National Center on Substance Abuse and Child Welfare

Special Topic:

Considerations for Families in the Child Welfare System Affected by Opioids

Contents

Introduction

The National Center on Substance Abuse and Child Welfare (NCSACW) developed the Child Welfare Training Toolkit to educate child welfare workers about substance use and co-occurring disorders among families involved in the child welfare system. The training is intended to provide foundational knowledge to help child welfare workers:

1. Understand substance use and co-occurring disorders.
2. Identify when substance use is a factor in a child welfare case.
3. Learn strategies for engaging parents and families in services.
4. Understand potential effects for the parent, children, and caregivers.
5. Learn the importance of collaboration within a system of care. Through a deeper understanding of these topics, child welfare workers can apply knowledge gained to their casework and improve their own practice.

The Training Toolkit consists of 10 modules—7 core and 3 special topics training modules:

Module 1: Understanding the Multiple Needs of Families Involved with the Child Welfare System

Module 2: Understanding Substance Use Disorders, Treatment, and Recovery

Module 3: Understanding Co-Occurring Substance Use Disorders, Mental Health/Trauma, and Domestic Violence

Module 4: Engagement and Intervention with Parents Affected by Substance Use Disorders and Mental Health/Trauma

Module 5: Case Planning, Family Strengthening, and Planning for Safety for Families with a Substance Use Disorder

Module 6: Understanding the Needs of Children of Parents with Substance Use or Co-Occurring Disorders

Module 7: Collaborating to Serve Parents with Substance Use Disorders

Special Topic: Considerations for Families in the Child Welfare System Affected by Methamphetamine

Special Topic: Considerations for Families in the Child Welfare System Affected by Opioids

Special Topic: Understanding Prenatal Substance Exposure and Child Welfare Implications

The entire Training Toolkit can be delivered in a series, or each module can be delivered individually as a stand-alone training. Each module is approximately 2 hours

in length and contains a range of materials that can be adapted to meet the needs of child welfare trainers for in-person workshops or more formal training sessions. This flexibility allows the facilitator to determine the best format and timing for the training, according to the needs of the agency and staff. The special topics, in particular, lend themselves to brown-bag or lunchtime trainings.

Each module includes a Facilitator's Guide with training goals and learning objectives, a PowerPoint presentation, resources, and references. The PowerPoint presentation contains talking points and key details in the notes section of the slides. These talking points are not intended to serve as a script to read aloud to attendees, but rather as key points to highlight while presenting. Facilitators are encouraged to infuse their own content knowledge, expertise, and real-world experience to bring the training to life. NCSACW integrated discussion questions and experiential activities throughout the training sessions.

The Facilitator's Guide includes a list of resources where facilitators and participants can find additional information on related topics. Facilitators can customize content to include state or local child welfare practice information and terminology where appropriate.

NCSACW provides a free online tutorial, *Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals*, which is a self-guided online training that complements the content of this Training Toolkit. Toolkit facilitators may encourage the training participants to complete the online tutorial to augment their knowledge. The online tutorial is approved for 4.5 Continuing Education Units.

Intended Audience

The Training Toolkit contains information considered foundational for child welfare practice. The content is general enough for all child welfare workers, but it should be tailored to the audience's experience and role in child welfare practice (such as investigations, in-home services, or ongoing case management) to enrich the learning opportunity.

Facilitator Qualifications

Facilitators should be knowledgeable about substance use disorders, mental health, and child welfare systems. They should be familiar with the laws and policies that affect child welfare agency decision-making to ensure that the information is presented in the proper context. If the facilitator does not have specific knowledge in substance use disorders or mental health, he or she should partner with local substance use and mental health treatment agencies for support.

Terminology

Field-specific terms are used during the course of this training. To understand the purpose and intended meanings of these terms, please review the Trainer Glossary available at https://ncsacw.samhsa.gov/training/toolkit. This glossary is also a useful resource for training participants.

