1,000 per month, an amount out of reach for most child welfare clients.
- Limitations on treatment duration and/or changes in clients' insurance coverage also may be factors in premature tapering of MAT drugs.



## ASPE FINDINGS: MAT BARRIERS<sup>62</sup>

- MAT is not always well understood by stakeholders, who may encourage tapering of MAT prematurely and do not insist that medications be accompanied by necessary psychosocial and recovery support services, undermining clients' opportunities for success.
- Divergent understanding and views of MAT also mean that parents with OUD receive mixed messages about appropriate treatment, which may undermine referral and treatment engagement.

## ASPE FINDINGS: MAT BARRIERS

A number of study interviewees—including some of those who were supportive of MAT—expected that MAT patients would rapidly be stepped down from buprenorphine or methadone and be completely off medication before reunification.<sup>63</sup>

While this approach may be feasible in some cases, these expectations are not realistic for most parents with children in the child welfare system. SAMHSA guidance suggests that the duration of patients' MAT needs may range from under 12 months to years, or even a lifetime, depending on the individual circumstances.<sup>64</sup>

Recovery timelines are typically much longer than the timelines within which children in foster care must be placed in a permanent, stable household.<sup>65</sup>



## OTHER CONSIDERATIONS



- If assessment delays, capacity limitations, waiting lists, or health coverage issues (e.g., MAT coverage, pre-authorization requirements) delay parents' treatment admission, shorten the length of stay in treatment, or limit the types of treatment they may undertake, parents may be at increased risk of not being able to provide a safe and stable environment for their children within the child welfare timelines.<sup>66</sup>

## OTHER CONSIDERATIONS: POLYSUBSTANCE USE<sup>67</sup>

- The use of marijuana, stimulants, or other addictive drugs should not be a reason to suspend OUD treatment.
- However, evidence demonstrates that patients who are actively using substances during OUD treatment have a poorer prognosis.

## OTHER CONSIDERATIONS: “ABSTINENCE ONLY”<sup>68</sup>

- Researchers suggest that programs that restrict or discontinue medications for OUD (“abstinence only” programs) should be subject to evaluation prior to payment by insurers. Treatments should have proven efficacy as to not render unnecessary harm.

## DISCUSSION OF YOUR LOCAL SUD TREATMENT/MAT SYSTEM

- What, if any, treatment barriers are present (especially related to MAT)?
- Do you have ***family*** outpatient treatment and/or support groups or SUD placements; SUD placements that allow children?





What opportunities do YOU see for making progress addressing local treatment/MAT barriers and challenges?



# SYSTEM COMPONENT: RECOVERY SUPPORT



# RECOVERY DEFINED

SAMHSA defines  
recovery as:

- A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.<sup>69</sup>





# A CULTURE OF RECOVERY

- There is a growing network of recovery community organizations (RCOs) that have proliferated across the country, creating cultures of recovery and advancing recovery-positive attitudes, programs, and prevention strategies. Policymakers and health care system leaders in the United States and abroad are beginning to embrace recovery as an organizing framework for approaching addiction as a chronic disorder from which individuals can recover, so long as they have access to evidence-based treatments and responsive long-term supports.<sup>70</sup>

# RECOVERY ORIENTED SYSTEM OF CARE (ROSC)<sup>71</sup>

Florida defines ROSC as “a network of clinical and nonclinical services and supports that sustain long-term, community-based recovery.” Behavioral health systems and communities form ROSCs to:

- Promote good quality of life, community health, and wellness for all.
- Prevent the development of behavioral health conditions.
- Intervene earlier in the progression of illnesses.
- Reduce the harm caused by substance use disorders and mental health conditions on individuals, families, and communities.
- Provide the resources to assist people with behavioral health conditions to achieve and sustain their wellness and build meaningful lives for themselves in their communities.

# SHAME AND DISCRIMINATION

- People who have SUDs (recovering or not) have essential worth and dignity. The shame and discrimination that prevents many individuals from seeking help must be vigorously combated. Recovery is more than treatment.<sup>72</sup>
- This shame can be exacerbated for parents of children in the child welfare system, especially when their substance use has been formally connected to child maltreatment.

