Parental Substance Use, Opioid Misuse, and Child Welfare

Campaign for Trauma-Informed Policy and Practice
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Assistant Secretary for Planning and Evaluation

Today's Presentation

- Discuss background on the issues that gave rise to this study.
- Present contextual data on the opioid epidemic.
- Describe our quantitative research results on the extent to which trends in substance use and foster care vary together.
- Present our qualitative research findings from interviews with child welfare and stakeholders.
- Q&A and discussion.

Study Objectives

- Identify the impact of substance use prevalence on child welfare caseloads, including:
  - Total reports of child maltreatment
  - Substantiated reports of child maltreatment
  - Foster care entries

- Gather perspectives from local experts to better understand:
  - How substance use disorders affect child welfare systems?
  - What child welfare agencies, partner organizations, and community factors contribute to this relationship?

The Study Design

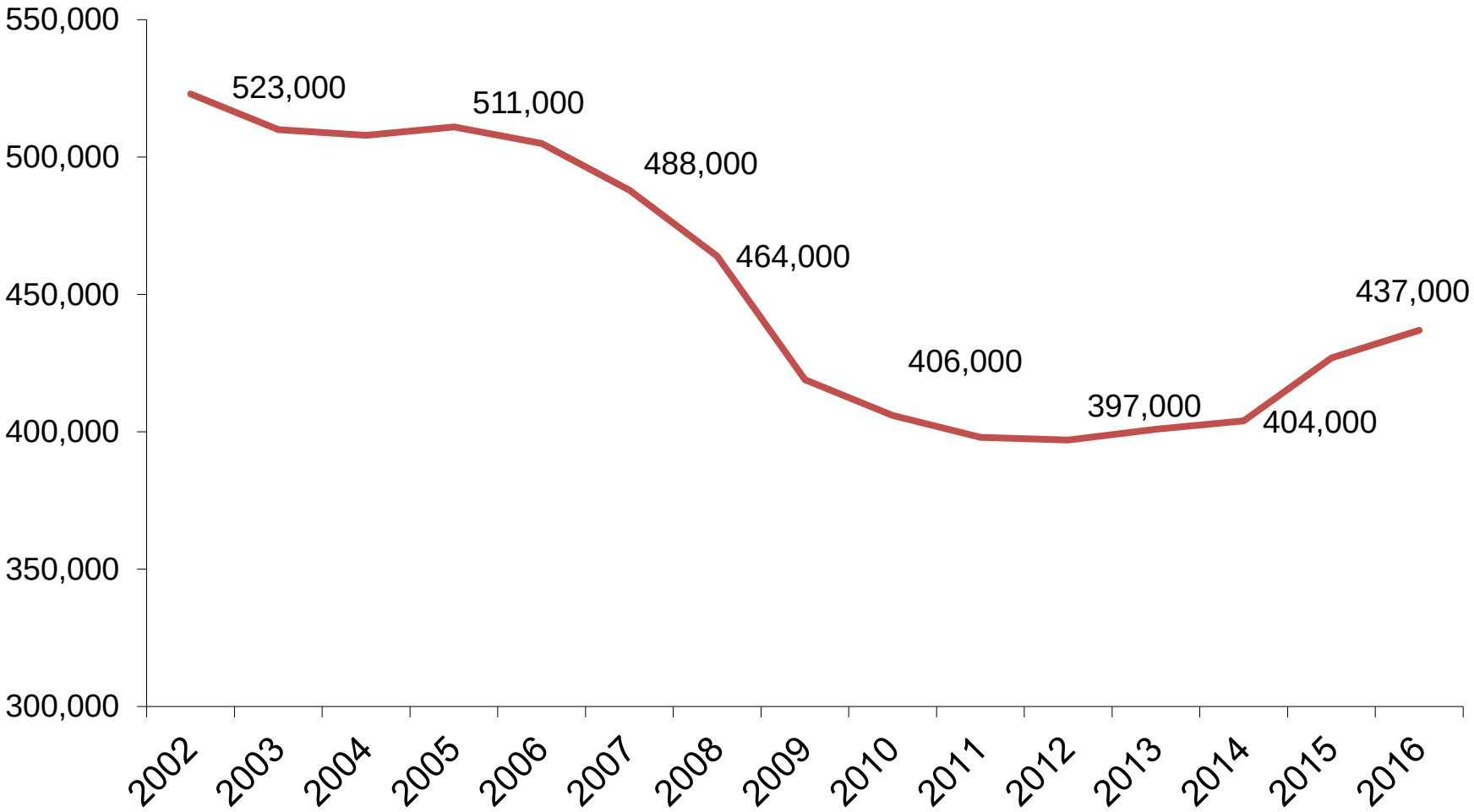
- Statistical analysis on administrative data for most counties in the US.
- Semi-structured interviews with 188 local experts in 11 sites in the country, including:
  - Child welfare administrators and caseworkers
  - Judges and court professionals
  - Substance abuse treatment administrators and providers
  - Public health providers
  - Law enforcement officials

Research Questions

- What is the relationship between substance use prevalence and child welfare caseloads, including reports of child maltreatment, substantiated reports of child maltreatment, and foster care entries?
- What are the mechanisms by which parental substance use, including opioid misuse, affect child welfare caseloads and outcomes?
- In what ways, if at all, does opioid misuse impact child welfare differently than other types of substances?
- What challenges does the child welfare system face in working with families with substance use disorder?
- What is the role of community-level factors and how do they contribute to the relationship between substance use and child welfare caseloads?
- What is the role of substance use treatment in child welfare-involved families?

BACKGROUND

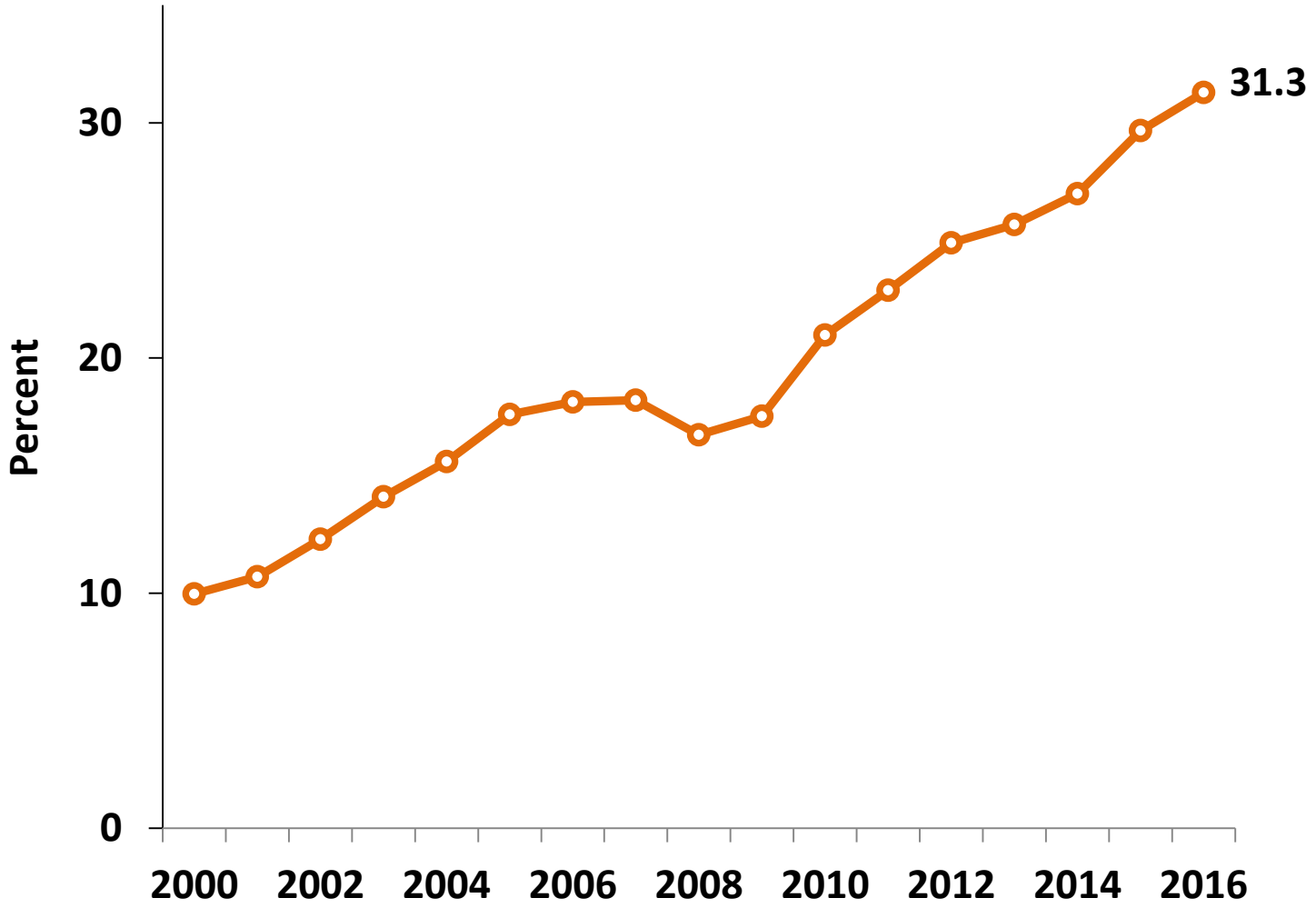
National End of Year Foster Care Caseloads, 2002-2016



Source: Adoption and Foster Care Analysis and Reporting System (AFCARS), DHHS, Administration on Children and Families, Children's Bureau.