Special Topic Description and Objectives

The goal of this special topic training is to provide an overview of the effects of opioid use on families. This training offers information on the different opioids, their effects, and signs of use. An overview of overdose risk and prevention strategies is also included. Participants will learn referral and treatment options for parents affected by a substance use disorder. The training provides child welfare professionals with an understanding of medication-assisted treatment (MAT) and the importance of a family-centered treatment approach.

After completing this training, child welfare workers will:

- Discuss the context and prevalence of opioid use.
- Identify the effects of opioid use on children and families.
- Recognize the signs of opioid use in families involved with child welfare.
- Understand overdose risk and prevention.
- Understand the effects of parental opioid use on risk and safety of children.
- Identify evidence-based and practice-informed engagement and treatment strategies, including medication-assisted treatment, to address opioid use disorders.
- Discuss the principles of family-centered treatment and recovery.

Training Tips

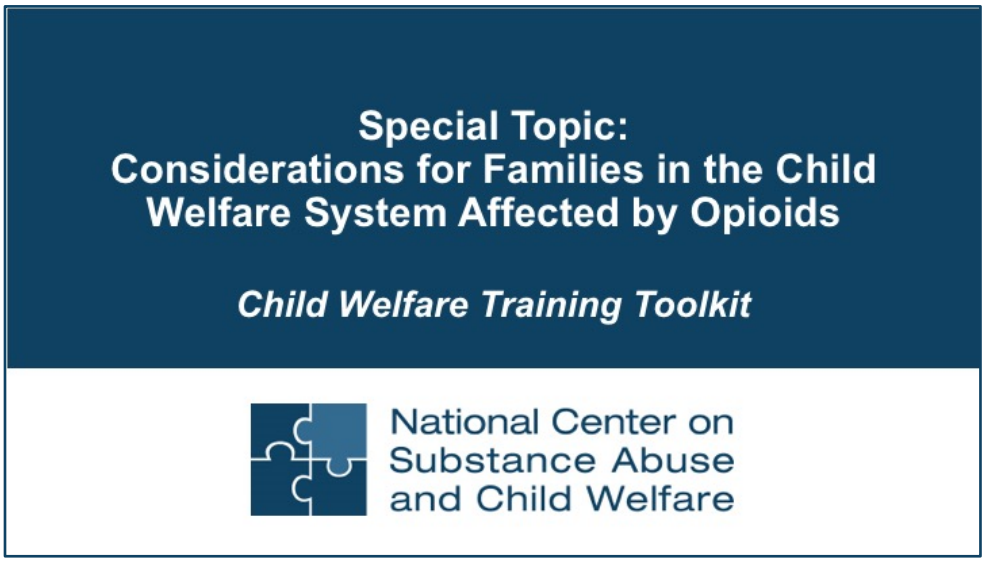
- ✓ Partner with a local expert on substance use disorders to cofacilitate the training.
- ✓ Share any community initiatives on opioids.
- ✓ Use the ***** bolded** discussion questions integrated in the module talking points to enrich the training.
- ✓ Share specific screening tools for substance use disorders used or vetted by the child welfare agency.
- ✓ Supplement content with information about how child welfare workers can locate treatment for parents in the community.
- ✓ Highlight child welfare programs that have expertise in serving families affected by substance use disorders or that provide family-centered treatment.
- ✓ Contact the National Center on Substance Abuse and Child Welfare for more information about using the Collaborative Values Inventory, a self-administered questionnaire that provides jurisdictions with an anonymous way of assessing the extent to which group members share ideas about the values that underlie their collaborative efforts, in your community.

