Partnering to Address Substance Use Disorders in the Child Welfare Caseload

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Strengthening Partnerships

Improving Family Outcomes

An Initiative Funded by the

Substance Abuse and Mental Health Services Administration (SAMHSA)

and the

Administration for Children, Youth and Families (ACYF), Children’s Bureau

www.ncsacw.samhsa.gov
ncsacw@cffutures.org
Collaborative Initiatives in California

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Symbol</th>
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<tbody>
<tr>
<td>SAMHSA Family Treatment Drug Court Performance Management</td>
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<tr>
<td>OJJDP Family Drug Court</td>
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<tr>
<td>Doris Duke Prevention and Family Recovery</td>
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<tr>
<td>Regional Partnership Grant</td>
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<tr>
<td>Children Affected by Methamphetamine</td>
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<tr>
<td>In Depth Technical Assistance</td>
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Current Initiatives: ▼ ▲ □
Previous Initiatives: ▲ □ ▼ ▼

http://www.cffutures.com/pfr
https://www.ncsacw.samhsa.gov/technical/rpg-i.aspx
https://www.ncsacw.samhsa.gov/technical/idta.aspx
I. Data and Trends: National and California
   • Prenatal Exposure
   • Marijuana
   • Opioids

I. Re-thinking Substance Use Disorders, Treatment and Recovery

II. What Works for Families Affected by Substance Use Disorders

III. Where do we Go From Here
   • CAPTA
   • Drug Medi-Cal Organized Delivery System Waiver
Drugs of the Decades

1960s

1980s

1990s

2010s
8.3 million children

Determining how parental SUDs affect family safety, permanency, well-being is a key task.

2002 – 2007 SAMHSA National Survey on Drug Use and Health (NSDUH)
Number of Children in Out of Home Care, United States 2000-2015

Parental Alcohol or Other Drug Use as a Contributing Factor for Reason for Removal, United States 2000 to 2015

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

Source: AFCARS Data, 2000-2015
Prevalence of Parental Alcohol or Other Drug Use as a Contributing Factor for Removal: California and Major Counties, 2015

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

Source: AFCARS Data, 2015
Subject: Percent of Children Removed with Parental AOD as a Reason for Removal by Age, 2015

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

Source: AFCARS Data, 2015
Age of Children in Foster Care: California, 2015
N=55,983

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

Source: AFCARS Data, 2015
Estimated Number of Infants* Affected by Prenatal Exposure, by Type of Substance and Infant Disorder


United States Marijuana Legislation
As of April 30, 2017

- Adult-use regulated law: 8 states & Washington, DC*
- Comprehensive medical marijuana law: 22 states
- Low THC product law: 16 states
- No marijuana access law: 6 states

*19 states with pending bills
## Risks to Children: Medicinal Use and Legalized Recreational Use of Marijuana

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Medicinal Use</th>
<th>Legalized Recreational Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Production/Manufacturing</td>
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<tr>
<td>Children’s Exposure via Ingestion (e.g. Edible Products)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prenatal Exposure</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Parenting Capacity</td>
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</table>
Annual Rate of Exposure Among Children Under 6 Years

1,969 children under age 6 reported to the National Poison Data System for exposure.

Rate of exposure increased from approximately 5 per 1,000,000 children to 25 per 1,000,000 children.

2.82 times higher in states where medicinal use was legalized.

Mean age of exposure 1.81 years.

77.7% of children were under 3 years of age.

Neonatal Abstinence Syndrome

An expected and **treatable condition** that follows prenatal exposure to opioids

Symptoms begin within 1-3 days after birth, or may take 5-10 days to appear and include:

- Blotchy skin; difficulty with sleeping and eating; trembling, irritability and difficult to soothe; diarrhea; slow weight gain; sweating; hyperactive reflexes; increased muscle tone

Timing of onset is related to characteristics of drug used by mother and time of last dose

Most opioid exposed babies are exposed to multiple substances


From Medicaid data, the mean length of stay for infants with NAS was 16.4 days at an average cost of $53,000.

Rate of Neonatal Abstinence Syndrome Over Time

*2013 Data in 28 States from the Center for Disease Control publicly available data in Health Care and in 28 states

Neonatal Abstinence Syndrome: Treatment

Non-Pharmacological Treatment
- Swaddling
- Breastfeeding
- Calm, low-stimulus environment
- Rooming with mother

Pharmacological Treatment
- Individualized based on severity of symptoms
- Standardized scoring tool to measure severity of symptoms
- Assessment of risks and benefits

The concurrent goal of treatment is to soothe the newborn’s discomfort and promote mother-infant bonding.