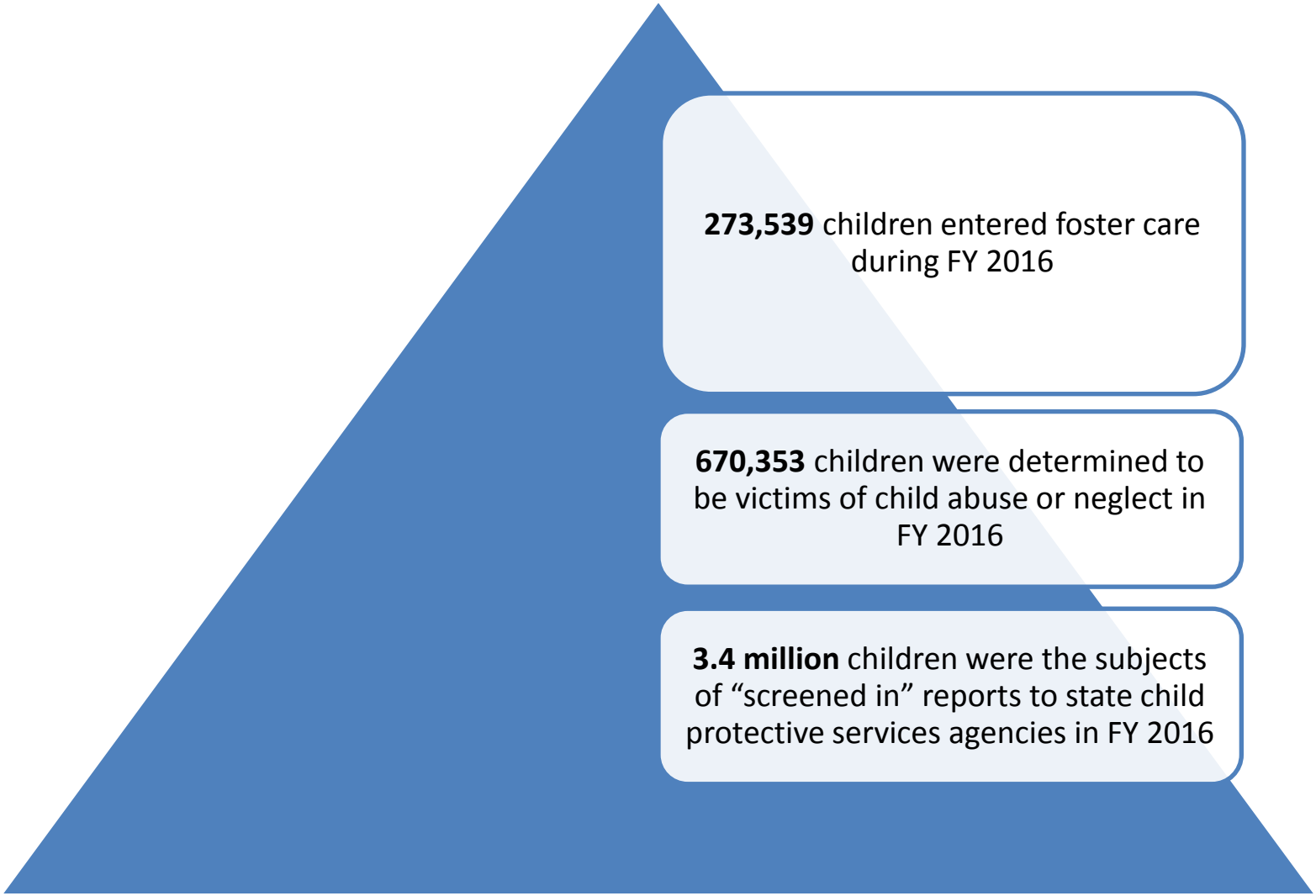
Removals to Foster Care Due to Parental Abuse of Drugs

National Average: 2000-2016

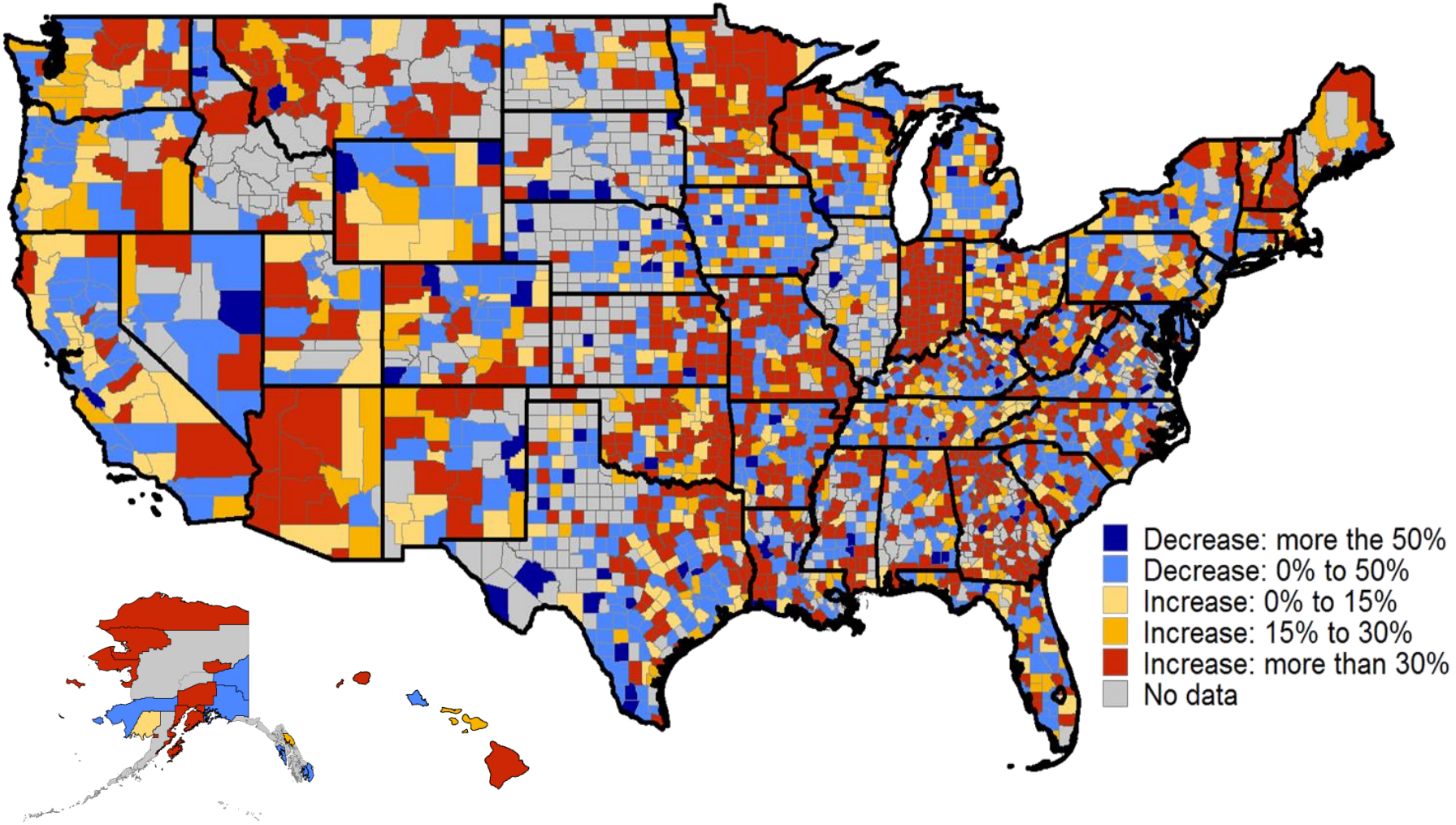


Source: Adoption and Foster Care Analysis and Reporting System (AFCARS), DHHS, Administration on Children and Families, Children's Bureau.