Materials

- ✓ Computer and projector
- ✓ Speakers
- ✓ Internet access
- ✓ PowerPoint slides
- ✓ Facilitator's Guide
- ✓ Flip chart paper or white board (for use as a visual aid during discussion)

PowerPoint Presentation and Talking Points

Slide 1



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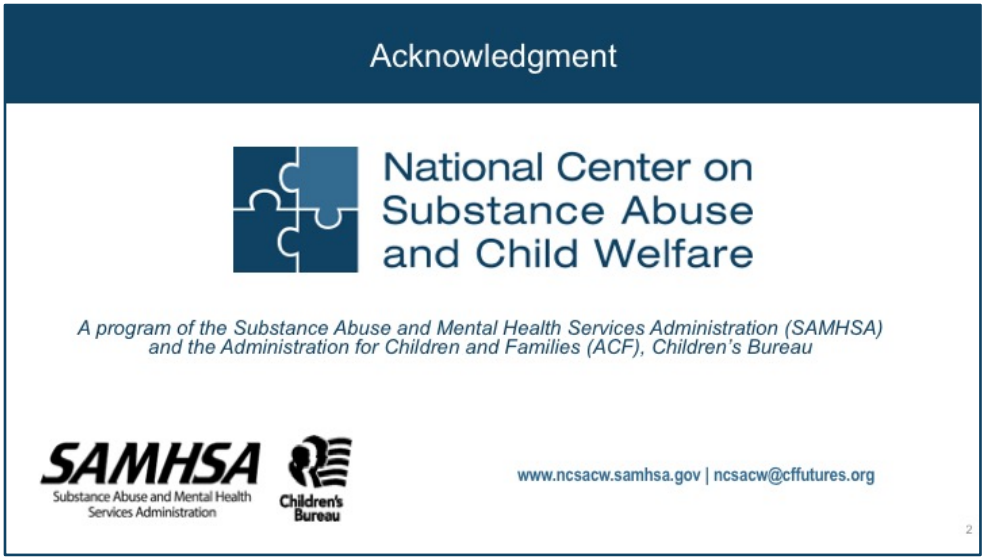
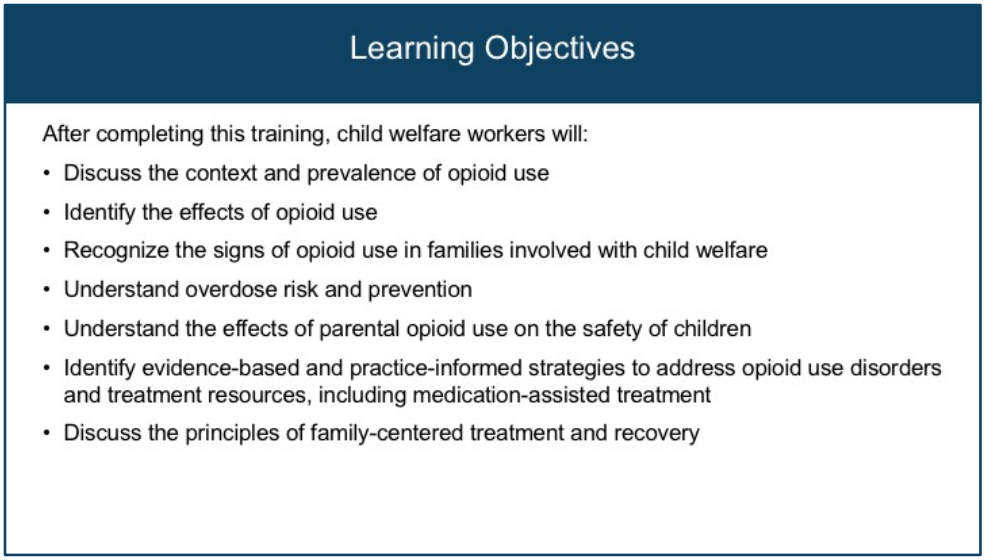