**Standard of care:** Medication Assisted Treatment plus counseling

- Methadone or Buprenorphine

**Benefits**

- Stable intrauterine environment (no cyclic withdrawal)
- Increased maternal weight gain
- Increased newborn birth weight and gestational age
- Increase PNC adherence
- Decrease in illicit drug use - reduction of HIV/HCV acquisition
- Decrease risk of overdose
- Other supportive services

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(2008). Mental Health Services Administration, SAMHSA. Medication-assisted treatment for opioid addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) 43. DHHS Publication No. 05-4048. 2005 Rockville Maryland


American Society of Addiction Medicine, National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (2015)

A Chronic, Treatable Disease

• Substance use disorders are preventable and are treatable brain diseases

• Discoveries in the science of addiction have led to advances in drug abuse treatment that help people stop abusing drugs and resume their productive lives

• Similar to other chronic diseases, addiction can be managed successfully

• Treatment enables people to counteract addiction's powerful disruptive effects on brain and behavior and regain areas of life function
What Works for Families Affected by Substance Use Disorders and Child Abuse or Neglect
Regional Partnership Grants (RPGs)

53 Grant Programs

2007 - 2012

17,820 adults
25,541 children
15,031 families
CAM Grantees

- Clarke County, WA
- Butte, CA
- Sacramento, CA
- Santa Cruz, CA
- San Luis Obispo, CA
- Santa Barbara, CA
- Riverside, CA
- Colorado
- Nebraska (6 FDCs)
- Oklahoma
- Dunklin County, MO
- Pima County, AZ

- 3,244 adults
- 5,131 children
- 2,479 families

2010 Children Affected by Methamphetamine Grant

2014
7 Common Ingredients and Strategies

• System of **identifying** families
• Early **access** to assessment and treatment services
• Improved **family-centered** and two generation **parent-child** services
• Improved management of **recovery services** and **compliance**
• Responses to participant **behavior** — implementing contingency management
Increased judicial or administrative oversight

**Collaborative approach** across systems
- Improved information sharing protocols
- Collaborative governance
- Cross-training of staff
- Inclusion of services from other child- and family-serving agencies: child development, maternal and child health, hospitals, parent-child therapy, and home visiting
Collaborative Practice and Policy

5Rs

- Recovery
- Remain at home
- Reunification
- Re-occurrence
- Re-entry
Re-occurrence of Child Maltreatment

Percentage of children who had substantiated/indicated maltreatment within 6 months:

- **Total RPG Children = 22,558**
- **n = 4776**

- CAM Children: 2.3%
- RPG Children - FDC: 3.4%
- RPG Children - No FDC: 4.9%
- RPG - 25 State Contextual Subgroup: 5.8%
Re-entry – Foster Care within 12 Months

Percentage of Children Re-entered into Foster Care Within Twelve Months

- CAM Children: 5.0%
- RPG - Children: 5.1%
- RPG - 25 State Contextual Subgroup: 13.1%
Here’s What We Know

- Child Welfare cannot solve this problem from within child welfare.
- Substance use and child maltreatment are multi-generational problems that can only be addressed through a cross-system collaborative approach.
- Treatment must be family-centered and focus on both parents’ and children’s needs.

Building bridges to Family Well-Being
Requires the collaborative effort of multiple health and human service arenas

Often, there are many already existing but separate initiatives

Each system has a different set of mandates and target population

Underlying differences: Systemic and Individual Level
  - Stigma
  - Personal values and experiences
  - Different approaches: Rehabilitative and Punitive
Key Lessons Learned in Collaborative Practice: What do the data say?

We can’t coordinate or fix what we can’t count.

• Number of infants with prenatal exposure

• Number of infants for whom notification to CPS is made

• Number of infants and parents with Plan of Safe Care, treatment admission and retention

• Number of child welfare cases affected by parental substance use disorders
Key Lessons Learned in Collaborative Practice: Treatment that Supports Families

- Encourages retention in treatment
- Increases parenting skills and capacity
- Enhances child well-being
- Is cost-effective

Family Centered Treatment is not Residential Treatment
& Family Recovery is not Treatment Completion

Parent Recovery
- Parenting skills and competencies
- Family connections and resources
- Parental mental health
  - Medication management
- Parental substance use
- Domestic violence

Child Well-being
- Well-being/behavior
- Developmental/health
  - School readiness
  - Trauma
  - Mental health
- Adolescent substance abuse
- At-risk youth prevention

Family Recovery and Well-being
- Basic necessities
- Employment
- Housing
- Child care
- Transportation
- Family counseling
- Specialized Parenting

Family Centered Treatment for Women with Substance Use Disorders: History, Key Elements and Challenges
» http://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf
Continuum of Family-Based Services

Where do we go from here?
2016 Primary Changes in CAPTA

- Further clarified population to infants “born with and affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder,” specifically removing “illegal”

- Required Plan of Safe Care to include needs of both infant and family or caregiver

- Specified data to be reported by States

- Specified increased monitoring and oversight for States to ensure that Plans of Safe Care are implemented and that families have access to appropriate services
CAPTA: State Policy Implications

