Children and Family Futures

Strengthening Partnerships, Improving Family Outcomes

# U.S. House of Representatives
# Committee on Oversight and Reform

## Medical Experts: Inadequate Federal Approach to Opioid Treatment and the Need to Expand Care

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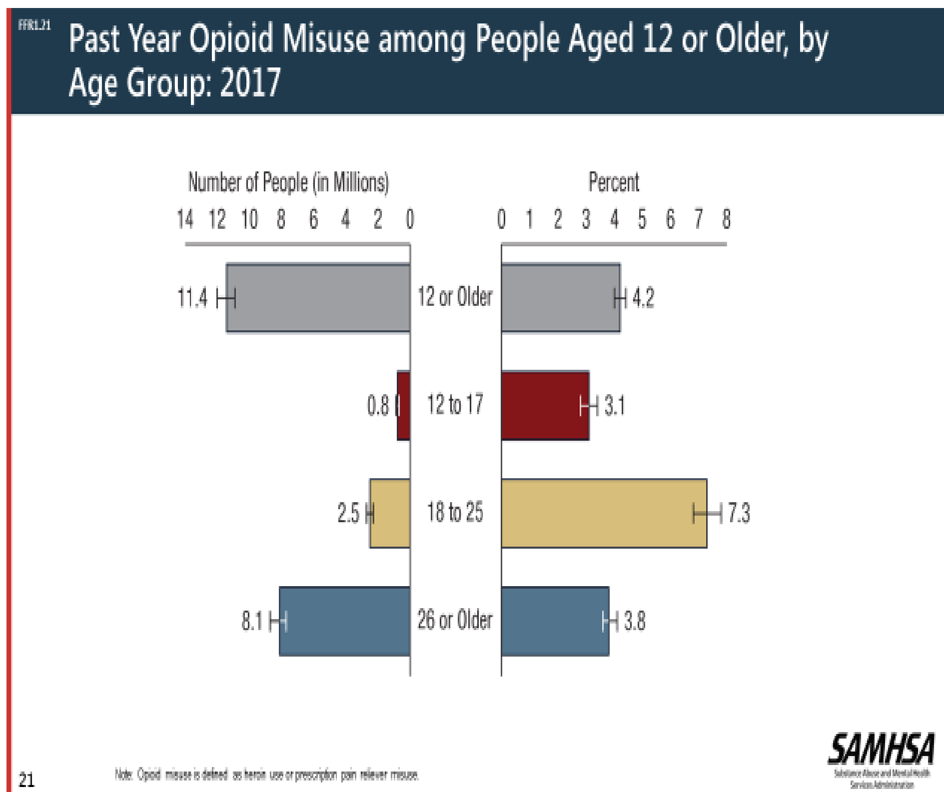
To answer the question on why it's so hard for families to access services requires an explanation of the data on this topic.

**Brief Summary of the Data Related to Parents with Opioid and other Substance Use Disorders in Child Welfare Services**

In the three most recent changes in drug use patterns in our country, cocaine, methamphetamine, and opioids, adolescents and younger people at prime child-bearing ages, 18 to 26 year-olds, tend to be those who are most at risk to experiment and develop severe substance use disorders. This age group is also more likely to be unprepared to become parents. When these young parents also have a substance use disorder, they too often expose their child to substances during pregnancy, place their children in risky situations, or neglect their children so that child protective services are called upon to step in and protect the child.

As shown in 2017 survey data, the age group most likely to misuse opioids were also persons in prime child bearing ages. Approximately 7.3% or roughly 2.5 million 18 to 25 year-olds reported opioid misuse (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018).

Graph 1: Number and Rates of Past Year Opioid Misuse by Age




Among all age groups, there are two aspects of parental opioid use that affect the child welfare system: (1) prenatal opioid and other substance use exposure when it is determined that there are immediate safety factors resulting in the newborn being placed in protective custody; and, (2)

post-natal use that affects parents' or the legal caregivers' ability to safely care for their children, including parents' incarceration.

Congress has specified that hospital notification of cases of prenatal substance exposure is not substantiated child abuse or neglect.[1] Rather, when infants are identified by hospital staff as affected by substance abuse, CPS is notified and the child welfare staff conducts an assessment of the family's risk and safety factors. Safety refers to immediate threats of danger (a parent actively using opioids and not pursuing treatment could be a safety threat) and risk refers to the likelihood of maltreatment occurring in the future (a family with parental opioid use, not fully compliant in treatment, and no other adult in the home to care for the child could be a risk factor).

Since 2003, Congress has required that states who receive funds from the Child Abuse Prevention and Treatment Act (CAPTA) state grants are to make assurances that they are operating programs and have policies that a plan of safe care is developed when health care professionals identify infants affected by substance abuse. In 2016 Congress amended the requirements in CAPTA related to infants with prenatal substance exposure as part of the Comprehensive Addiction and Recovery Act (CARA) and clarified that plans of safe care are to include all "infants affected by substance abuse" (specifically removing the category of just illicit drugs), "withdrawal symptoms, and fetal alcohol spectrum disorder." Congress leaves operational definition of these terms to the states and included the treatment needs of the family/caregiver in the plan of safe care. States and local governments have been working to implement these changes and there were additional funds appropriated for the past two years in CAPTA, with a priority that states implement plans of safe care for these infants and families.

