A Transformative and Evidence-based System Response for Parents with Opioid Misuse and Their Children: Challenges and Opportunities

Quick Reference Resource

This Quick Reference Resource is a companion worksheet to the face-to-face training, "A Transformative and Evidence-based System Response for Parents with Opioid Misuse and Their Children: Challenges and Opportunities." Training participants are encouraged to consider information presented in the training, network with other child welfare team members in the room, and complete this worksheet documenting available and relevant resources in their community.

Screening and Assessment			
Research-informed recommendations	**Applied considerations**	**Supporting resource(s) in my community**	**Contact Information/ notes**
Ongoing screening – Screening parents and children involved in the child welfare system for the effects of SUDs (including OUDs) and other co-occurring risk factors is an essential part of determining risk and safety.[1] Although families may not reply honestly to screenings conducted as part of initial investigations, it is likely that indications of substance use disorders (SUDs) will emerge as workers become more familiar with family histories.[2]	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. If screening results suggest that family members have a SUD, judges and attorneys should ask for information regarding follow-up assessments, referrals to services, and protocols for supporting and monitoring family members through treatment.[3]		
When a diagnostic OUD assessment is needed – Assessments of parents with SUDs **should be informed by the totality of information**. 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.[4] A diagnostic assessment for opioid use	The more that treatment and child welfare staff **systematically communicate** with each other, the more complete and beneficial the assessment process will be.[7] The assessment setting should create a **welcoming environment** that is nonjudgmental, respectful, and empathetic. The Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol (TIP) 63 provides detailed opioid assessment		

disorder (OUD) is needed if a person screens positive for non-medical use of opioids (e.g., opioid misuse or illicit opioid use), discloses such use, or if signs or symptoms of non-medical opioid use are present.[5] Assessments that are done separately by either child welfare or SUD 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.[6]	procedure guidance.[8] Without supporting SUD-related information from the child welfare system staff a SUD assessor may only have the parent's word (self-report) on which to base an assessment.		
Speedy access to SUD services – The first 24 hours after a client's initial phone contact is a critical period in initiating assessment and treatment.[9] If SUD assessment delays, capacity limitations, waiting lists, or health coverage issues 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.[10]	If the transition from assessment to treatment is marked by 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.[11] To facilitate a smooth and prompt access process, consider **care management/case management, recovery support assistance, and warm handoffs.**		
Drug testing – Because alcohol and other drug use are often contributing factors in child maltreatment, effective alcohol and drug testing is often necessary to ensure treatment compliance and manage safety and risks concerns.[12] Drug testing during the comprehensive assessment process and during treatment is recommended. The frequency of drug testing is determined by a number of factors including: the stability of the patient, the	Drug tests do not provide information about whether a person has a SUD (or in fact where they are on the substance use spectrum, it confirms drugs used at a point in time only). **Drug testing by itself is not an effective gauge of progress**, and drug testing results should always be considered in light of other parental choices, actions, and behaviors. An effective program of drug testing should be random, monitored to protect against tampering, and results should be quickly evaluated and		

type of treatment, and the treatment setting.[13] SAMHSA recommends drug testing before patients start OUD medication (pharmacotherapy) and during treatment for monitoring. During ongoing pharmacotherapy with buprenorphine or methadone, drug testing can confirm medication adherence.[14]	addressed with clients.[15] Consider framing drug testing in a clinical, nonpunitive way. For example, before obtaining a drug test, ask the person, "What do you think we'll find on this test?" The person's response is often quite informative and may make the person less defensive than confrontation with a positive test result.[16]		

Medication-Assisted Treatment (MAT) Pharmacotherapy			
Research-informed recommendations	**Applied considerations**	**Supporting resource(s) in my community**	**Contact information/notes**
MAT, effective standard of care – Overcoming opioid dependence is not simply a matter of eliminating opioid/other substances from the body. The changes in the brain caused by opioid dependence will not correct themselves right away, even though the opioid use has stopped. An individual can experience drug cravings for months and even years after they stop using.[17] MAT is an effective standard of care for OUD. MAT **increases social functioning and retention in treatment**.[18] When caseworkers and courts understand the scope of appropriate MAT for their clients, they are better able to advocate for appropriate services as well as monitor participation and measure progress. For example, they can assure that parents receive not only a buprenorphine prescription but also an appropriately designed case plan with	It is important for different stakeholders in the same community to come to a consensus on the benefits of MAT and how it should be implemented for parents involved in the child welfare system in their jurisdiction or region. Messages about MAT should consistently convey that **MAT includes not just medication but a program of counseling and recovery supports**.[20]		