The Child Welfare System



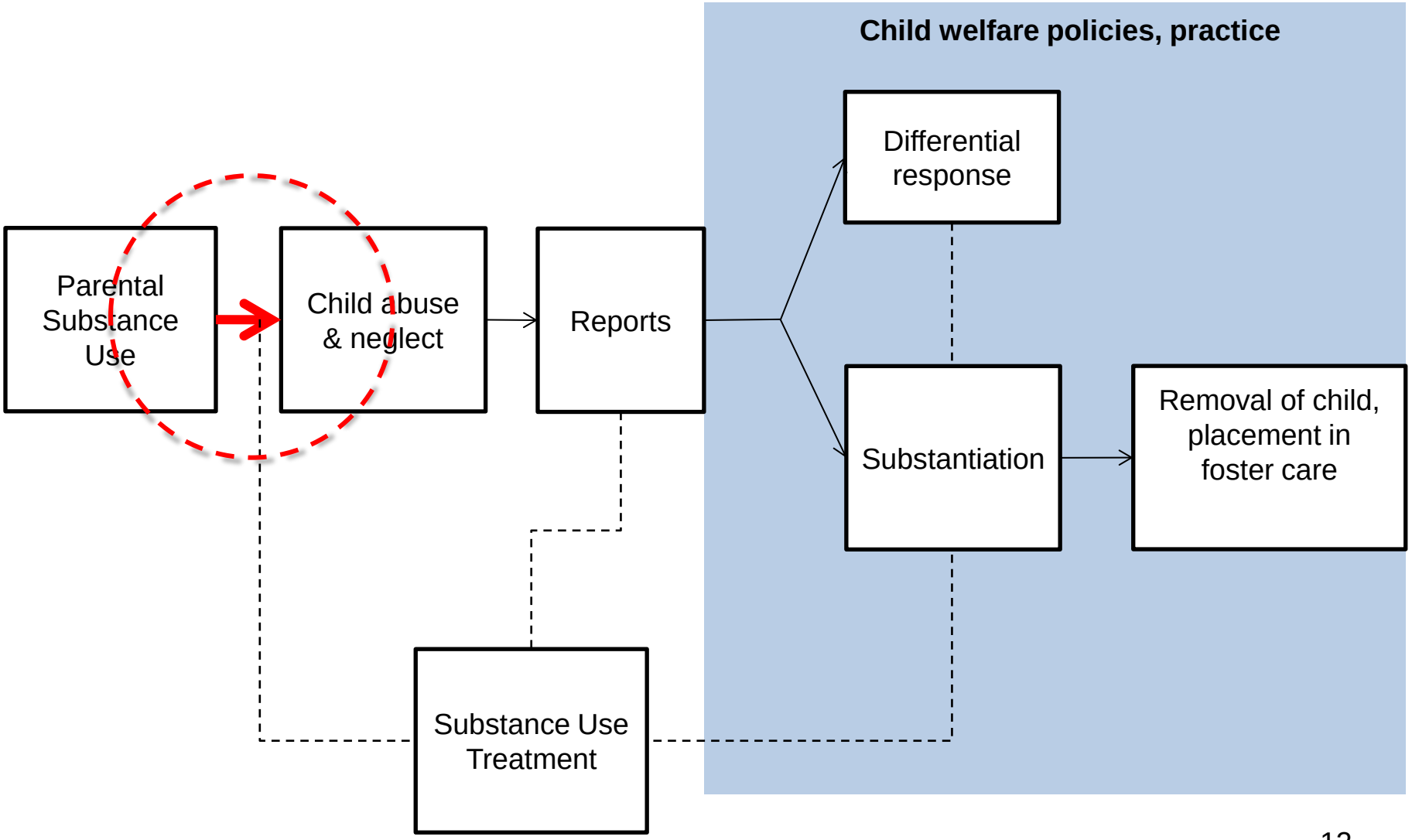
Percent Change in Foster Care Rate per 100,000 Children 2012 to 2016



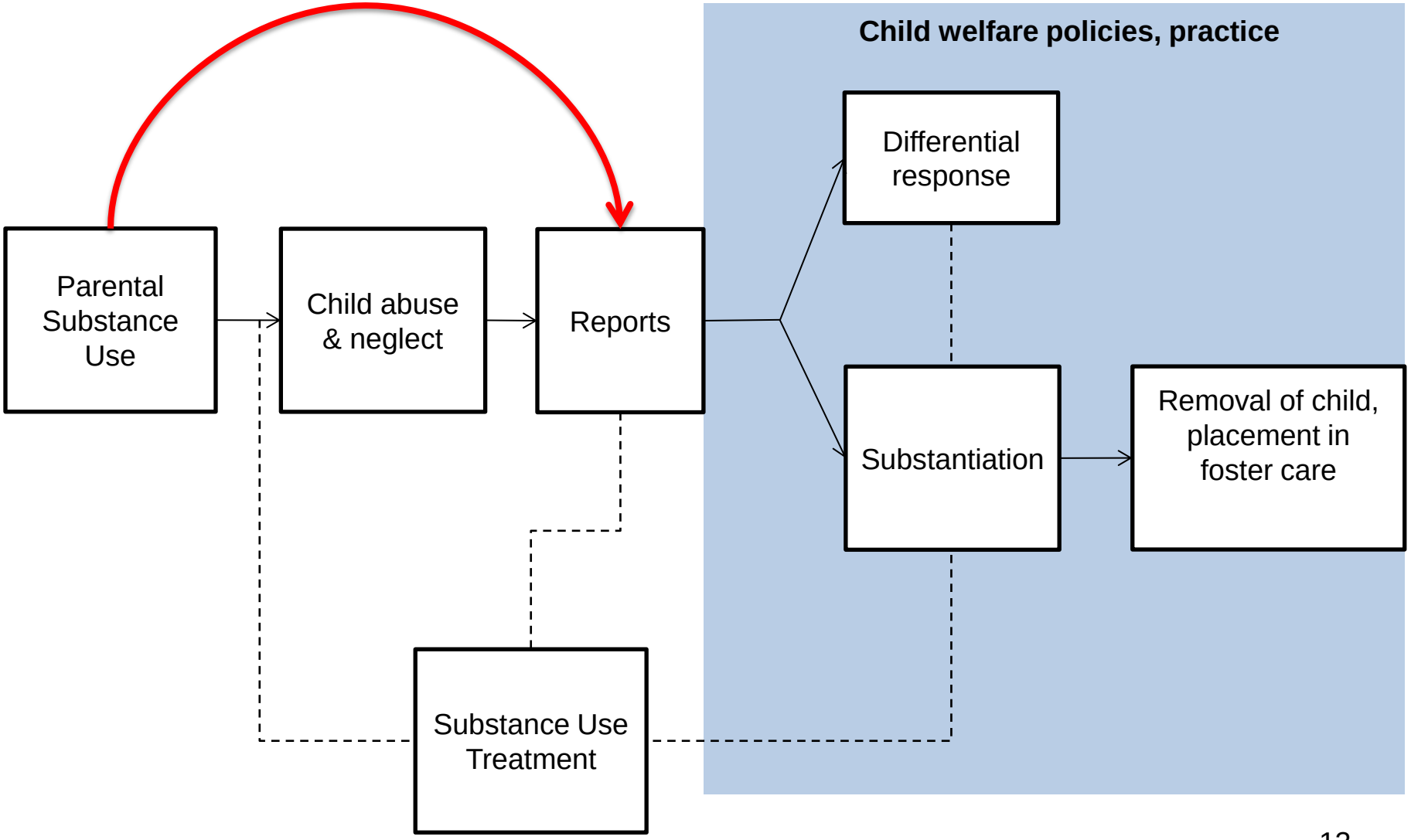
Source: Only counties with more than 10 cases displayed. Foster care children from the U.S. Department of Health and Human Services, Administration on Children and Families, Children's Bureau; population data from U.S. Census Bureau; rates calculated by ASPE.

THE MECHANISMS

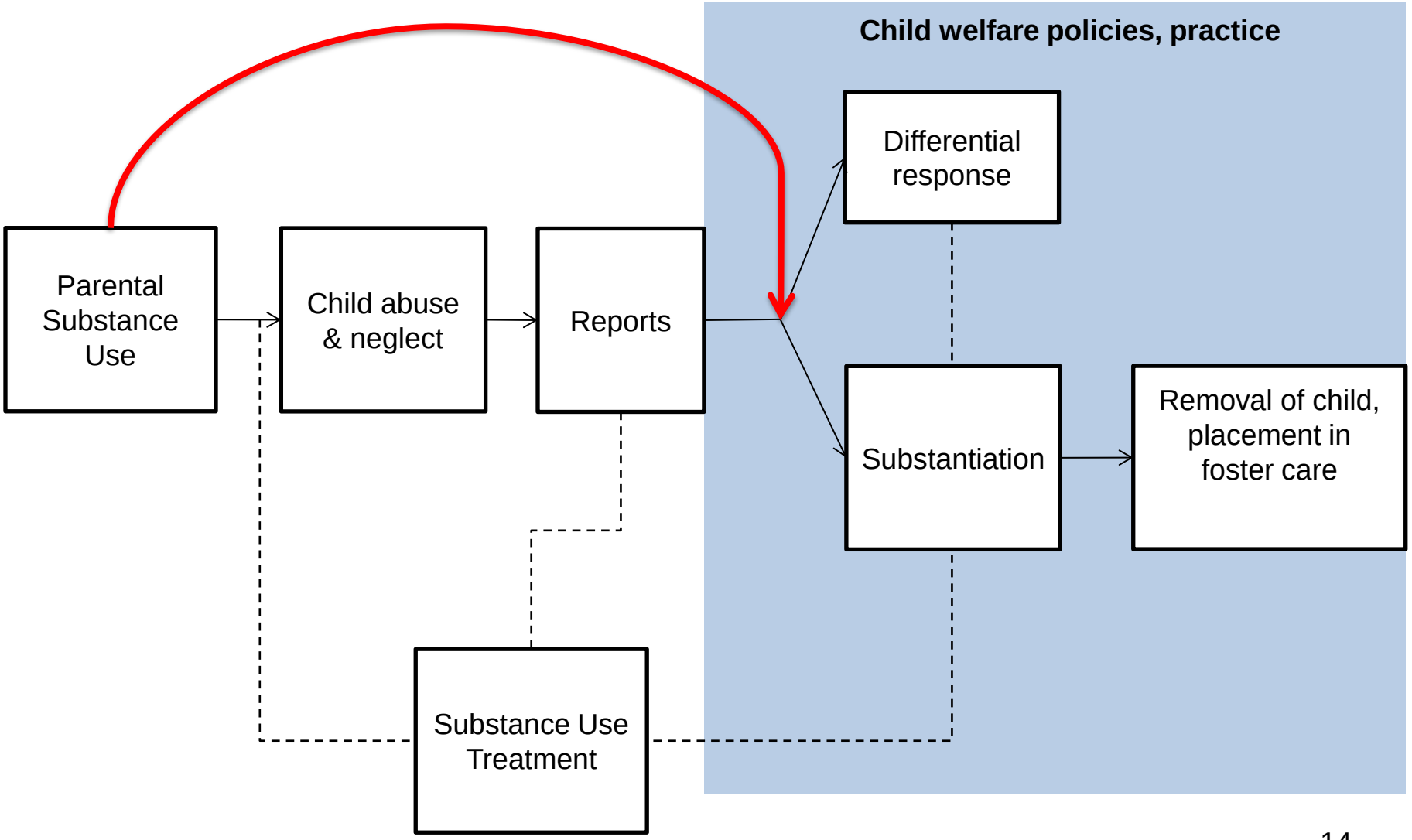
Substance Use Prevalence Could Lead to More Child Abuse/Neglect