# RECOVERY PATHWAYS

- There are many paths to recovery. People will choose their pathway based on their cultural values, their socioeconomic status, their psychological and behavioral needs, and the nature of their SUD.<sup>73</sup>



# RECOVERY SUPPORT SERVICES (RSS)



- Recovery support services (RSS) refer to the collection of community services that can provide emotional and practical support for continuing remission as well as daily structure and rewarding alternatives to substance use.<sup>74</sup>

## RSS EXAMPLES<sup>75</sup>

- Just as the development of a SUD involves profound changes in the brain, behavior, and social functioning, the process of recovery also involves changes in these and other areas. These changes are typically marked and promoted by acquiring healthy life resources—sometimes called “recovery capital.” These recovery services and resources include:
  - ✓ Housing;
  - ✓ Education;
  - ✓ Employment;
  - ✓ Social resources; and
  - ✓ Overall health and well-being.



# RECOVERY HOUSING (INCLUDING MAT CAPABLE)



- Recovery-supportive houses (also called recovery residences) provide both a substance-free environment and mutual support from fellow recovering residents. Many residents stay in recovery housing during and/or after outpatient treatment, with self-determined residency lasting for several months to years.<sup>76</sup>



# RSS<sup>77</sup>

- This collection of community services can provide emotional and practical support for continuing remission as well as daily structure and rewarding alternatives to substance use.
- RSS for parents with SUD/ODU in the child welfare system are especially important and will include supports to help them strengthen both personal and parental capacities.



## EVIDENCE-BASED/BEST PRACTICES: RSS<sup>78</sup>

- One large randomized trial showed that providing recovery coaches to mothers with a SUD who were involved in the child welfare system reduced the likelihood of the mother's child having a future arrest by 52 percent.
- Other rigorous studies have found that providing recovery coaches for mothers with SUD reduces subsequent births with prenatal substance exposure and also increases rates of family reunification.

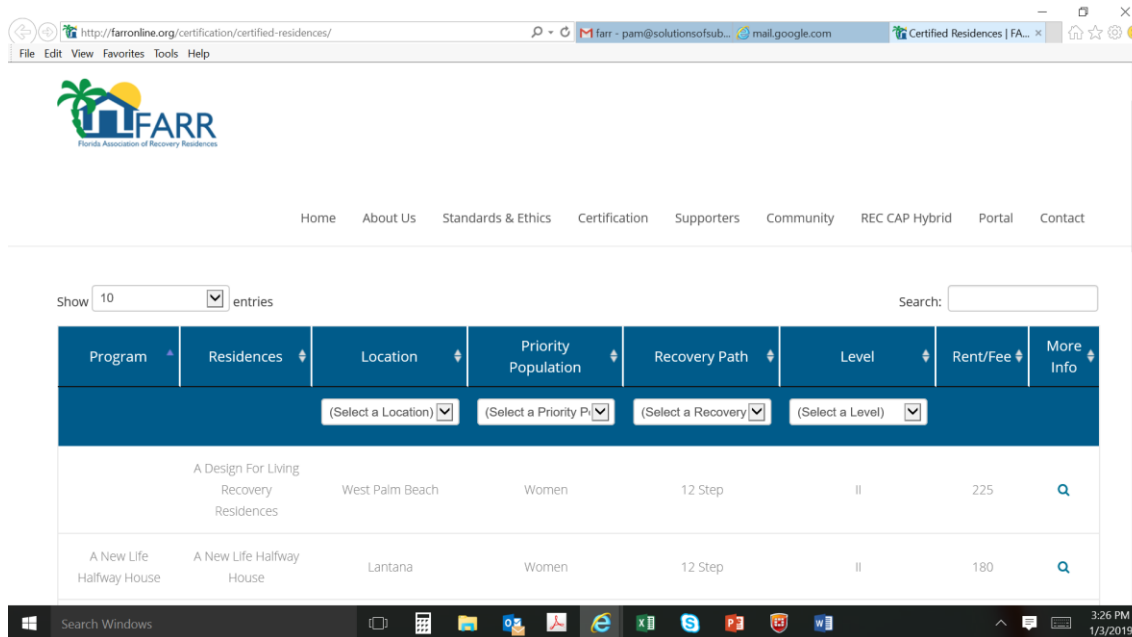
## EVIDENCE-BASED/BEST PRACTICES: RSS<sup>79</sup>