therapies and services that provide real opportunities to reunite safely with their children.[19]			
MAT, effective standard of care for pregnant women with OUD – MAT is the recommended standard of care for pregnant women with OUD and is considered **the best option for healthy fetal development, despite the risk of neonatal abstinence syndrome (NAS**).[21] The benefits of pharmacotherapy for OUD during pregnancy outweigh the risks of untreated OUD.[22] Pregnant women with OUD should **not** be encouraged to withdraw from pharmacotherapy for OUD during their pregnancy or shortly after delivery. Withdrawal of pharmacotherapy for OUD and tapering (incremental reduction) during pregnancy have a high failure rate[23] and expectant women with OUD often return to opioid misuse and its attendant risks.[24]	Remaining on pharmacotherapy will help a pregnant woman with OUD 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 close observation, monitoring, and intensive behavioral and social supports should be put in place.[25] Decisions about withdrawal of pharmacotherapy for OUD and tapering during pregnancy should be **a decision between the woman and her medical team and be an informed decision and not mandated or coerced**.		

Recovery Support			
Research-informed recommendations	**Applied considerations**	**Supporting resource(s) in my community**	**Contact information/notes**
Recovery support services (RSS) essential to recovery – 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. Recovery support services (RSS) can provide emotional and practical support for continuing remission as well as daily structure and rewarding alternatives to substance use.[26] **RSS such as 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**.[27] A substantial body of research indicates Alcoholic Anonymous (AA) is an effective recovery resource (evidence on effectiveness for other types of mutual aid groups is promising). There is promising evidence to suggest that recovery-supportive housing can be both cost-effective and effective in supporting recovery.[28]	Florida defines a Recovery Oriented System of Care (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:[29] ▪ 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. Examples of nonclinical RSS that can support individuals and parents with OUD/other SUDs include:[30] ✓ Housing; ✓ Education; ✓ Employment; ✓ Social resources; and ✓ Overall health and well-being. **RSS for parents with SUD/OUD in the child welfare system are especially important and**		

	will include supports to help them strengthen both personal and parental capacities. For example, people with SUDs who have dependent children may need child care services to enable them to participate in treatment programs and recovery support services.		

Continuing Care			
Research-informed recommendations	**Applied considerations**	**Supporting resource(s) in my community**	**Contact information/notes**
Continuing care following SUD treatment – 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.[31] 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.[32]	**Continuing care for parents with SUD/OUD in the child welfare system is especially important**. Examples of continuing care:[33] • Extended monitoring (e.g., drug testing); • Performance-based incentives (e.g., incentives for negative drug tests) • Alternative forms of service delivery (e.g., home visits, telephone-based care, and web-based interventions as alternatives, other checkups). • Community support (e.g., support from friends, family members, and peers).		

Workforce Development, Collaboration and Training			
Research-informed recommendations	**Applied considerations**	**Supporting resource(s) in my community**	**Contact information/notes**
Workforce collaboration, development and training – Positive outcomes in child welfare depend on multiple stakeholders from different fields, yet the different stakeholders' timelines and expectations are not always aligned.[34] Educational efforts can help to **encourage common expectations about the provision of MAT and outcomes** from it and can clarify research evidence for providers. Without relevant information and training, child welfare caseworkers tend to fall back on gut feelings or familiar rubrics for success that are not always a good fit for parents in MAT programs. MAT providers are not always familiar with child welfare services, have little or no contact with clients' children, and do not always see clients' children or parenting issues as especially relevant to clients' recovery.[35] Multidisciplinary training that satisfies the continuing education requirements across the range of professionals who work with these families in child welfare, SUD treatment agencies and the courts can help bridge the divide and improve agencies' abilities to understand each other's perspectives.[36]	Child welfare agency administrators and staff, judges and court personnel, attorneys working on behalf of **various parties to child welfare cases, court appointed special advocates, and behavioral health and MAT providers can work together to understand the scope of appropriate MAT for their shared clients.** Collaboration can be formalized across disciplines to improve both the likelihood of recovery and family stability.[37] Examples can include: √ Shared approach to case coordination; √ Holding cross-disciplinary meetings including treatment professionals and child welfare caseworkers; √ Treatment providers involving child welfare staff in treatment planning and providing regular updates; √ Treatment providers invited to participate in family team meetings during which families can create plans for safe care of their children and engage recovery supports to move toward stable recovery); and √ cross-training between child welfare and substance use treatment staff is.[38]		

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