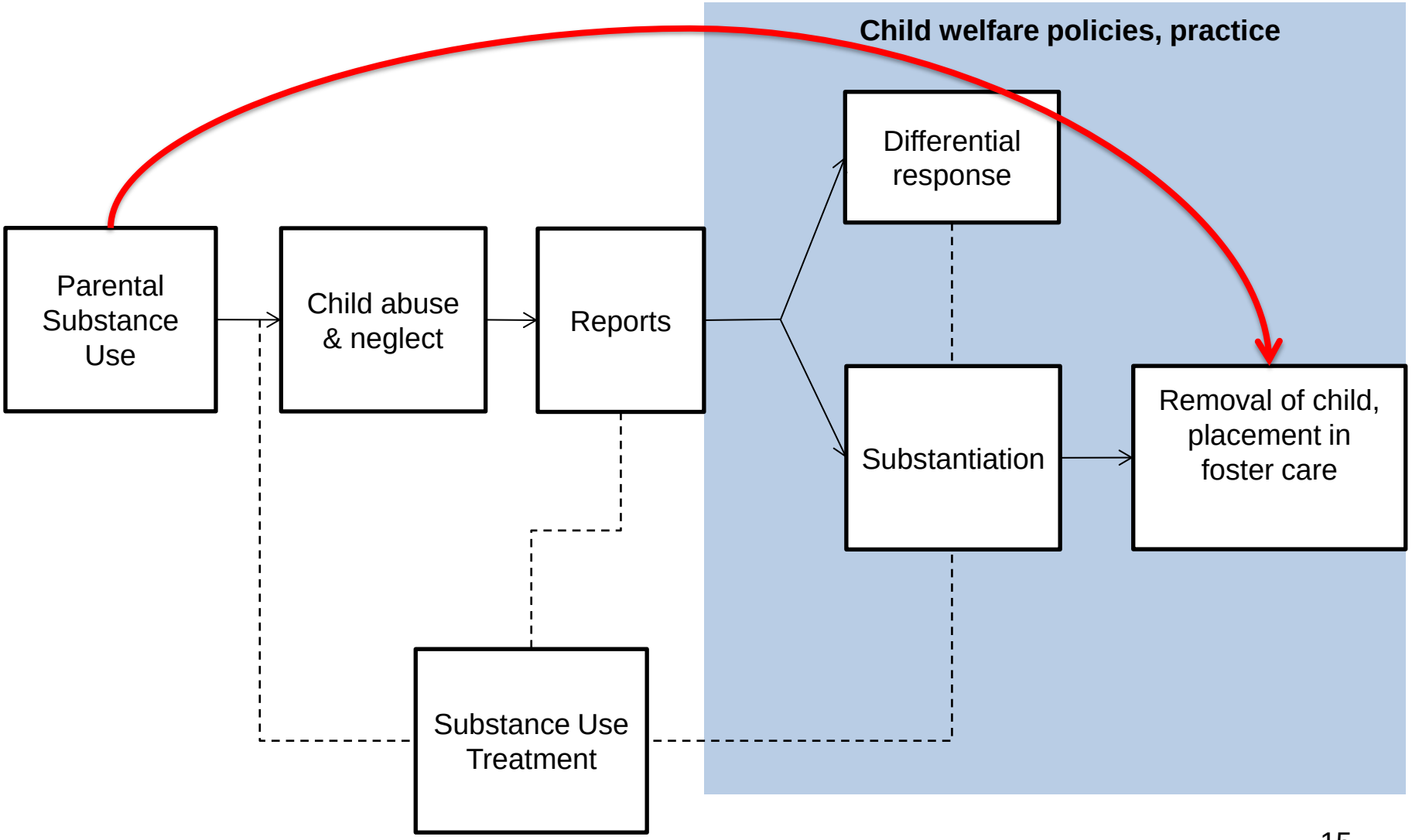
Substance Use Prevalence Could Lead Reporters to Change Behavior



Substance Use Prevalence Could Lead Caseworkers to Change Practice



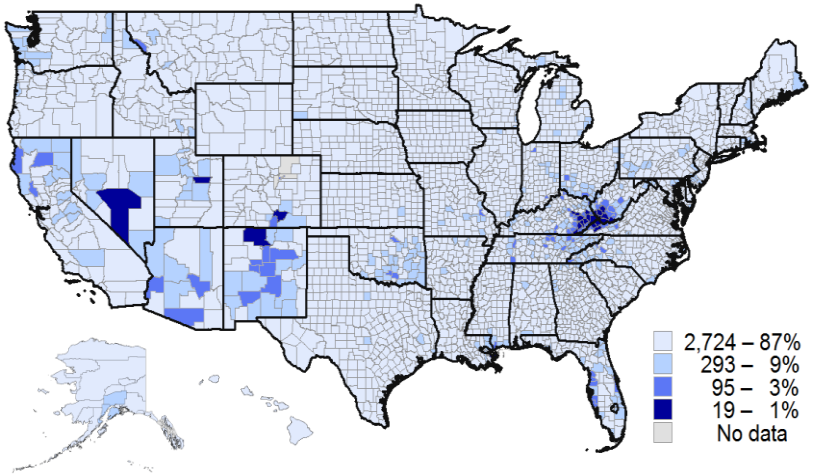
Substance Use Prevalence Could Lead Courts to Change Practice, Government Change Policies