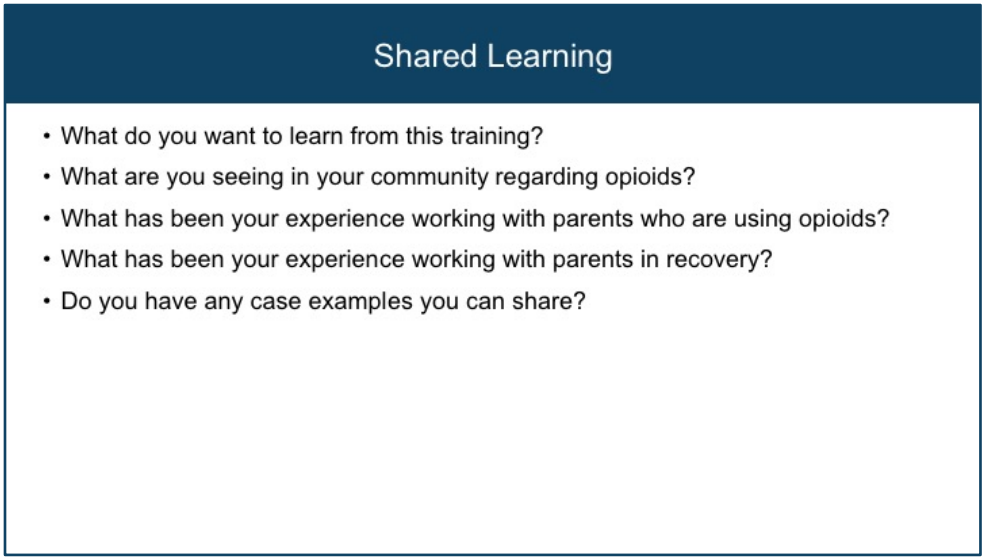
This toolkit was developed by the National Center on Substance Abuse and Child Welfare (NCSACW), an initiative of the U.S. Department of Health and Human Services jointly funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the Administration on Children, Youth and Families (ACYF), Children's Bureau's Office on Child Abuse and Neglect (OCAN).

Slide 3



The goal of this special topic training is to provide an overview of the effects of opioid use on families. This training offers information on the different opioids, their effects, and signs of use. An overview of overdose risk and prevention strategies is included. Participants will learn referral and treatment options for parents affected by a substance use disorder. Child welfare workers will gain an understanding of medication-assisted treatment (MAT) and the importance of a family-centered treatment approach.

Slide 4



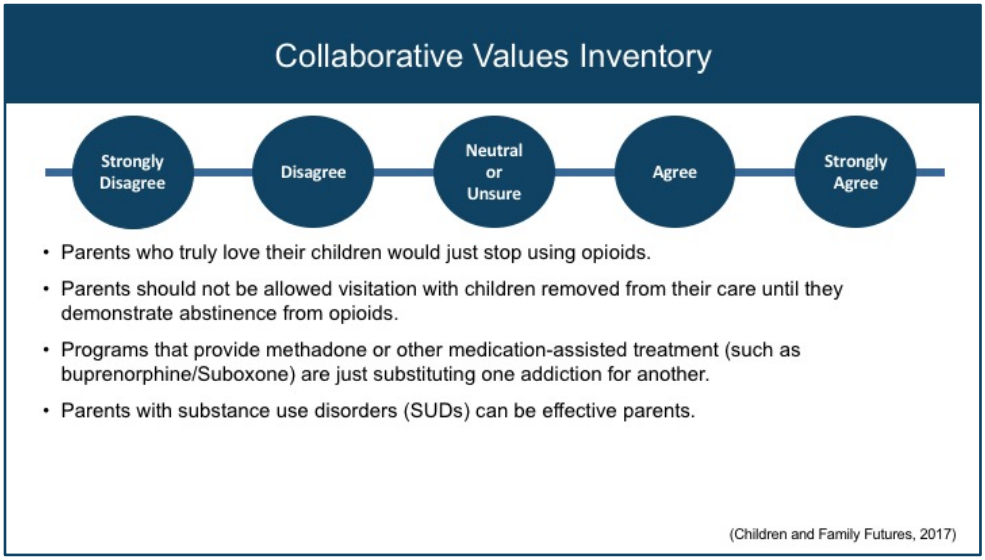
*****Get feedback on participants' expectations for the training. Ask the participants to write down what they hope to get from the training.**

Although this training is specific to opioids, there are other modules of the training toolkit that can be presented following this training to meet the needs of participants.