Since the first estimates of the incidence of Neonatal Abstinence Syndrome ("NAS")[2] were made in the year 2000, consistent increases have been reported in the literature. There was a 3-fold increase from 1.2 to 3.4 per 1,000 hospital births from 2000 to 2009 (Patrick et al., 2012) and 5.8 per 1,000 hospital births in 2012 (Patrick et al., 2015). The Center for Disease Control (CDC) examined publicly available data from 1999 through 2013 and found similar results, with NAS incidence increasing from 1.5 to 6.0 per 1,000 births (Ko et al., 2016). In 2014, the incidence had increased again to 8.0 per 1,000 births (Winkelman et al., 2017) which translates to over 30,000 infants.

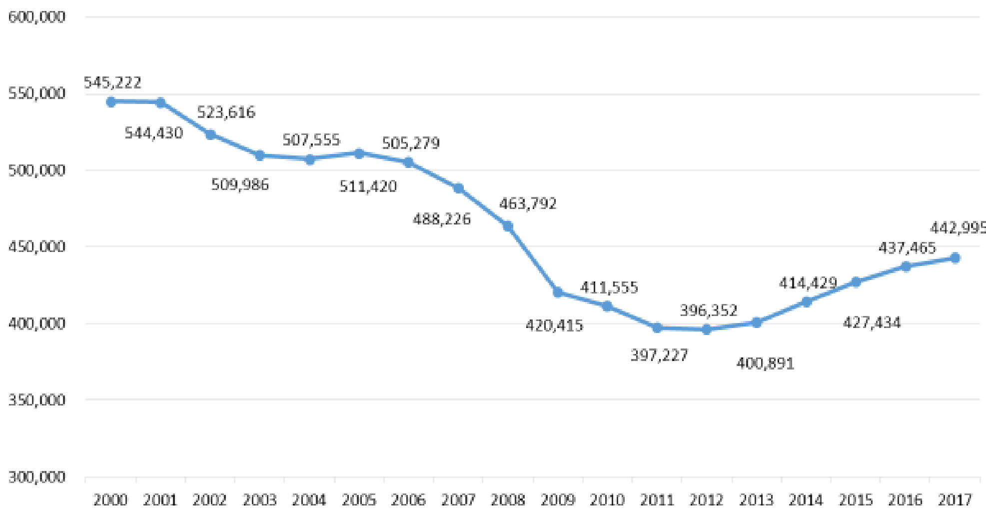
The data are not available to know if this increase in babies diagnosed with NAS are directly related to the increase in infants being placed in protective custody. The Adoption and Safe Families Act ("ASFA") in 1997, increased the nation's focus on reducing the number of children in out-of-home care by providing incentives for states to increase the number of adoptions and to allow funding waivers to try innovative programming to prevent child removals. Soon after ASFA was enacted, the highest number of children in out-of-home care ever recorded was in 1999, with approximately 567,000 children (U.S. DHHS, 2006). That began the trend of more than a decade of decreasing the number of children in out-of-home care. The ASFA changes

[1] The exact language is that "…such notification shall not be construed to – (I) established a definition under Federal law of what constitutes child abuse or neglect; or (II) require prosecution for any illegal action."

[2] The correct term and diagnostic category for infants who experience withdrawal from opioids is Neonatal Opioid Withdrawal (NOWs) and Neonatal Abstinence Syndrome (NAS) is used to refer to all types of substances or when the specific substance is unknown. In practice however, few practitioners distinguish between the two and generally classify all infants with NAS rather than correctly identifying NOWs when appropriate.

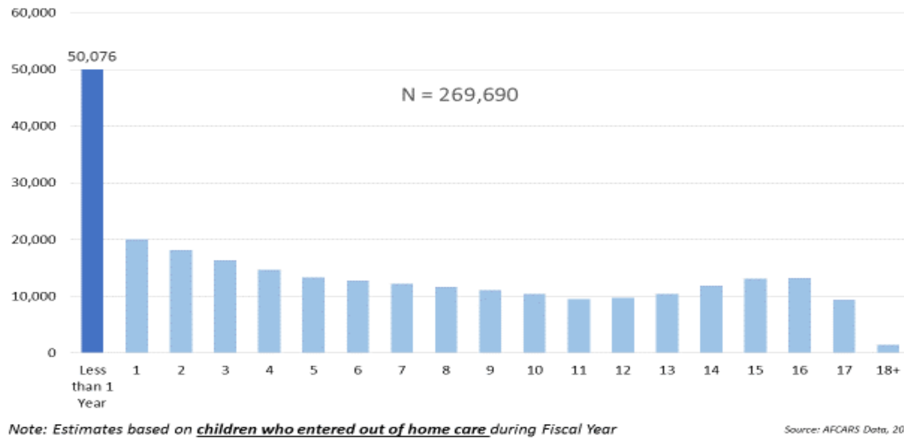
were having significant effects on the overall system despite the methamphetamine era of the late 1990s and early 2000s. Overall caseloads continued to decrease reducing the numbers of children in care to a low point in 2012 of just over 396,000 children. That trend began to reverse in 2011-2012 (shown as federal fiscal year 2012 in graph 2). In 2011-2012 the number began to rise and has continued a steady increase for the past five years. The increasing number of children in care since 2012 are both new intakes as well as children who are remaining longer in care because they cannot return to their home and alternative homes have not been found.