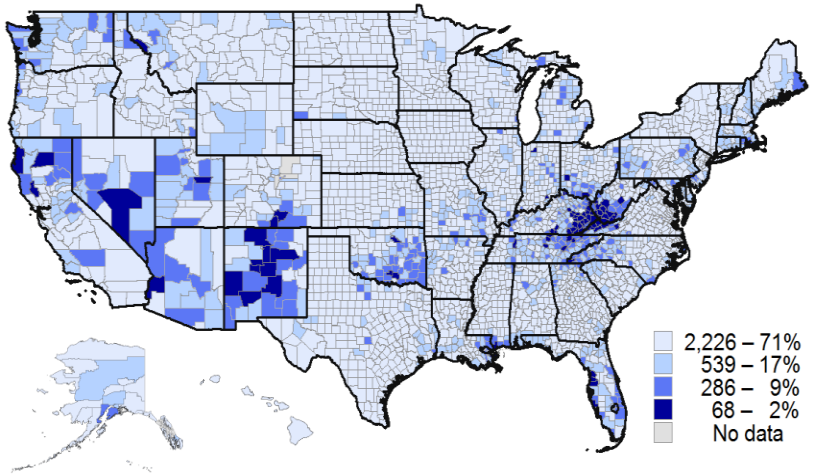
DRUG MORTALITY RATES AND FOSTER CARE

Drug Mortality Rates by County: 2004–2016

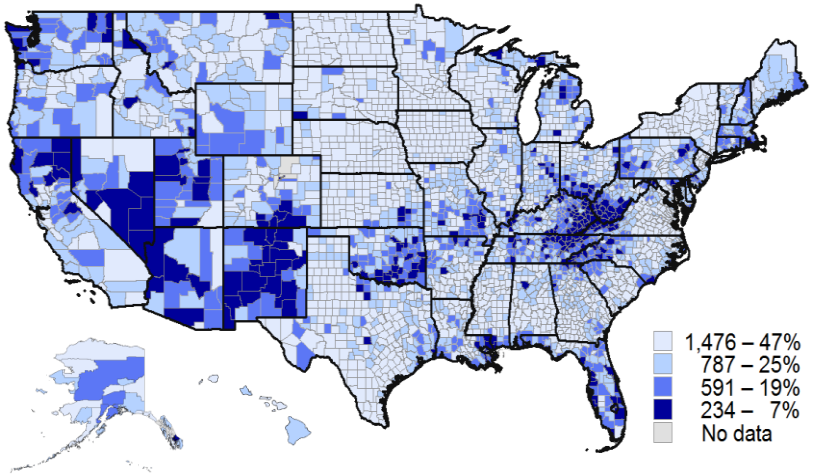
2004



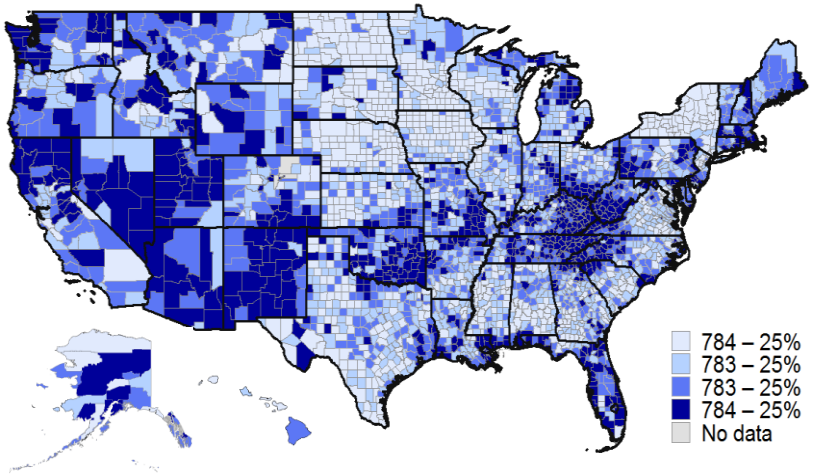
2008



2012

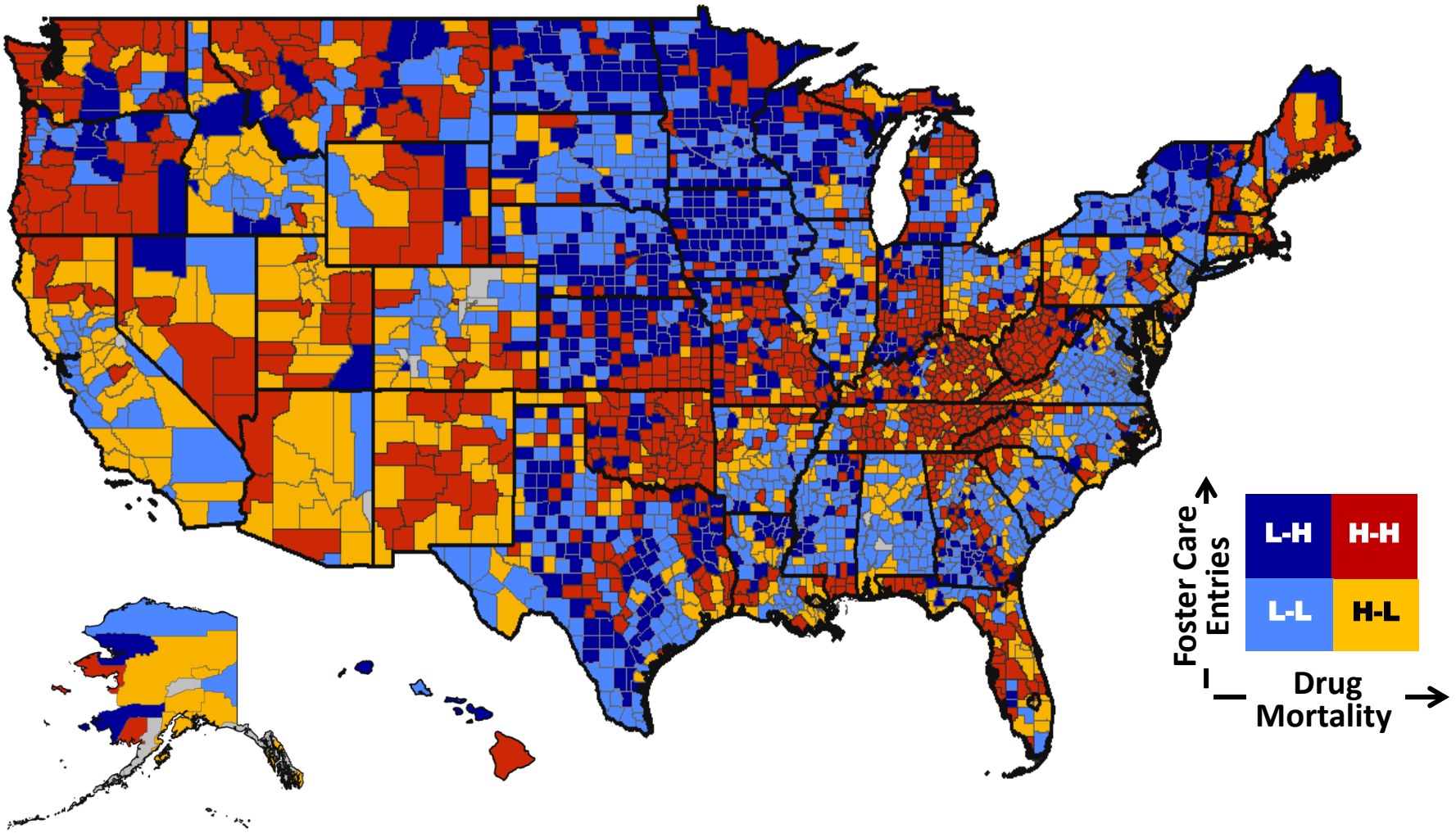


2016



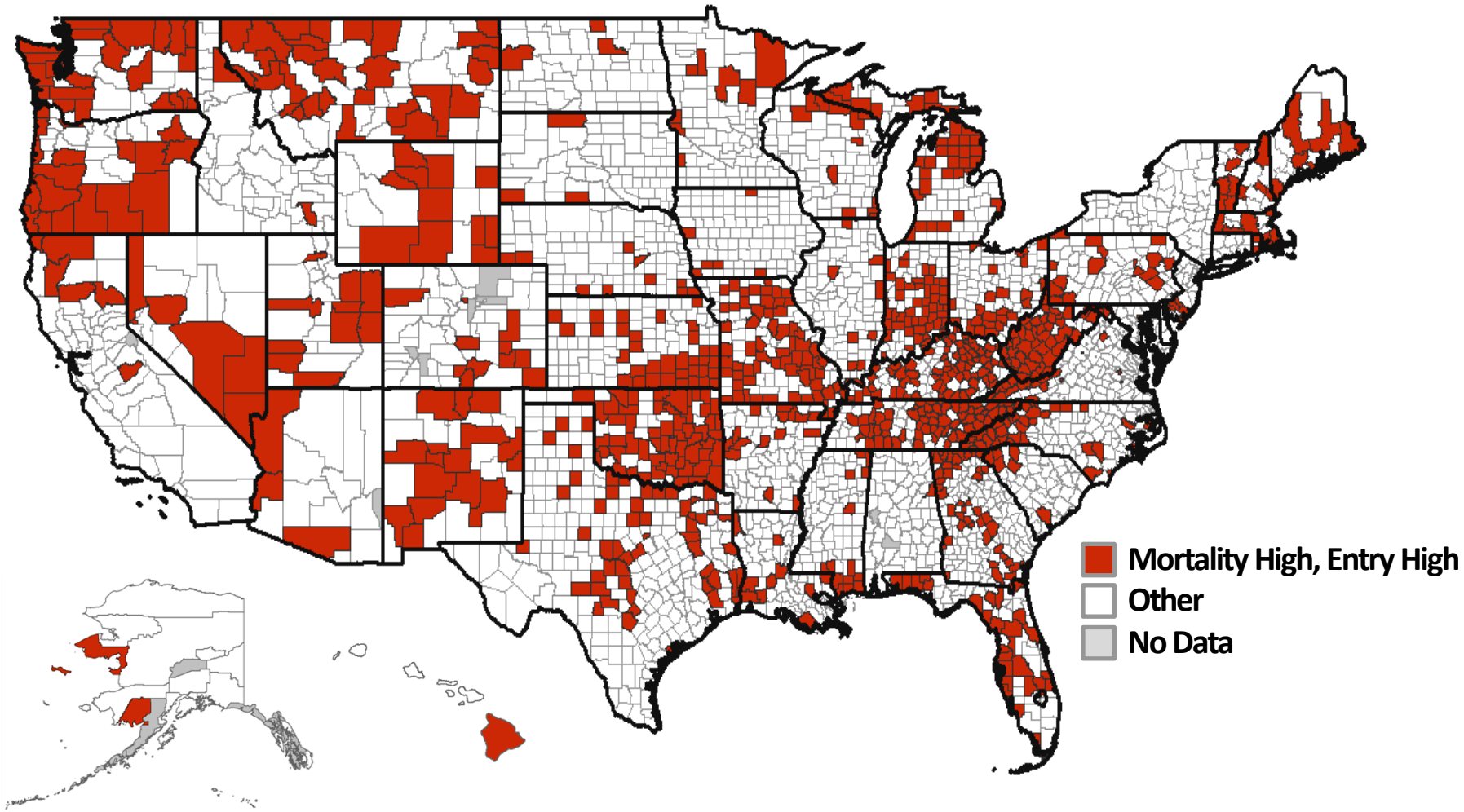
Source: NCHS 2016 County-Level estimates. The 2016 quartile upper bounds are: 11.1, 15.4, 20.6, and 81.7.

Drug Mortality and Foster Care Entry Rates: 2016



Note: “Drug Mortality high” refers to a rate above the median of 15.4 deaths per 100,000 people; “Foster Care entries high” refers to a rate above the median rate of 906 per 100,000 children.

Drug Mortality and Foster Care Entry Rates: 2016

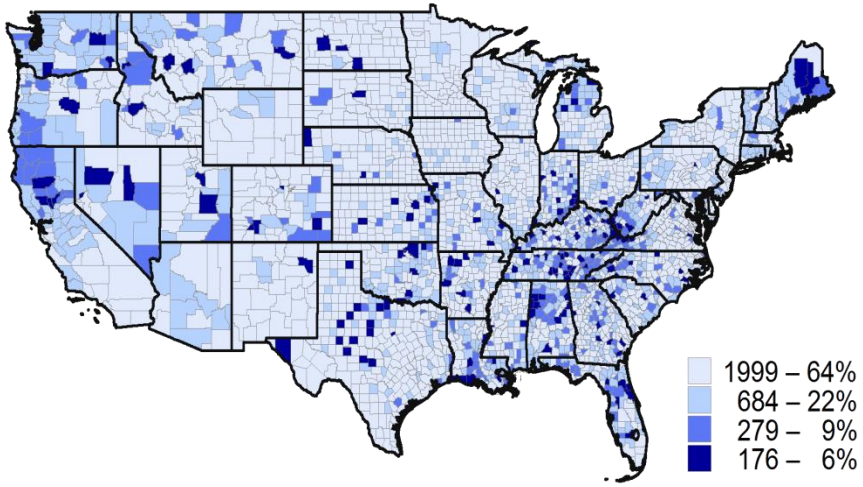


Note: These entry rates do not exclude counties with 10 or less foster care entries. High/Low Drug Mortality refers to counties whose rate is above/below the median of 15.4 per 100 thousand. High/Low Foster Care Entry refers to counties whose entry rate is above/below the median of 906 per 100 thousand children.