Understand what participants' experiences are in their community. Are opioids a big problem for the community? Are there community initiatives to be aware of? This is also an opportunity to share resources for all participants. Keep a list of resources in the community and highlight those at the end of the training.

Case examples can be used throughout the training to help achieve the learning objectives.

Slide 5



Differences in values among participants are important to recognize, as they may come up in the training and can come up with the families who participants are working with. These questions can be asked at the beginning of this training to help understand the different values and perspectives participants bring to the training. Have a brief discussion with participants on how their individual values can affect their work with families.

*****Review the slide questions from the Collaborative Values Inventory (CVI), a validated tool that assesses how much a group shares beliefs and values that underlie its work. Participants can share their experiences or keep their answers private. Discussion should be limited to clarifying participants' values, instead of debating individual answers to questions. Participants' responses will fall along a continuum. How might personal values and beliefs affect an individual's work with families affected by substance use disorders?**

Slide 6

Slide 7

Families and child welfare agencies have been affected by multiple drug epidemics over the past several decades—cocaine in the late 1980s, methamphetamine in the early 2000s, and now opioids.

Although drug epidemics may shift over time, the child welfare system continues to see families affected by substance use disorders.

Slide 8

Examples of Opioids

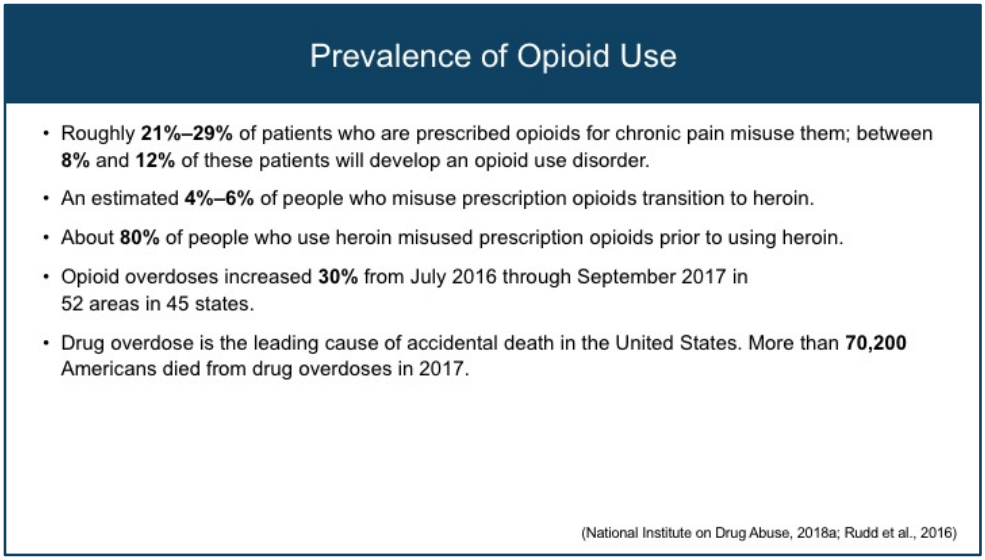
Derived fully or partially from opium:

- Heroin
- Codeine
- Hydromorphone (Dilaudid)
- Oxycodone (OxyContin, Roxicodone, Percodan, Percocet)
- Hydrocodone (Vicodin or Lortab)
- Pentazocine
- Morphine
- Fentanyl (Duragesic, Actiq, Sublimaze)
- Meperidine
- Propoxyphene

(National Institute on Drug Abuse, n.d.)

Opioids are a class of drugs that include the illicit drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone (OxyContin), hydrocodone (Vicodin), codeine, morphine, and others.