Graph 2: Number of Children in Out-of-Home Care at End of Fiscal Year in the U.S., 2000 to 2017



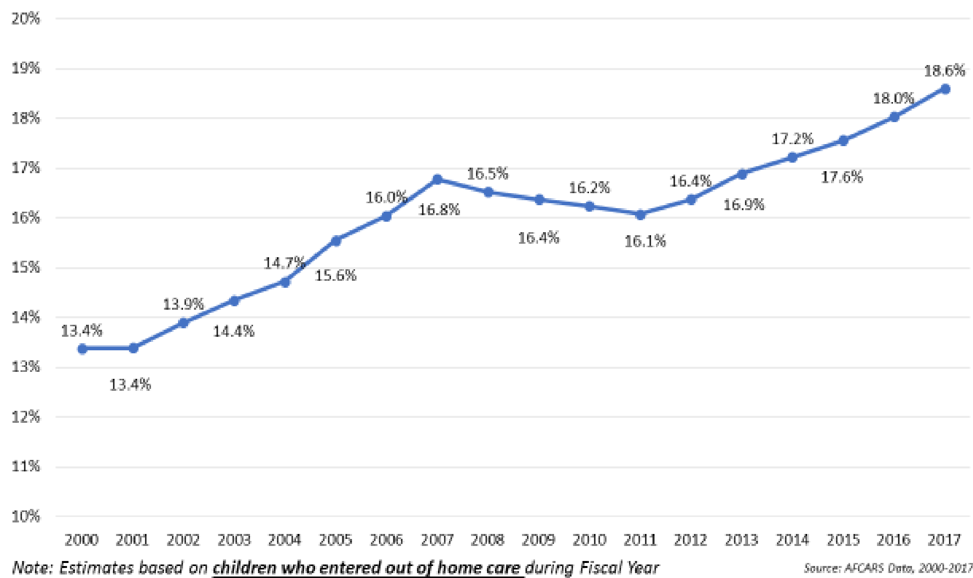

Part of the change in the child welfare caseload includes a trend to a larger number of infants. Of the nearly 270,000 children who entered care in 2017, the largest group were infants (see Graph 3). Again, the data are not available at the national level on the percentage of those infants who experienced prenatal substance exposure. Better data would help us understand the dynamics of these trends in more depth.

Graph 3: Number of Children who Entered Out-of-Home Care, by Age at Removal in the U.S., 2017



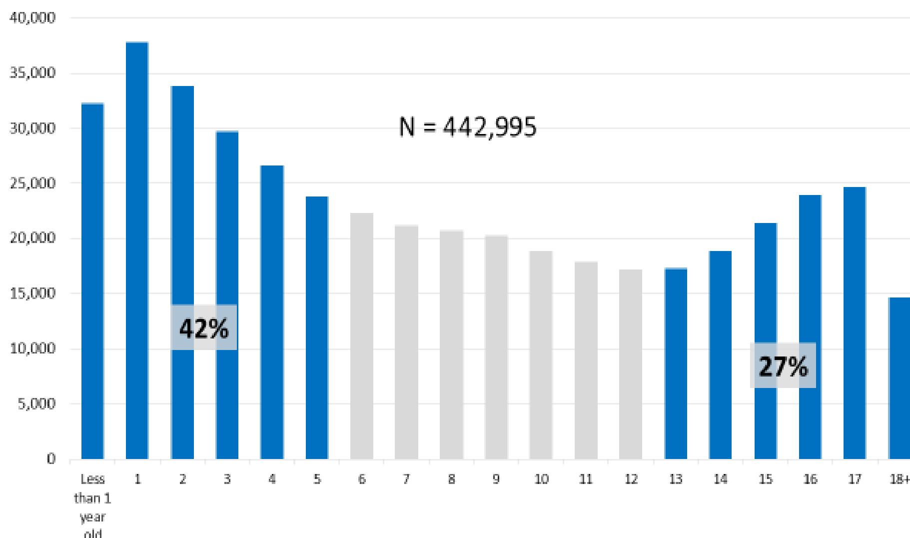

Infants placed in out-of-home care are an increasing rate of all children in care as shown in Graph 4. In 2017, infants were nearly 1 out of every 5 children placed in care.

Graph 4: Percent of Children under Age 1 who Entered Out-of-Home Care in the U.S., 2000 to 2017.




These trends are resulting in an increasing shift toward younger children making up a larger percentage of children in out-of-home care with children under six now representing 42% of children in care.