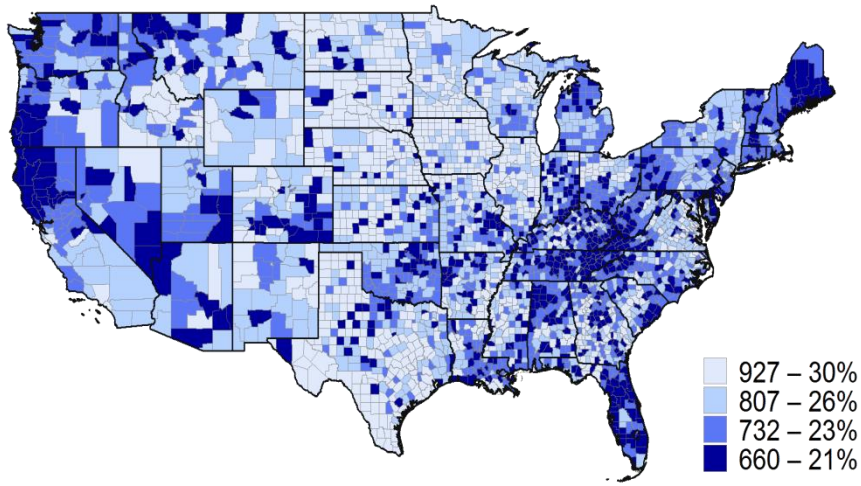
RETAIL OPIOIDS SALES AND FOSTER CARE

Change in Per Capita Retail Opioid Sales: 2006-2016
(volume MMEs)