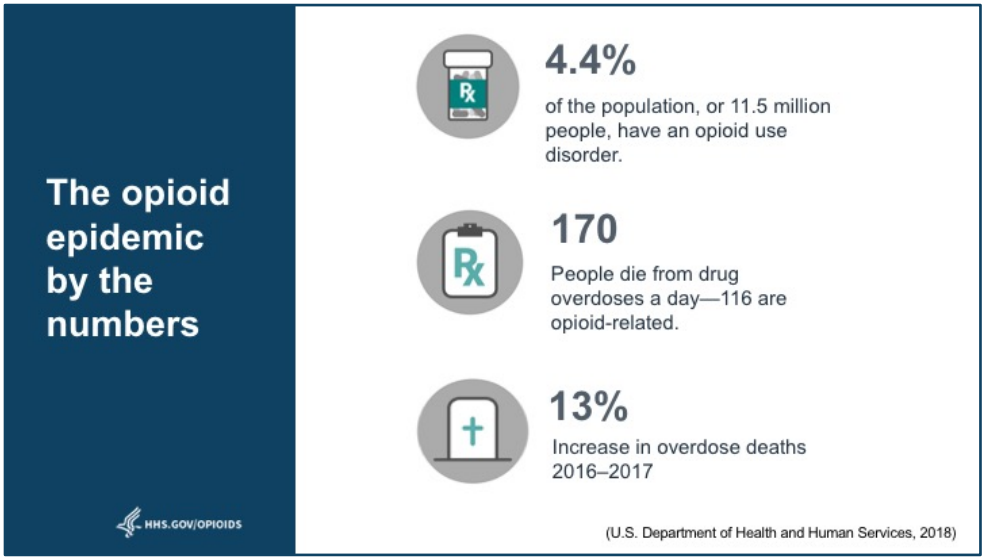
Slide 9



Review the above statistics on opioids and overdose. Certain areas of the country are more affected by opioids than others. Highlight that many people first start using prescription opioids, often those originally prescribed by a doctor.

*****If you have local data from your state or county, share this with the audience.**

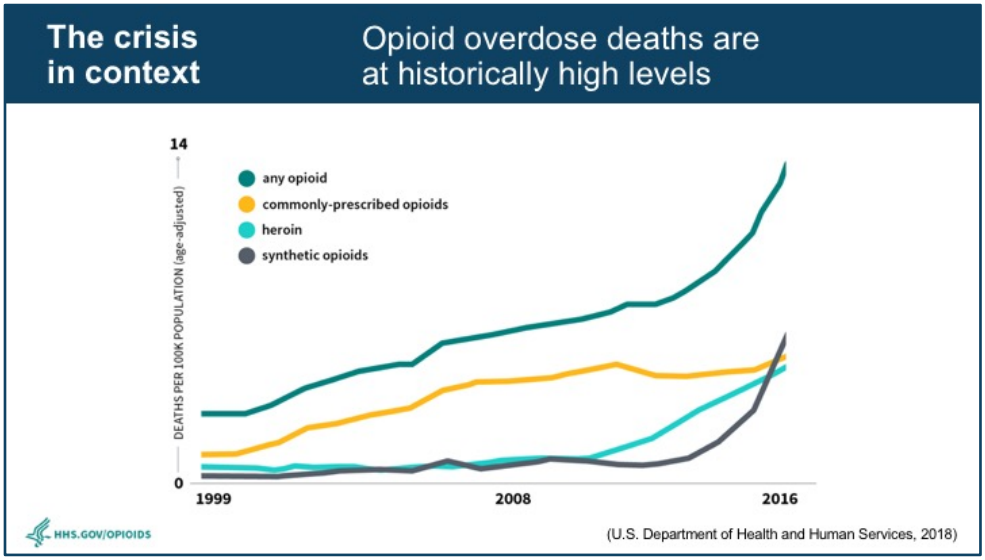
Slide 10



Most Recent Death Data (April 2018)

- Provisional data show that drug overdose deaths occurring in the United States increased by 13.0% from the 12 months ending in September 2016 to the 12 months ending in September 2017, from 60,147 to 67,944.
- Drug overdose deaths accounted for 2.4% of deaths in the United States for the 12-month period ending in September 2017.
- Opioids were involved in more drug overdose deaths in the United States for the 12-month period ending in September 2017 (45,657), up from 39,437 in the previous year.
- The opioid crisis is pressing, personal, and it's a priority.
    - **Each day we are losing more than 170 Americans to drug overdoses,** and that number continues to grow.
        - **116 of these overdoses are opioid-related**
- This is the deadliest drug epidemic in our history.
    - In 2015, 52,404 people died of overdoses in America, the majority of them (33,091) from opioids.
    - **The number of drug overdose deaths rose to 63,632 in 2016.**
        - 42,249 people died from overdoses involving opioids.