Graph 5: Number of Children in Foster Care at End of Fiscal Year by Age in the U.S., 2017



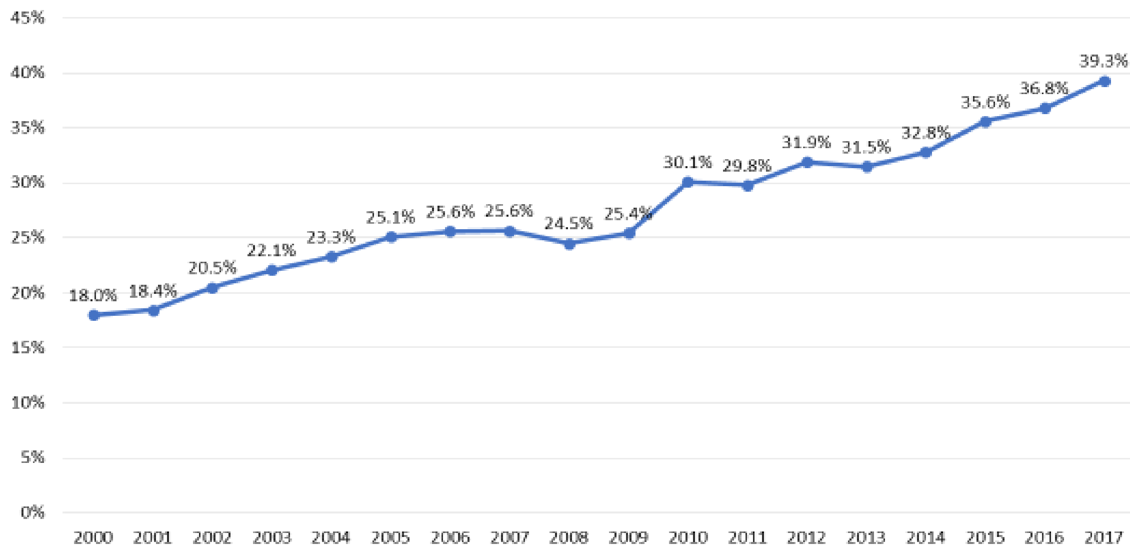

This rate of young children coming into care is especially troubling, as children ages birth to 3 years old are at their most vulnerable. Infancy and toddlerhood is a time of rapid development across all domains of functioning. The brain of a newborn is about one-quarter the size of an adult's and by the age of three, the brain has developed to about 80 percent of its adult size (Nowakowski, 2006). Thus, these data indicate a short window of time for intervention with these children and families. It is imperative that the development of that child take place in a stable environment with a caregiver who fosters mutual attachment with the child.

Staff at Children and Family Futures have been monitoring the AFCARS data for nearly 20 years and we understand the challenges of using the data to precisely measure parental substance use disorders in child welfare services. However in some states, there have been specific policy changes to improve the accuracy of data collection. However, there has not been a new study of the prevalence of substance use in child welfare in over a decade. In 2015, Seay published a review of all of the studies to date and found that across research methods and populations studied, the average estimate among children placed in out-of-home care was that 59.1% were from families with a parent that substance use was associated with the child's placement.

There are several variables that are optional items for states to collect and report to the federal government that are factors associated with the child's placement in out-of-home care. Four of those optional data collection items are related to substance use: Alcohol use by parent; drug use by parent; alcohol use by child; and, drug use by child. Graph 6 shows that between 2000 and 2009 were fairly steady rates of increase in parental alcohol and drug use associated with child removal.

Since 2009, however, states report a more rapid 14 percentage point increase. The numbers rose from 25% of cases in 2009 to 39% in 2017, in parental alcohol or drug use as factors in the child's removal. In this analysis the percent is based on either drug or alcohol being reported.

Graph 6: Incidence of Parental Alcohol or Drug Use as a Reason for Removal in the United States Factor in Out-of-Home Placement, 2000 to 2017.




Children and Family Futures staff have been to every state in the country and asked child welfare professionals if what they observe coincides with these data representing the incidence of parental substance use. Not a single state's staff believe these data accurately reflect their experience and they tell us that these numbers are significant undercounts and that they even vary across counties. They report the vast majority of cases in which a child is placed in protective custody are related to parental substance use disorders. Judges who oversee cases of child abuse and neglect most often state that parental substance use disorders are in virtually all but a very small number of the cases they adjudicate.