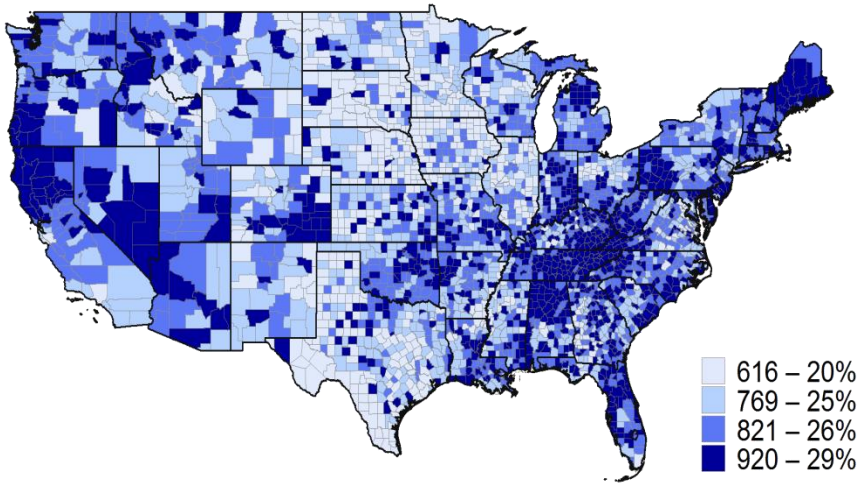
2006



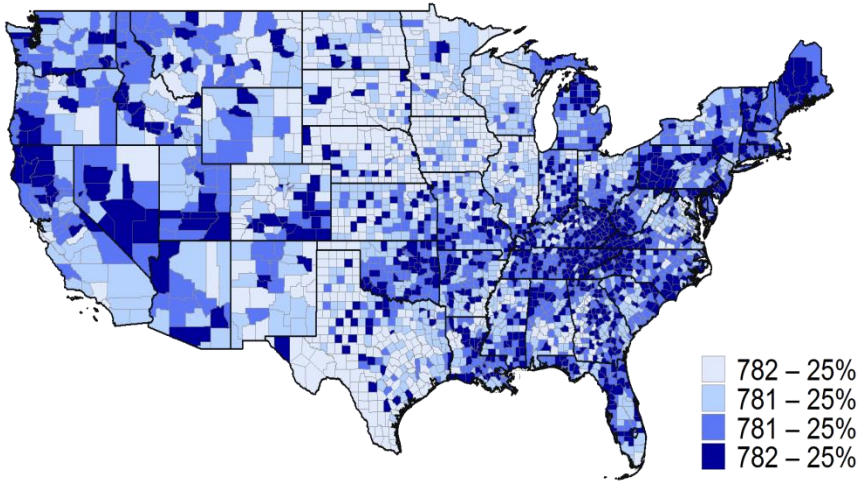
2009



2012

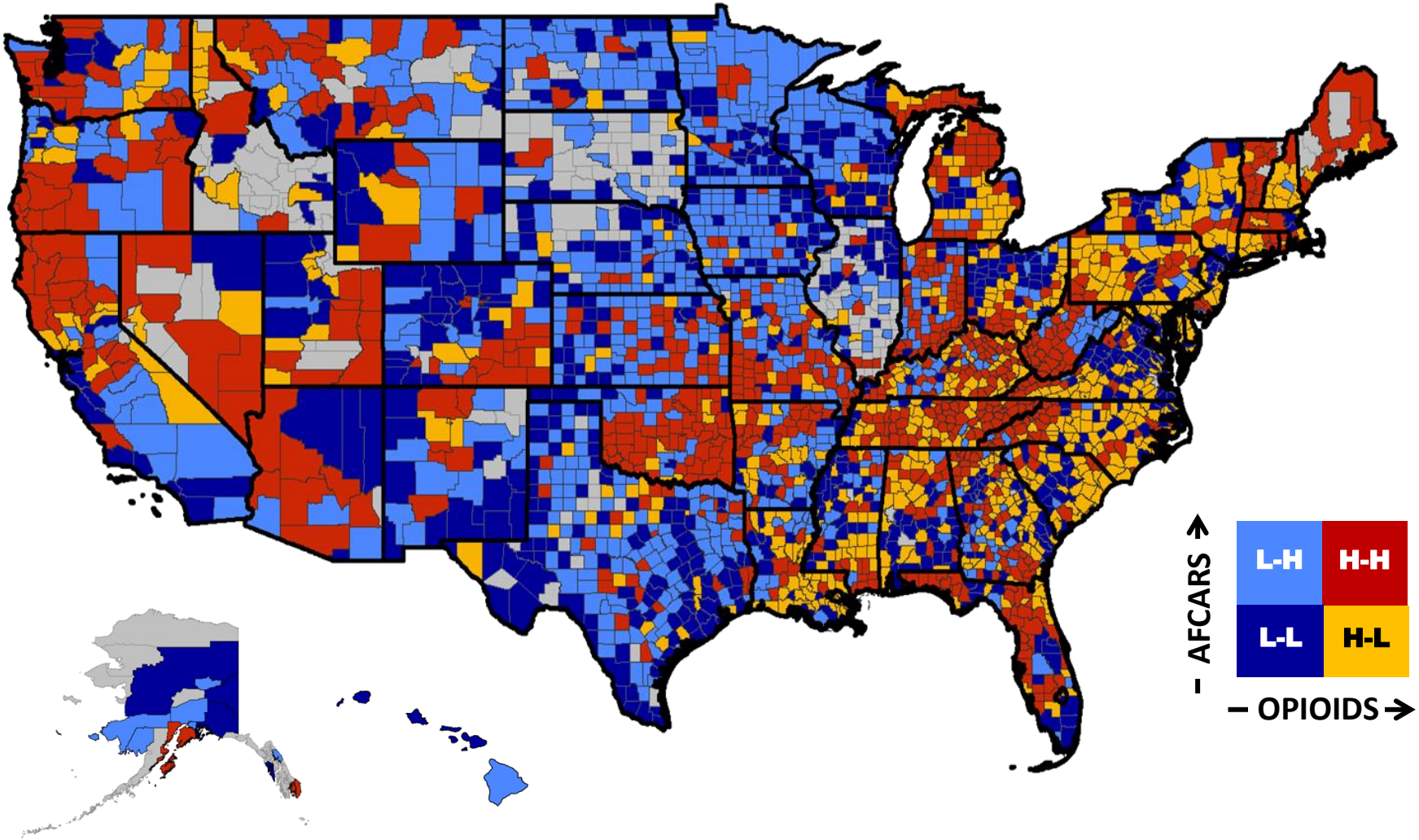


2016



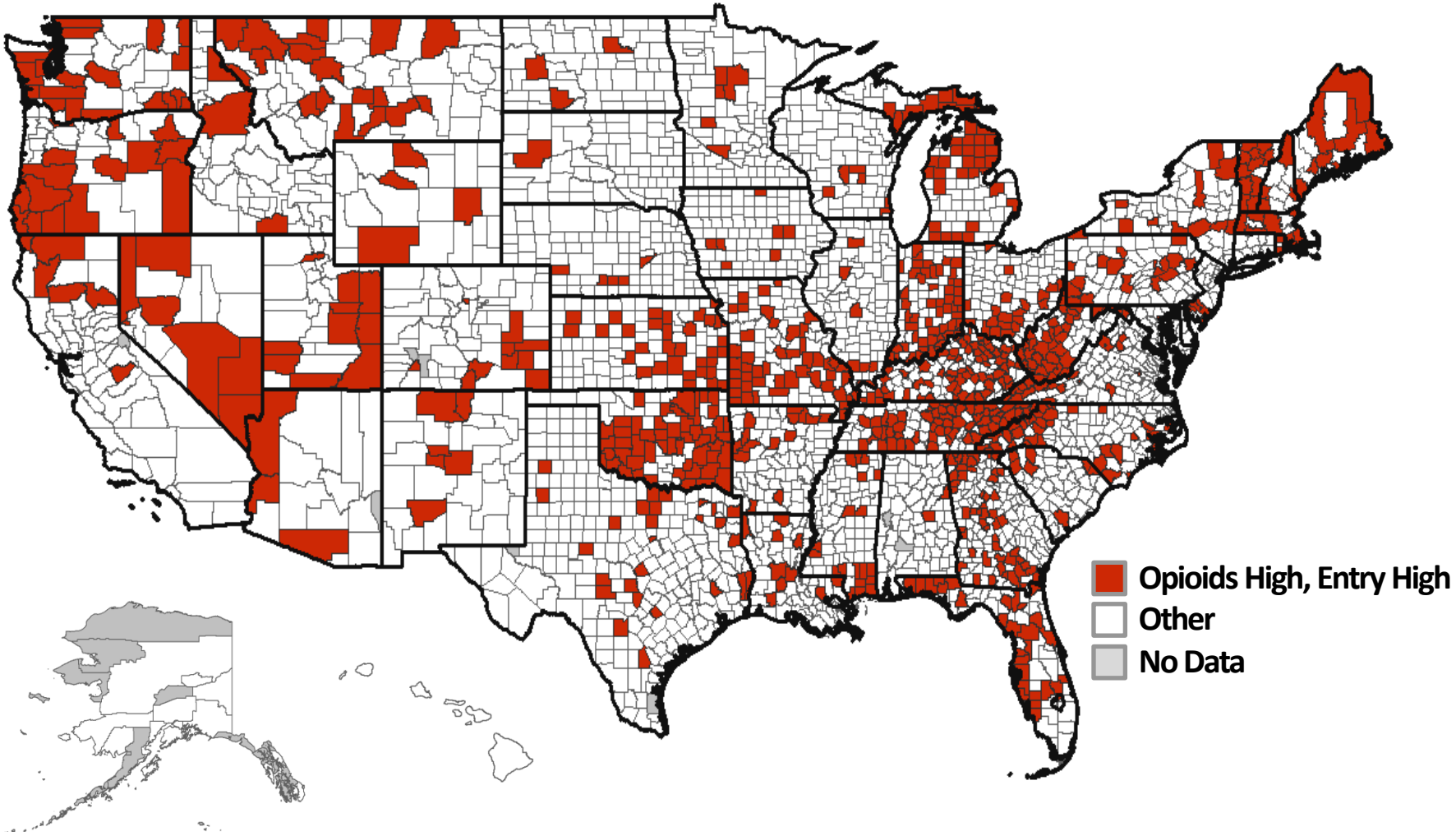
Note: Each maps drawn using 2016 quartile boundaries: [0 to 50] (50 to 76] (76 to 111] (111 and up]

Retail Opioid Sales Rates and Foster Care, 2016



Note: Prescription Opioids high/low refers to a rate above/below the median of 76.4; Foster Care entries high/low refers to a rate above/below the median of 906.

Retail Opioid Sales Rates & Foster Care Entry Rates, 2016



Note: Prescription Opioids high/low refers to a rate above/below the median of 76.4; Foster Care entries high/low refers to a rate above/below the median of 906.

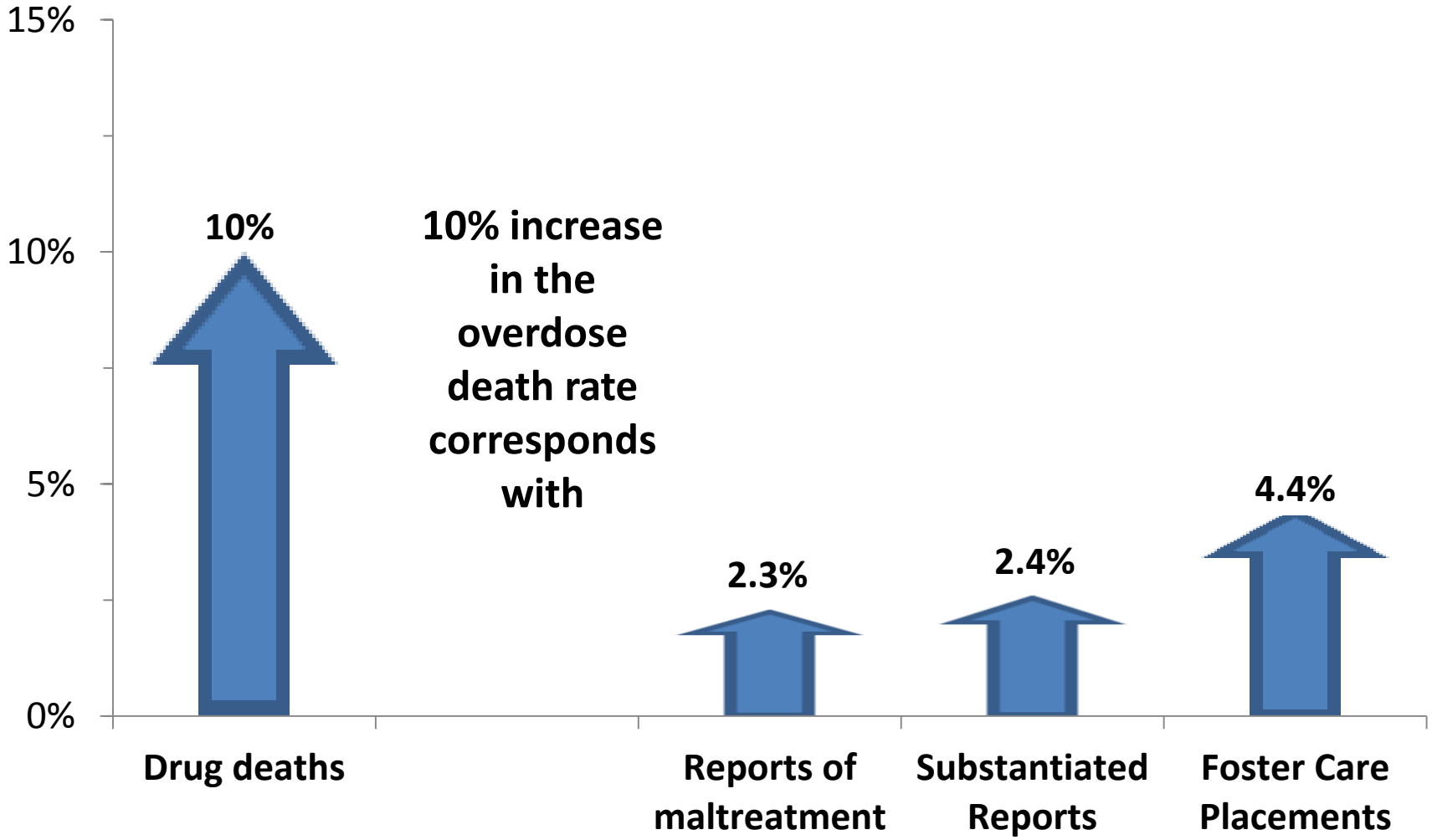
MODELING RESULTS

Modeling Results

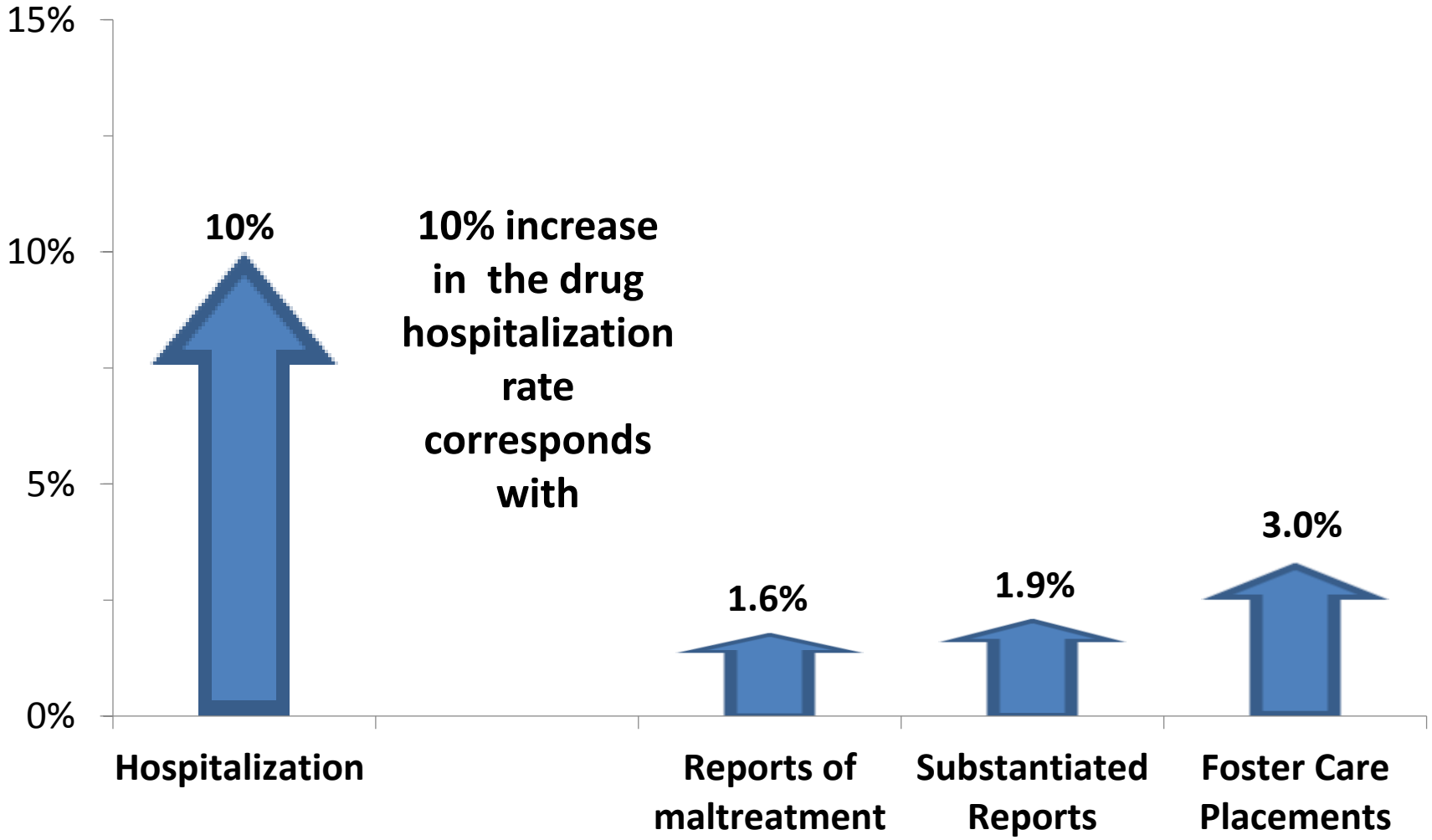
- Increases in drug overdose death rates and drug hospitalization rates correspond to increases in all three child welfare measures.