Slide 11



This graph shows **the latest in deadly developments—the emergence of synthetic opioids like fentanyl.** Note the bottom dark gray line—and its dramatically sharp increase in recent years.

Additional info:

Zeroing in on opioid deaths, this graph shows how large of a factor opioids and opioid variations are in the steep rise of overdose deaths.

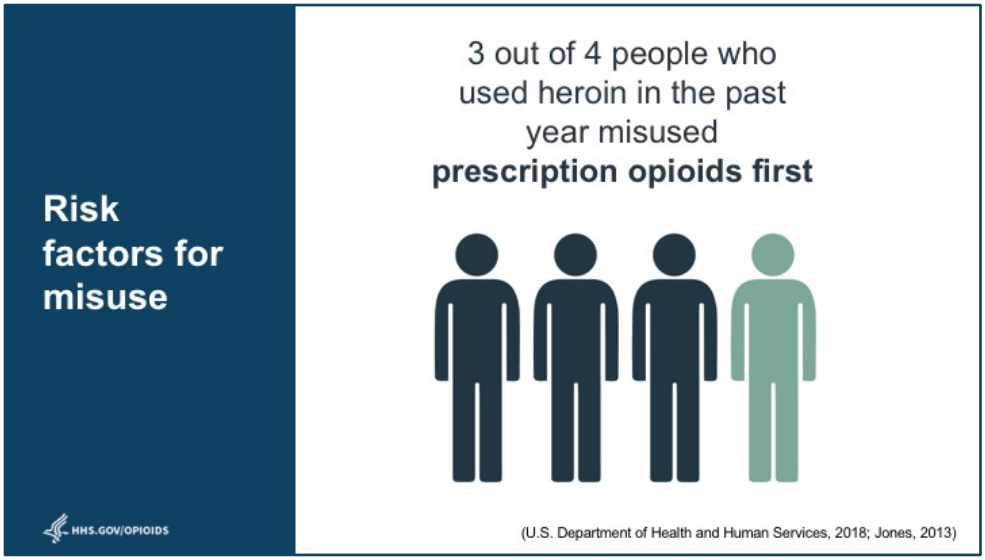
- Turquoise line—Deaths from prescription opioids
- Yellow line—Commonly prescribed opioids
- Teal line—Heroin deaths
- Dark gray line—Synthetic opioids like fentanyl and carfentanyl; note how the epidemic is morphing and how deadly these drugs can be. Often these synthetic opioids are added to heroin, unbeknown to the person who is using the heroin.

Since 2000, more than 300,000 Americans have died from an overdose involving prescription or illicit opioids.

Overdose deaths involving prescription opioids have quadrupled since 2000, and deaths involving heroin have increased more than 300% in the past 5 years.

Since 2013, we have seen a sharp increase in deaths involving synthetic opioids (e.g., fentanyl and fentanyl analogs); increasing from 5,544 deaths in 2014 to more than 19,000 in 2016.

Slide 12



People can start with being prescribed an opioid for a medical condition. Some people may start using opioids by taking a friend's or relative's prescription.