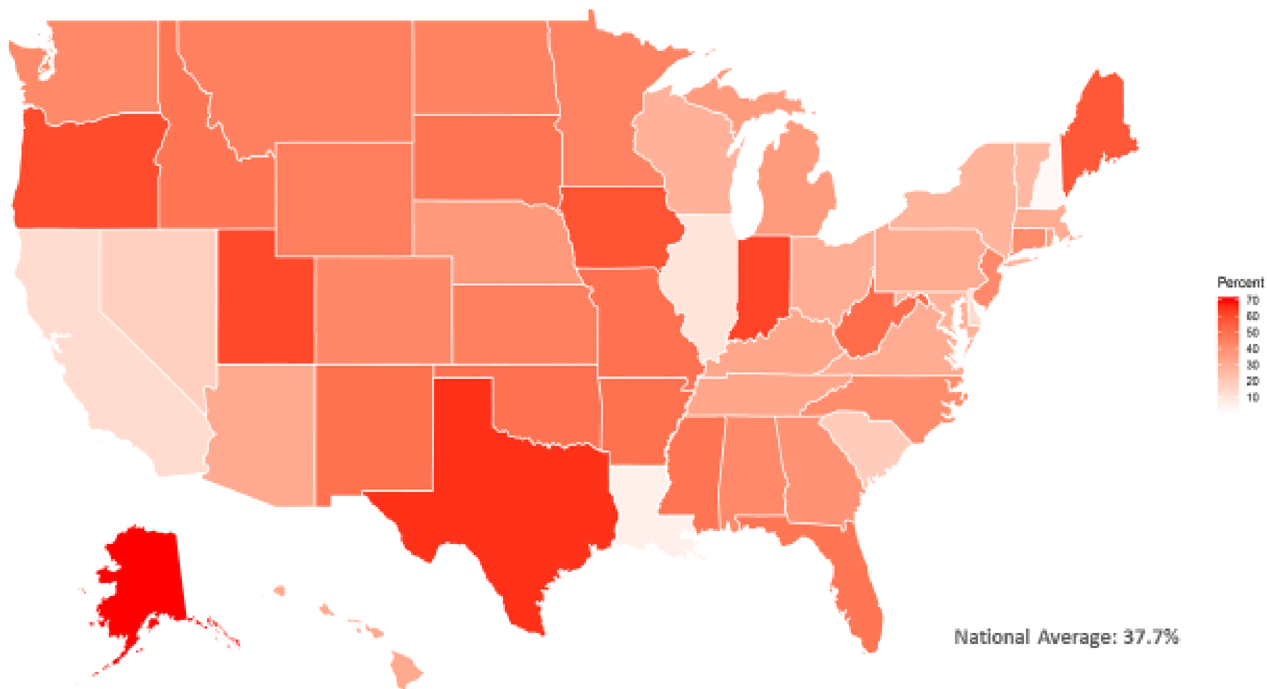
My experience suggests that there are several reasons that AFCARS data significantly undercount the prevalence of parental opioid and other substance use disorders in child welfare:

1) The collection of the variable regarding parental substance use is not required to be submitted to the federal government;
2) Most states do not have a standardized screening tool to assess if parental substance use or type of substance is a factor associated in the child's placement in care;
3) The child welfare worker may not become aware that substance use is a factor in the family until they have been working with the family for an extended period and the "place in the data system" to record that factor is only in the initial intake screen, not in on-going services;

4) The state's data system does not have an easy, consistent way for the data regarding factors associated with the child's placement at intake to be entered into the data system; and,
5) Significant numbers of parents are not available for this data collection or substance use assessments to be conducted because they are incarcerated, they have abandoned their infant out of lack of hope for their recovery, or they have died.

Thus, there is wide variation across states in the prevalence reported as shown in the map in Graph 7. The data range from states reporting less than 5% to 70% of parents with substance use as a factor in the child's placement in out-of-home care. States with the highest prevalence rates, Alaska, Texas and Maine for example, are states that have implemented standardized substance use screening tools and instructions to record the results. This child welfare practice is exemplified in Maine and New Hampshire, contiguous states that have nearly opposite prevalence rates. We know that Maine and New Hampshire have experienced the impact of opioids in child welfare in similar ways yet, their child welfare data on this is dramatically different. The reason that Maine reports nearly a 70% prevalence rate of parental substance use among children placed in care is that more than a decade ago, Maine's child welfare agency implemented a standardized screening tool into its practice.

Graph 7: Prevalence of Parental Alcohol or Other Drug Use as a Contributing Factor for Reason for Removal by State, 2017




The Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services conducted a mixed methods study of quantitative indicators of the opioid impact on foster care and a series of qualitative interviews. Their study was to determine the strength of the relationship at the county level of government and they conducted interviews with 188 professionals to understand the impact of opioids on child welfare systems. Specifically

they evaluated the rates of drug overdose deaths and drug-related hospital stays and emergency room visits impact on foster care reports of maltreatment, substantiated reports in which child protection investigators have confirmed that maltreatment occurred, and foster care entries. They found:

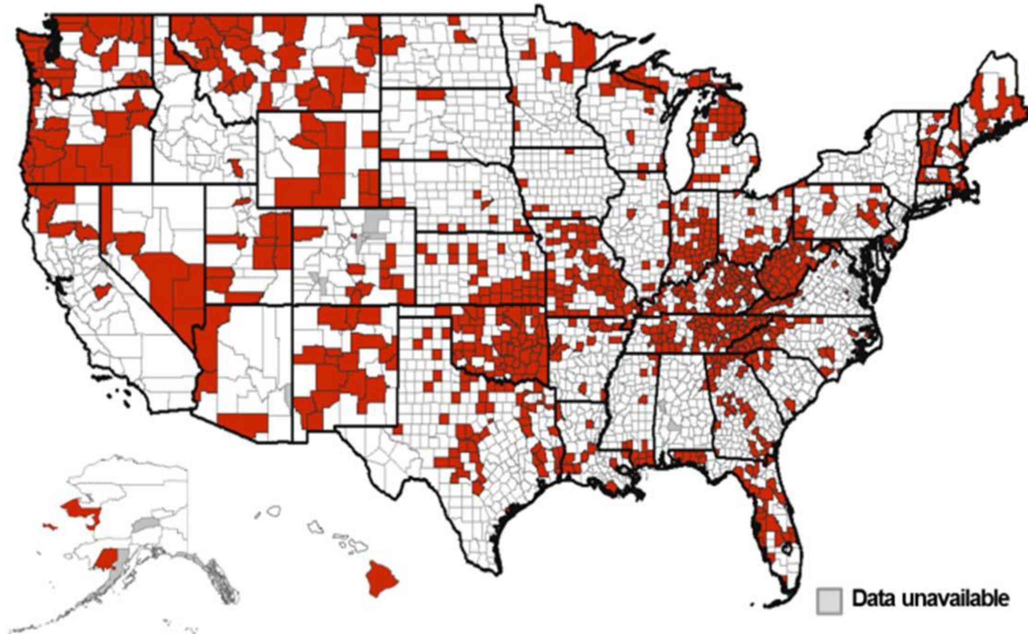
- **Higher rates of overdose deaths and drug hospitalizations correspond with higher child welfare caseload rates.** They estimate that in the average county across the country, a 10 percent increase in the overdose death rate corresponded to a 4.4 percent increase in the foster care entry rate. Similarly, a 10 percent increase in the average county's drug-related hospitalization rate corresponded to a 2.9 percent increase in its foster care entry rate.