- Peer recovery coaches identify as being in recovery and use their knowledge and lived experience to inform their work. They, and other non-peer recovery coaches, may connect people to recovery housing and social services, help people develop personal skills that maintain recovery, and help connect persons community services while addressing any barriers or problems that may hinder the recovery process.
- Peer support studies have demonstrated reduced relapse rates and increased treatment retention. Peer support should be available at multiple touch points, such as emergency and inpatient units and harm reduction organizations.

## EVIDENCE-BASED/PROMISING PRACTICES: RSS<sup>80</sup>

- A substantial body of research indicates Alcoholic Anonymous (AA) is an effective recovery resource. While other mutual aid groups including Narcotics Anonymous (NA) have not been studied as extensively, evidence on effectiveness is promising.
- There is promising evidence to suggest that recovery-supportive housing can be both cost-effective and effective in supporting recovery.

# FLORIDA ASSOCIATION OF RECOVERY RESIDENCES<sup>81</sup>



The screenshot shows the FARR website with a table of certified residences. The table has columns for Program, Residences, Location, Priority Population, Recovery Path, Level, Rent/Fee, and More Info. There are two rows of data visible.

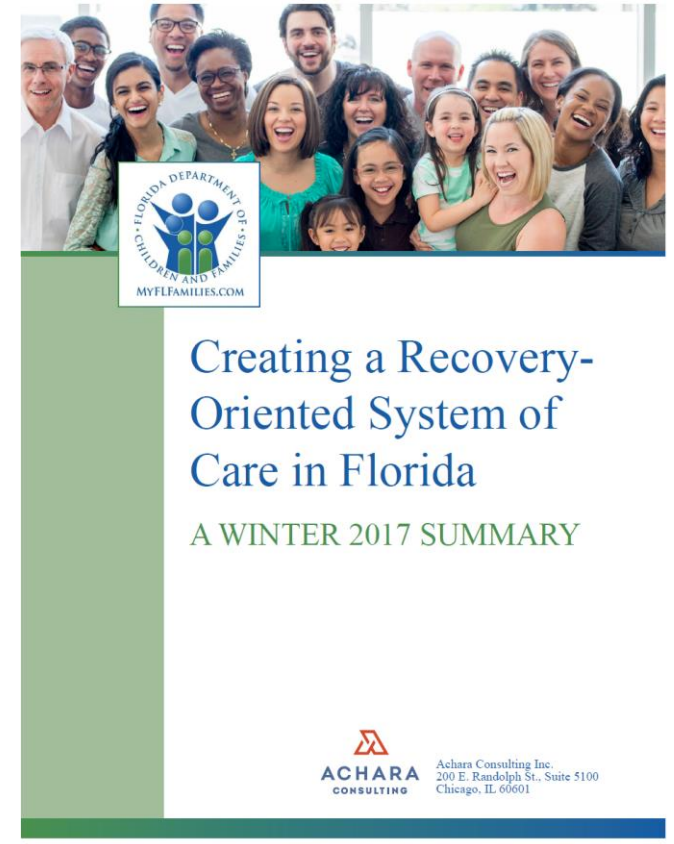
Program	Residences	Location	Priority Population	Recovery Path	Level	Rent/Fee	More Info
A Design For Living Recovery Residences		West Palm Beach	Women	12 Step	II	225	<a href="#">Q</a>
A New Life Halfway House	A New Life Halfway House	Lantana	Women	12 Step	II	180	<a href="#">Q</a>

- <http://farronline.org/certification/certified-residences/>

# RECOVERY (ROSC) RESOURCE<sup>82</sup>

## Florida Department of Children and Families (DCF) ROSC Resource

- [http://www.peersupportfl.org/wp-content/uploads/2017/10/CreatingROSC\\_Florida\\_Final.pdf](http://www.peersupportfl.org/wp-content/uploads/2017/10/CreatingROSC_Florida_Final.pdf)



## DISCUSSION OF YOUR LOCAL SUD RECOVERY SUPPORT SYSTEM

- Are your local recovery support resources sufficiently robust?
- What, if any, recovery support barriers are present?
- What are the opportunities to strengthen them?