- Substance use prevalence corresponds with more challenging child welfare cases, with more children being removed from their families.

Drug Overdose Deaths and Child Welfare Case Rates
2011-2016



Drug Hospitalization and Child Welfare Case Rates
2011-2016

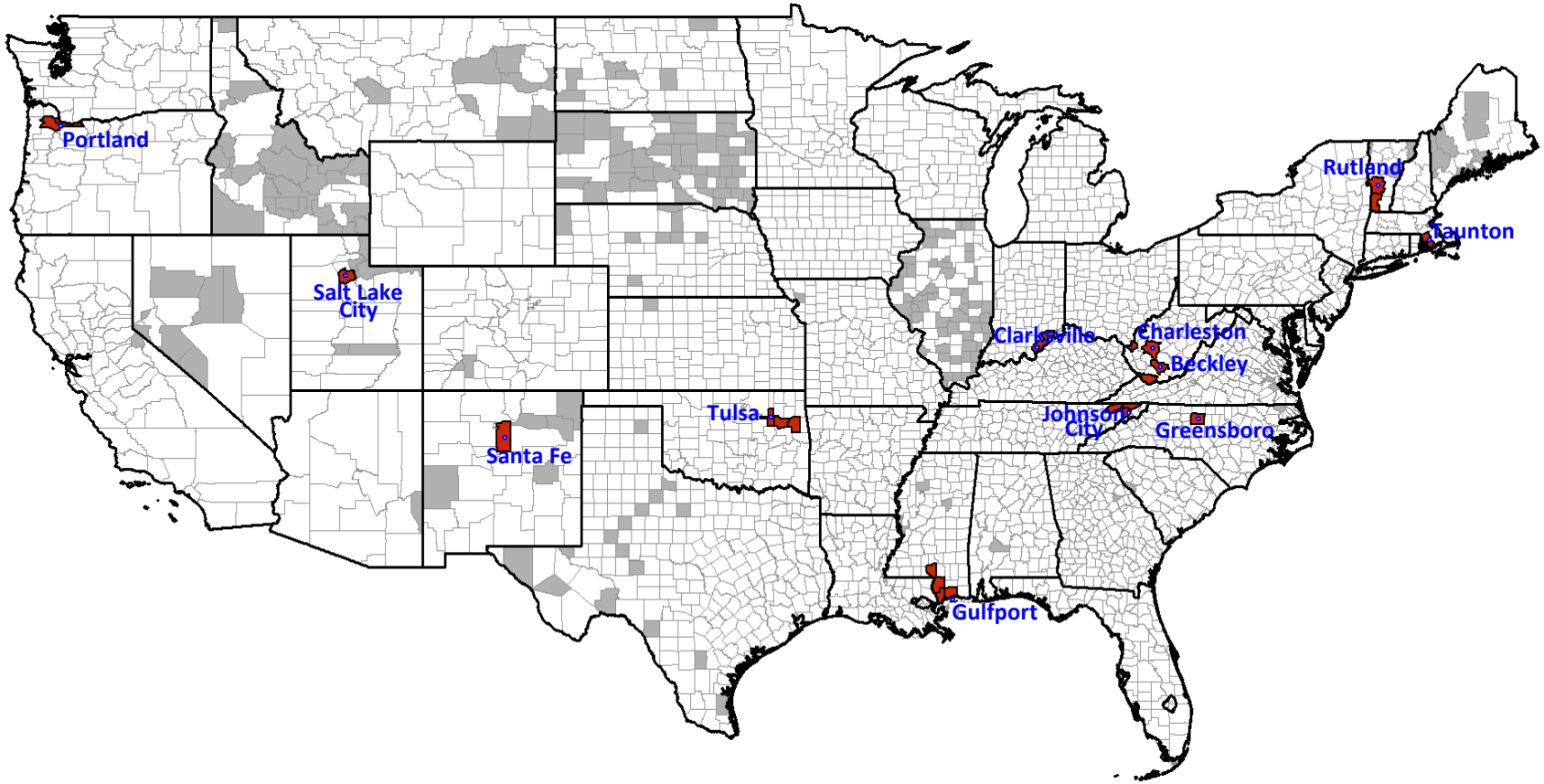


HOW SUBSTANCE USE AFFECTS SOME CHILD WELFARE SYSTEMS

Participants

- Semi-structured interviews with 188 local experts in 11 sites in the country, including:
  - Child welfare administrators and caseworkers
  - Judges and court professionals
  - Substance abuse treatment administrators providers
  - Public health providers
  - Law enforcement officials

188 Individuals Were Interviewed in 11 Sites



Findings

- For child welfare-involved families, it's not an opioid crisis everywhere, heroin is prevalent and polysubstance use is pervasive.
- Poverty and/or trauma underlie the current drug epidemic.
- Collaboration between child welfare and substance use treatment providers is difficult.
- Agencies and caseworkers are overwhelmed and often pessimistic.
- Cross-state issues abound.
- Communities experience continued treatment shortages, particularly family friendly treatment.
- Intensifying shortages of foster homes.
- Medication assisted treatment is challenging to implement in child welfare contexts.

Practice Issues in Our Sample

- Safety:
  - Child welfare agencies in the sample aren't clear on how marijuana fits in—at birth, infants are testing positive for marijuana (and other substances).
  - Caseworkers often find differential response inappropriate for cases involving severe substance use.
- Permanency:
  - Multi-generational drug use is common which impacted kinship care placements in our sample.
  - There are divergent opinions about how good is "good enough" for reunification.
- Well-Being:
  - Trauma histories of parents and trauma experiences of children/youth.

Challenges and Perspectives on Treatment

- Timeliness of substance use assessments and treatment remains a significant concern. Treatment timelines do not always align with child welfare timelines, though there is much support for AFSA.
- Substance use assessments may not be timely and the content may be unsystematic or unhelpful in a child welfare context.
- Communities in our sample continue to experience shortages of family-friendly treatment.
- Some child welfare agencies bypass the “regular” substance use treatment system and fund treatment for families involved with the child welfare system themselves.

Specific Challenges Regarding Medication-Assisted Treatment

- We found there were misunderstandings in the sites we visited about medication assisted treatment (MAT). What MAT is, how it works, and how it relates to child safety is not always understood by practitioners across fields, and even within the substance use treatment field.

- The availability of MAT was limited in the participant sites and was frequently implemented in ways not consistent with evidence-based best practices.

- MAT drugs (methadone and buprenorphine) are widely perceived to be at risk of abuse and diversion. In some places buprenorphine was identified by child welfare officials as the community's primary drug of abuse.

Difficulties of Collaboration

- Systemic barriers may hinder collaboration between child welfare agencies substance use disorder treatment programs, and courts.
  - Difference between systems level and case level collaboration.
- Cross-state issues complicate everything:
  - Interstate placement challenges,
  - Medicaid payment issues, and
  - Cross state access to Prescription Drug Monitoring Program data.

OPPORTUNITIES FOR IMPROVEMENT

Opportunities for Improvement
Child Welfare

- Develop best practice guidelines for substance use assessments in child welfare.
- Improve treatment engagement and recovery support activities.
- Build consensus across stakeholder groups regarding:
  - when children can remain at home with support.
  - milestones required for reunification when parents of children in foster care are participating in SUD use treatment.

Opportunities for Improvement SUD Treatment for Parents

- Promote more active partnerships between substance use treatment agencies and child welfare agencies to enhance treatment engagement and recovery support.
- The potential of the Family First Prevention Services Act authority to develop the capacity of child welfare agencies to purchase treatment services effectively for families.
- Develop consensus among stakeholders on medication-assisted treatment, essential psychosocial components, and recovery supports needed by families in the child welfare system.

Other Opportunities for Improvement

- Consider the development of innovative home visiting models that focus on engaging parents in SUD treatment and provide recovery supports, if possible, avoiding the need for child welfare intervention.
- Increase the use of family drug courts and/or incorporate their best practices into more conventional family courts.
- Consider the potential utility of other substance use treatment modalities such as sober living homes and other recovery housing models during or following formal treatment.

Q & A and Discussion

- Do the findings resonate with you?
- What are you seeing in your local communities?
- What service models and innovations are successful in your community? What has been challenging?
- How are stakeholders in your communities collaborating with one another?
- How is substance use/misuse, access to and use of treatment intersect with trauma in your communities?

Thank You!

Copies of the products from this study may be downloaded at: https://aspe.hhs.gov/child-welfare-and-substance-use

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