- **Higher indicators of substance use (e.g., overdose deaths) correspond to more complex and severe child welfare cases (e.g. placement in care versus in-home services).** As cases became more severe—from report to substantiation to foster care placement—the relationship with substance use increased (i.e., the strength of the statistical model increased).

- **Hospitalization rates varied by substance, but different substances had similar relationships with foster care entry rates.** Use of any substance can put children at risk, and statistical analysis found that hospitalization due to different categories of substances have comparable relationships with foster care entry rates. Opioids, stimulants (including cocaine and methamphetamine), and hallucinogens had dramatically different hospitalization rates, with the rate of opioid-related stays being the largest (Radel et al., 2018).

This map shows by county the areas of the U.S. where the rate of both overdose death and foster care entries are above the national median.

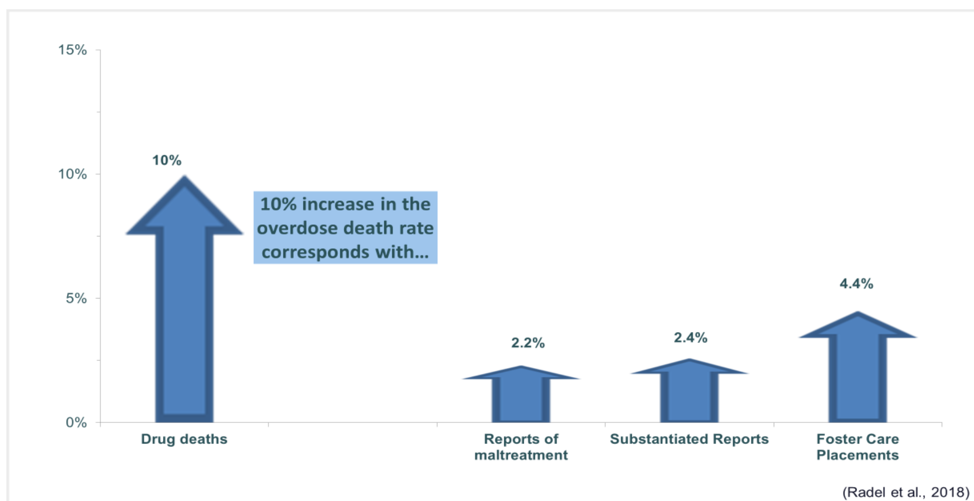
**Graph 8: Counties with Rates of Drug Overdose Deaths and Foster Care Entries Both above the National Median in 2016**




Sources: CDC/NCHS, National Vital Statistics System, Mortality; HHS/ACF, Adoption and Foster Care Analysis and Reporting System.

Again from the Radel et al., (2018) study, Graph 9 summarizes the ASPE findings. As a county experiences a ten percent increase above the rate of the national median of overdose deaths, it also experiences a 2.3% increase in reports of child maltreatment, a 2.6% increase in substantiated child maltreatment, and a 4.4% increase in foster care placement. These increases place an additional burden on child welfare and related systems to manage the increased caseloads.

Graph 9: Summary of the Relationship between Rates of Overdose Deaths and Child Welfare Indicators



ASPE also conducted interviews with 188 child welfare professionals from across the country. They found that the problems related to parents with opioid and other substance use disorders in child welfare had intensified over the prior few years and that families were more complex in terms of their services needs and the experiences of children requiring intervention. For example, they reported that for reunification to succeed child welfare workers needed to assess for and then obtain multiple services such as family therapy, parenting skills, child development, and domestic violence interventions. They also found gaps in access to treatment resources, particularly medication-assisted treatment (MAT), substance use disorder assessment protocols using current methods of evidence-based practice, and availability of family-centered treatment for child-welfare involved families. Workers reported that child welfare agencies had to arrange and pay for substance use disorder treatment as the publicly-supported treatment systems in their communities were not accessible due to the number of people accessing the limited resources available. As to the scope of the current caseload, the Assistant Secretary's report stated,

> "Caseworkers are overwhelmed by the volume of cases, the lack of treatment resources, and the sheer magnitude of the problem. These factors all lead to high stress, burnout, and turnover. While this consequence is not a new phenomenon in child welfare practice, community leaders see it as worse now than in the past."