## CONTINUING CARE COMPONENT

## CONTINUING CARE DEFINED

- There is not a standard definition for continuing care, how frequently it should be provided, or for how long. A common example following residential treatment is outpatient services provided in reducing frequency for a few months up to one or two years. At one point this phase of care was referred to as “aftercare” but the more common term is now “continuing care,” which better conveys the idea that active treatment continues in this phase.<sup>83</sup>
- Continuing care is the support plan following SUD treatment. The goal of a continuing care model is to focus on the successes made during the initial phase of care — for example, through outpatient and residential programs — by providing follow-up care throughout recovery. Continuing care model focuses on active and ongoing care management.<sup>84</sup>

## CONTINUING CARE EXAMPLES<sup>85</sup>

The *Journal of Substance Abuse Treatment* 2009; 36(2):127-30, identifies four components of effective continuing care interventions:

- **Extended monitoring:** The “gold standard” is in effective extended monitoring is drug testing via the collection of biological data, particularly urine samples.
- **Performance-based incentives:** Incentives for drug-free biological samples have been show to produce better results for abstinence among individuals with SUD.

## CONTINUING CARE EXAMPLES<sup>86</sup>

- **Alternative forms of service delivery:** Interventions that require frequent, in-person check-ins can be burdensome for some patients. Programs may consider home visits, telephone-based care, and web-based interventions as alternatives.
- **Community support:** People in recovery need support from friends, family members, and peers.

## WHY CONTINUING CARE IS IMPORTANT<sup>87</sup>

- Remission from a SUD can take several years and multiple episodes of treatment, recovery support services, and/or mutual aid. Even after a year or 2 of remission is achieved—through treatment or some other route—it can take 4 to 5 more years before the risk of relapse drops below 15 percent, the level of risk that people in the general population have of developing a substance use disorder in their lifetime.
- Because relapse is common, SUD interventions should extend beyond the acute phase of treatment and address functioning over time. Continuing care solidifies and sustains recovery by helping the individual develop and maintain a recovery-oriented life and sources of support.



## DISCUSSION OF YOUR LOCAL SUD CONTINUING CARE SYSTEM

- Are any continuing care barriers present?
- What if any opportunities exist for strengthening continuing care in your community?





SYSTEM  
COMPONENT:  
THERAPEUTIC  
AND SUPPORTIVE  
RESPONSES FOR  
CHILDREN



## EFFECTS OF PARENTAL OPIOID USE ON CHILDREN<sup>88,89,90</sup>

- Children are likely to have experienced significant neglect, trauma, toxic stress, or at the minimum, the lack of a responsive parent
- Parent-child relationship is likely to be problematic
- Parental capacities are likely to be impaired
- Parental sobriety will not necessarily by itself address child/adolescents developmental, mental health, or SUDs

# SPECIALIZED COURTS<sup>91,92</sup>



- Florida Early Childhood Courts (ECC)
  - Problem-solving courts for child welfare cases involving children under 3
  - 21 sites
- Family Dependency Drug Courts (FDDC)
  - 15 sites

# QUESTIONS

- Are there ECC and/or FDDC representatives here?
- Do these courts overlap at all?
- How do families get into them?



# INFANTS AND TODDLERS<sup>93,94,95</sup>



Florida Early Steps Program for early intervention services

- Federal requirements that children under 3 with substantiated child abuse/neglect (in Florida – adjudicated) be referred for screening or assessment for developmental delays
- If eligible, Individualized Family Support Plan (IFSP) is developed
  - Home visits, parent coaching and support

# QUESTIONS

- Are there any Early Steps representatives here? If not, has anyone here had experience with Early Steps?
- How does the referral process go?
- What kind of services do children/families affected by SUD receive from Early Steps?