Development of a state-level collaborative body to enforce or develop and oversee related laws and policies (e.g. child abuse/neglect statutes on prenatal substance exposure)

Defining the population of infants: affected by substance abuse, withdrawal symptoms or fetal alcohol spectrum disorder

Determining populations of families and the appropriate organization to implement and oversee the Plan of Safe Care

Strengthening of state data systems to meet the reporting requirements
Policy and Practice Framework: 5 Points of Intervention

Pre-Pregnancy
Awareness of substance use effects

Prenatal
Screening and Assessment

Initiate enhanced prenatal services

Child
Identification at Birth
Parent

Post-Partum
Ensure infant's safety and respond to infant’s needs

Respond to parents’ needs

Infancy & Beyond
Identify and respond to the needs of the infant, toddler, preschooler, child and adolescent

Identify and respond to parents’ needs

SAMHSA, Substance Exposed Infants: State Responses to the Problem, 2009
Practice and Policy Issues

• Identification: Only a handful of states have **standardized screening tools** used to detect parental substance use during investigations of child abuse and neglect.

• Collection: The current data system **does not** require collection of parental substance use as a factor in child removals.

• **Variation** in data systems: NCANDS, AFCARS, SACWIS
• Expands reimbursable services beyond outpatient, intensive outpatient and opioid treatment to support a more comprehensive continuum of care based on the American Society of Addiction Medicine (ASAM) criteria

• All Medi-Cal beneficiaries living in counties that opt-in

• Previously eligible Medical-beneficiaries (250% of poverty level)

• Medi-Cal expansion population (138% of poverty level)

• Services must be determined medically necessary by qualified physician
## Services Available Under DMC-ODS

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<thead>
<tr>
<th>Service</th>
<th>Youth</th>
<th>Adults</th>
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<tbody>
<tr>
<td>Outpatient</td>
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<td>✅</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
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</tr>
<tr>
<td>Short-Term Residential (90 days)</td>
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<td>✅</td>
</tr>
<tr>
<td>Withdrawal Management</td>
<td>N/A</td>
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</tr>
<tr>
<td>Opioid Treatment Programs</td>
<td>N/A</td>
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</tr>
<tr>
<td>Case Management</td>
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<tr>
<td>Recovery Support</td>
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<tr>
<td>Physician Consultations</td>
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Information on services for pregnant women is not available at this time.

A Policy Portfolio: Six Opportunities for Impact on Child Welfare Outcomes in Families affected by Parental and Prenatal Drug Exposure

1) Drug Medi-Cal funding for expanded evidence-based family treatment drawing on lessons of successful programs

2) Implementation of Plans of Safe Care under CAPTA for prenatally exposed infants

3) Revision of CWS/CMS to include upgraded Parental Substance Abuse screening data: “make it yellow”
4) Establish clear policy for in-home services for substance-affected children and families, including Home Visiting $ 

5) Focus marijuana revenues and Cures/opioid funding on evidence-based family prevention and treatment 

6) Expand family treatment courts and/or infuse FTC principles in child welfare-treatment-court collaboration
Moving Forward: The Three Rs of Collaboration

Relationships: Developing Your Governance Structure

Results: Identifying Data for Effective Planning

Resources: Identifying and Implementing Key Strategies

We can no longer say, “We don’t know what to do.”


3. Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Legal Professionals

Updated September 2015: New content including updates on opioids and Family Drug Courts!

https://ncsacw.samhsa.gov/training/default.aspx
Additional Training Resources


What You Need To Know About Substance Abuse and Mental Health Disorders To Help Families in Child Welfare.

The toolkit contains the following six modules:
- Understanding the Multiple Needs of Families Involved With the Child Welfare System
- Understanding Substance Use Disorders, Treatment, and Recovery
- Understanding Mental Disorders, Treatment, and Recovery
- Engagement and Intervention With Parents Affected by Substance Use Disorders, Mental Disorders, and Co-Occurring Disorders
- Developing a Comprehensive Response for Families Affected by Substance Use Disorders, Mental Disorders, and Co-Occurring Disorders
- Understanding the Needs of Children of Parents With Substance Use or Mental Disorders

Each module is approximately 2-3 hours and can be delivered over a series of weeks or through a 1-2 day training program. The modules each contain an agenda, training plan, training script, PowerPoint presentation, case vignettes, handouts, and reading materials. References include a trainer’s glossary, training guide, and a bibliography.

Don’t miss out on this valuable product!
Get your FREE toolkit today!

Modules can be downloaded individually or as a package at https://www.ncsacw.samhsa.gov/training/toolkit/.

https://ncsacw.samhsa.gov/training/default.aspx
• Guide for Collaborative Planning
• 7 guides to identify collaborative strengths and challenges
• Facilitator’s Guide
• Case Study

• Substance Exposed Infants In Depth Technical Assistance: 8 states
• Policy Academy: 10 states

Web-Based Resource Directory
Additional Resources
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