In particular, caseworkers and professionals in areas of the country with higher indicators of substance use contrasted factors they perceived as contributing to caseloads and difficulty in family reunifications compared to prior eras such as crack and cocaine in the 1980s and methamphetamine in the 1990s. In particular they noted the impact on the entire family system with opioid use disorder. They reported that previously, family members and community institutions "shielded" children from the effects of their parents' use. These respondents reported that multiple generations of family members were frequently using substances so that finding substitute caregivers was more difficult and child welfare agencies were more likely to remove children and retain custody of the child (Radel et al, 2018).

In addition to this national picture, there is one study in the literature on medication-assisted treatment for opioid-using families in the child welfare system (Hall et al., 2016). The study is specific to the Sobriety Treatment and Recovery Team ("START") program operating in Kentucky. Dr. Hall reports on the 596 adult opioid users in the START sample and their experience with medication assisted treatment (MAT). The Kentucky evaluation of the START program has been underway since 2007 (Huebner et al., 2017). It was originally funded by a Regional Partnership Grant[3] and subsequently by the state of Kentucky which received permission from the federal government to use federal funds under a waiver program to continue the START program and the evaluation.[4] Of the 596 individuals with a history of opioid use in the START program, only 55 (9.2%) received medication assisted treatment although additional months of receiving medication increased the likelihood of parents retaining custody of their children (Hall et al., 2016).

[3] See RPG profile at: https://ncsacw.samhsa.gov/technical/rpg-ii.aspx?id=111)
[4] See explanation of waiver programs at:
https://www.acf.hhs.gov/sites/default/files/cb/waiver_summary_table_active.pdf)

To summarize

- Infants are the largest age group of children entering foster care, they are at least twice the number of children of other ages
- Children removed due to parental substance use has increased dramatically as reported by the states but it is significantly undercounted in state data bases
- There is a relationship between increased overdose death rates and increases in child welfare indicators including reports of maltreatment, substantiated reports or maltreatment, and entries into foster care
- Child welfare professionals across the country, report that parental opioid use disorders are having a major impact on increasing child removals and preventing reunification
- In Kentucky, of over 500 program participants who were using opioids in the START program, only 9% of participants received medication assisted treatment.

As noted above, these data are partial and there is general consensus in the field that they are significant undercounts. The weakness and variability of the data in turn affects the availability of treatment for these parents and children. The lack of family-focused treatment compounds the problem of too few effective treatment slots and programs, with the supportive services that have proven more effective than separating mothers and their newborns in the critical days and weeks after birth. This also perpetuates the treatment gap for children to be with their parents and to avoid their own trauma experience of placement in foster care.

**Interventions to Improve Outcomes for Children and Families**

Appropriate intervention is critical for the care of a child affected by parental substance use. Intervention is both to provide immediate safety but also to treat the trauma of the separation from the parent as well as the social emotional challenges the child has developed. There is increasing attention to Adverse Consequences of Childhood (ACEs) and specific trauma experiences that can be associated with adult morbidity and mortality. Being a child of a parent with a substance use disorder can be one of these trauma experiences. In fact, all the way back to 1991, Dr. Timothy Rivinus and his colleagues proposed that there should be a code in the Diagnostic and Statistical Manual of Mental Disorders (DSM) for children of parents with a substance use disorder entitled, Chronic Trauma of Childhood (Rivinus, 1991).

Perhaps our programs and interventions are just catching up to this as more effort is underway to understand the trauma that parents with substance use disorders have experienced as well as the trauma experienced by their children.

***Two generation parenting programs*** have been implemented in many family treatment drug court programs and show promising effects for reducing child welfare service recidivism. For example, since 2007, through the Regional Partnership Grant program (RPGs), the State of Kansas has been implementing the Strengthening Families Program (SFP), a two-generation program designed to improve both parent and child skills, capacities and social/emotional regulatory abilities for families with children ages 3-11 in foster care. Dr. Jody Brook has evaluated these efforts and has published their results in peer-reviewed studies. This statewide implementation shows SFP

participants demonstrated statistically significantly higher rates of reunification (Brook, McDonald & Yan, 2012), and SFP children spent 190 fewer days in foster care placement than did comparison children (Motoyama et al., 2013). Researchers have followed this cohort of children through 2015 (7 full years of data), and these children were not statistically more likely to re-enter foster care upon comparison (Akin, 2017). At a conservative average out of home care rate in Kansas of $86.00 per day, per child, SFP saved the state $16,340.00 per child served. In addition to these positive child welfare system outcomes, pre/post testing of program participants found: Parents/Caregivers demonstrated statistically significant improvements in substance use, parenting skills & capacities, family organization, family cohesion, family conflict, family resilience, family protective factors, and parenting risk behaviors. Children improved in the areas of overt and covert aggression, attentional deficit capacities/improved concentration, prosocial behaviors, hyperactivity, and children's depression. The State of Kansas is now testing, through the Regional Partnership Grants, a birth to 3-year old version of SFP for substance exposed newborns, so that these services can be offered to even younger children.

Over the past decade, there have been many programs initiated by Congress and hundreds of grants made by the administration to test strategies to improve outcomes for families. One significant model has been ***family treatment courts***. Beginning in the mid-1990s with two courts, the most recent count in 2018 estimates that there are approximately 500 family treatment courts operating across the country. Family treatment courts are specialized dockets operating within the juvenile or dependency court system which adjudicate cases of child abuse and neglect and parents have a substance use disorder as a factor in the case. The family treatment court works collaboratively with child welfare services, attorneys and community providers using a collaborative, family-centered approach to ensure accountability for treatment compliance and that services are available for family members.