## INFANTS-TODDLERS- YOUNG CHILDREN<sup>96</sup>

### Child-Parent Psychotherapy (CPP):

Therapeutic intervention that helps the young child heal and catch up developmentally within the context of their relationship with their parent AND helps the parent increase their capacity to nurture and care for their child





## QUESTIONS

Are there any CPP providers here? If not, has anyone here had experience with CPP?

How does the referral process go?

How does treatment progress information get provided to child welfare and court personnel?



# INFANTS-CHILDREN- ADOLESCENTS<sup>97</sup>

## Parent Training Programs:

- Skill-based and interactive
- Evidence-based or promising practice
- California Evidence-Based Clearinghouse for Child Welfare - good resource to find programs

<http://www.cebc4cw.org/topic/parent-training-programs-can/>



# QUESTIONS

What is available in  
your area?

How is this working  
(strengths and  
challenges)?





# OLDER CHILDREN AND ADOLESCENTS<sup>98</sup>



Among children who grow up in home with a parent with an OUD:

- 30-33% met diagnostic criteria for disruptive disorder
- 21-30% for anxiety or mood disorder
- 47-59% exhibited substance misuse behaviors

# RESPONSES<sup>99</sup>

- Routine trauma screens/referrals
- Mental health/behavioral health screens/referrals
- Substance use screens/referrals



## QUESTIONS

Do you typically use screening tools to help you decide about evaluation/treatment needs?

What resources are available in your area?

How is this process working (strengths and challenges)?





# SCHOOL AND CHILDCARE<sup>100</sup>

- Settings that can provide stable relationships, supports, structure, nurturance
- Use current laws and/or agreements to ensure school stability for older children and childcare stability for young children



## QUESTIONS

How is your jurisdiction maintaining school stability for children in foster care?

Is high quality childcare available in your area and is it being used for this population?

How is it working (strengths and challenges)?



# PARENTAL CAPACITY<sup>101,102,103</sup>



- Likely impacted by significant opioid use
- Likely won't improve just because of recovery
- Harms to children from the parental opioid use will create more parenting challenges



# ASSESSING PARENTAL CAPACITY

- Professionals providing interventions that involve the parents (e.g., Child-Parent Psychotherapy, home visits, parent training) should be able to provide information about parental capacity and progress



## QUESTION

What are the strengths and challenges in getting information about parental capacity from CPP, home visiting programs and/or parenting providers?



# ASSESSING PARENTAL CAPACITY

- How is your child doing?
- Tell me about your child and a typical day.
- How has your child been affected by your struggles?
- Who does your child feel comfortable with?







If you were very bold, what big idea would you recommend to improve your system for parents with opioid misuse and their children? What first step would you take to get started?



## SYSTEM COMPONENT: WORKFORCE DEVELOPMENT AND COLLABORATION

## POSITIVE OUTCOMES IN CHILD WELFARE DEPEND ON MULTIPLE STAKEHOLDERS FROM DIFFERENT FIELDS<sup>104</sup>

- For parents involved in the child welfare system, a multitude of actors are involved in child welfare decision-making processes, all with different roles, perspectives, and expertise.
- ASPE's study identified shared approaches to communication and case coordination such as holding cross-disciplinary meetings that include treatment professionals and child welfare caseworkers. In these settings, treatment providers involved child welfare staff in treatment planning and provided regular updates. In other sites, treatment providers were invited to participate in family team meetings, during which families could create plans for safe care of their children and engage recovery supports to move toward stable sobriety.

## POSITIVE OUTCOMES IN CHILD WELFARE DEPEND ON MULTIPLE STAKEHOLDERS FROM DIFFERENT FIELDS<sup>105</sup>

- Communication between SUD treatment providers, child welfare caseworkers, and courts, is generally recognized as essential to successful family reunification and yet there are often difficulties in collaborating across these silos.
- As a result of expanded MAT resources at state and local levels, new treatment providers have entered the field necessitating renewed efforts to ensure collaboration between child welfare and SUD professionals,
- While confidentiality regulations are often discussed as a barrier to cooperation, particularly when agencies are unaccustomed to collaborating within the structure of these regulations, establishing procedures for obtaining clients' consent at intake for information sharing is feasible.

## POSITIVE OUTCOMES IN CHILD WELFARE DEPEND ON MULTIPLE STAKEHOLDERS FROM DIFFERENT FIELDS<sup>106</sup>

- Clients working toward reunification typically want information on treatment progress shared with child welfare staff and readily provide consent.
- Should consent later be revoked, in the absence of shared information, child welfare staff typically will assume treatment noncompliance.
- Problems may still arise, however, if SUD treatment providers do not establish consent or if they use confidentiality rules as an excuse not to make the effort to communicate when consent has been established.



# CROSS TRAINING IS ESSENTIAL<sup>107</sup>

It is important to cross-train child welfare, SUD treatment and judicial professionals, infant mental health providers such as home visiting programs, caretakers, and family members to build an understanding of:

- Each other's systems;
- Legal requirements (e.g., Adoption and Safe Families Act [ASFA]; “reasonable efforts”);
- Goals of various systems and programs (e.g., adult versus child focused; recovery focus versus family safety);
- Approaches of various systems and programs (e.g., how to identify appropriate progress versus failure, responses to relapse);



## POSITIVE OUTCOMES IN CHILD WELFARE DEPEND ON MULTIPLE STAKEHOLDERS FROM DIFFERENT FIELDS<sup>108</sup>

- Shared interests, such as the importance of the parent–child relationship for social–emotional development of the child and the importance of multigenerational mental health);
- MAT (e.g., child welfare and related professionals do not have a clear understanding of the practice of MAT and the need to ensure that medications are accompanied by necessary psychosocial and recovery support services or clients’ opportunities for success will be undermined; the need to avoid tapering of MAT prematurely; and many other topics);
- MAT practices for pregnant women; and
- Importance of avoiding mixed messages about appropriate treatment, which may undermine a parent’s referral and treatment engagement efforts.

## POSITIVE OUTCOMES IN CHILD WELFARE DEPEND ON MULTIPLE STAKEHOLDERS FROM DIFFERENT FIELDS<sup>109</sup>

- In the communities participating in the ASPE study, buprenorphine providers were typically private-practice physicians with relatively little experience in SUD treatment, particularly for low-income women with child welfare involvement.
- Caseworkers and court professionals reported that these clinics did not often cooperate with child welfare agencies and courts in monitoring clients' progress in treatment. Cross training and collaborative opportunities could strengthen practice.

# OPPORTUNITIES: FAMILY FIRST PREVENTION SERVICES ACT (FFPSA)

Note: To be implemented in Florida over the next 1-3 years

- Reforms child welfare financing streams (Title IV-E/Title IV-B) to provider services to families “at risk” of entering the child welfare system
- Aims to *prevent* children from entering foster care by allowing reimbursement for MH services, SUD/ODU treatment, and in-home parenting skill training
- Also seeks to improved the well-being of children already in care by incentivizing state to reduce the placement of children in congregate care

# FFPSA: AN OPPORTUNITY FOR PARENTS WITH OUD

- Once the FFPSA option to use Title IV-E funds for evidence-based prevention services and programs goes into effect, it can provide substantial funding for OUD treatment services
- CW team members should keep the following in mind to ensure families can take full advantage:
  - Funding is NOT based on income—all “at risk” families qualify
  - FFPSA funding is limited to 12 months
  - Recovery takes time—the sooner parents affected by OUDs can be connected to treatment, the more time they have to achieve and sustain recovery

## FFPSA: AN OPPORTUNITY FOR PARENTS WITH SUD/OD

- This change has the potential to give child welfare agencies a larger role in shaping SUD treatment programs used by families involved with their agencies.



Where do YOU  
have discretion and  
freedom to act?  
What can you do  
now without more  
resources or  
authority?





THANK YOU!