Family treatment courts are just over 20 years old. Next month with the National Association of Drug Court Professionals, we will release national standards for the operation of family drug courts. In brief, there are several key practices that differ from standard practice in juvenile/family court that lead to better outcomes for families affected by opioid and other substance use disorders in child welfare and I've listed those in my written statement.

A meta-analysis published earlier this year concluded that...

> "Family Treatment Drug Courts should be considered as a critical model of choice for serving foster care involved families with substance use problems because of their sizeable and robust effect on promoting family reunification outcomes" (Zhang et al., 2019).

Some of these programs have shown how important it is for state agencies to work beyond the child welfare and treatment agencies to develop a full continuum of care that moves from early identification of treatment needs to aftercare services from a variety of other state agencies. These children and families are in great need of home visiting, maternal and child health, housing, and other services and supports from the full range of state agencies that deal with children and families. Too few of the newly funded treatment programs have focused on child welfare families as priorities, and too few have linked these other services to family-focused treatment. But it is

within state governments and some counties that these services can and must be pulled together. That is the antidote to isolated programs that never scale up: a continuum of services that show that state government and community leadership can work together to assemble these pieces into a coherent whole.

In addition to these specifics for family drug courts, it's critical to acknowledge that the majority of participants in all drug court programs are also parents. The parents may be disconnected from their children, but increasingly adult and veteran courts are recognizing the importance of providing services to the children of parents in drug court programs and embrace the theme that are drug courts are family courts as they work to restore families and prevent second generations of children with substance use disorders (https://www.cffutures.org/publication/transitioning-to-a-family-centered-approach/).

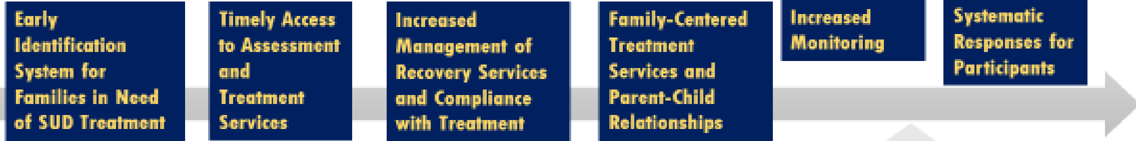
Another frequent model is providing ***peer mentors, family advocates and recovery specialists***. Some of these model programs have been in operation since the late 1980s. Four of these program models were recently described by the National Center on Substance Abuse and Child Welfare in a publication (https://ncsacw.samhsa.gov/resources/resources-recovery-support-specialists.aspx) and several of the programs have undergone rigorous evaluation with excellent outcomes.

Several other key models have been tested through these and other federal grants. Of note are the over 100 Regional Partnership Grants that have been awarded through five rounds of funding since 2007. Recently Children and Family Futures summarized the major themes of these grant programs in the graphic on the following page. It shows the six areas of practice and four areas of system changes that are needed to support practice changes to work across systems in a collaborative effort on behalf of families. The center area of the diagram illustrates the processes of the child welfare case and the timeline that is so critical for case processes. Finally, the bottom row shows the outcome areas that are the focus of the collaborative work.

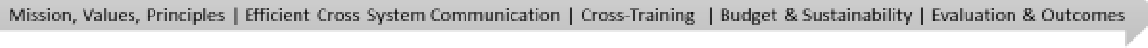
While we have seen many programs, models, grants and efforts over the past 20 years including the past two years of funding for the opioid crisis, what we can point to is a patchwork of programs, none of which operate at scale to meet the need. Recently as we begin work in a state, our staff have a standard practice of categorizing the substance abuse and child welfare initiatives by county. It is not unusual for us to find counties with more than five initiatives to work on substance abuse in child welfare. Without naming names, one state had 11 counties with 7 or more initiatives in the county. These are often disconnected initiatives with their own eligibility criteria, target population, and various constraints on the funding. It's not a strategy or a plan.

In 1991, my husband, Sid Gardner, wrote a paper entitled, ***Failure by Fragmentation.*** It certainly caught my eye and got a first date. Here we are 28 years later and our challenge is to reduce the patchwork of efforts and ensure that our on-going response to the nation's opioid and other substance use problem is robust and builds on our existing system of planning, licensing, health care and social services. We must take action to reduce that patchwork of fragmented programs and weave them into a tightly connected fabric of resilience.

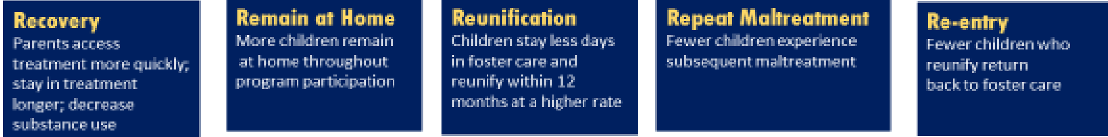
**Key Practices that Work:** Early identification, assessment, services, monitoring




**Policy Changes to Support Practices**



**Working together, systems can achieve key shared outcomes.**



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