FOR QUESTIONS, OR  
FOR ADDITIONAL  
INFORMATION

For additional opioid  
training modules:

■ <http://www.training.fadaa.org/>



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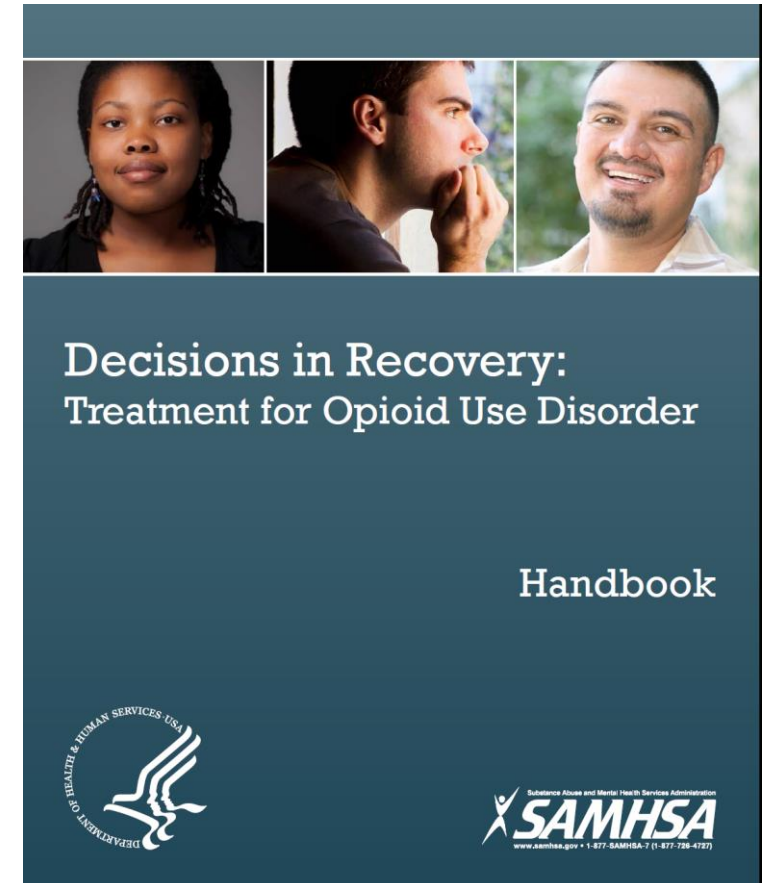
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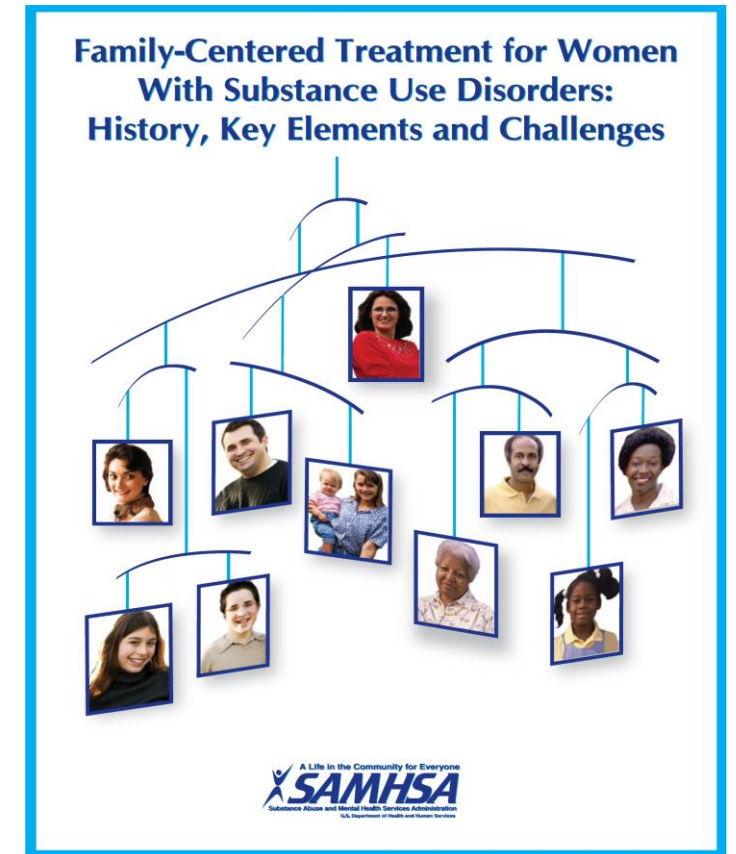
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**Family Treatment Court**

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