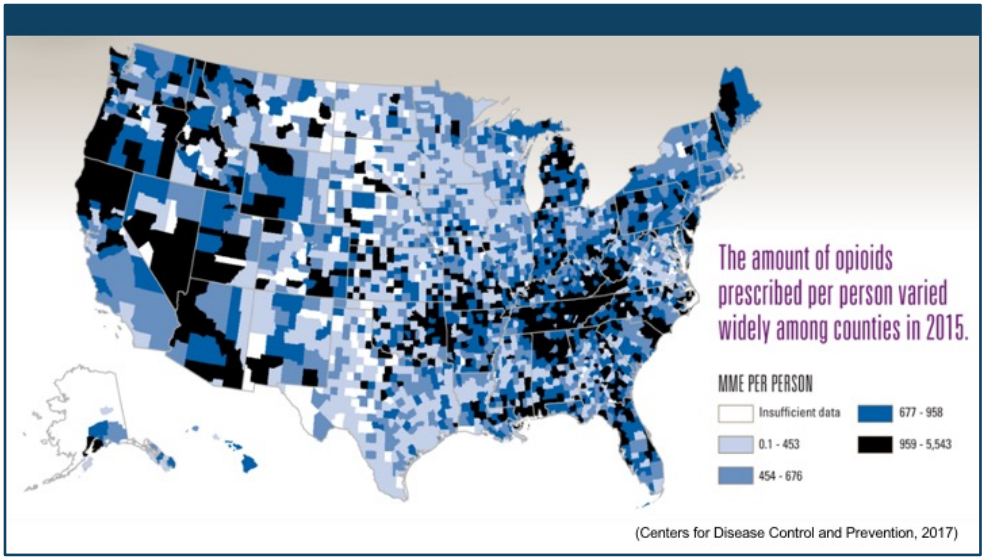
The prescribed opioid can also be misused (used more frequently or at a higher quantity). People may move on to using heroin, as it is often cheaper and more easily available.

People may use both prescription opioids and heroin, particularly as they develop a substance use disorder.

In 2016, more than 11.5 million Americans ages 12 and older reported misuse of prescription opioids, and nearly 950,000 reported heroin use in the past year.

- Slide credit—Grant Baldwin, CDC

Slide 13

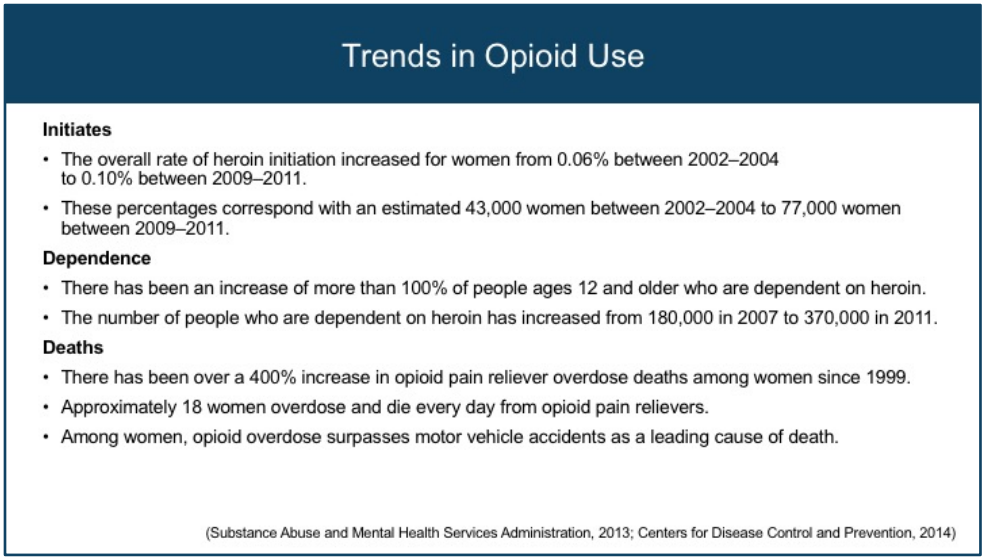


Current CDC guidelines identify 50 MME/day as a “high” opioid dose in a pain treatment setting; MME = morphine milligram equivalents.

Higher opioid prescribing puts patients at risk for misuse and overdose. The wide variation among counties suggests a lack of consistency among providers when prescribing opioids. The “CDC Guideline for Prescribing Opioids for Chronic Pain” offers recommendations that may help to improve prescribing practices and ensure that all patients receive safer, more effective pain treatment.

Find your community on the map to understand if there is a higher number of opioids being prescribed.

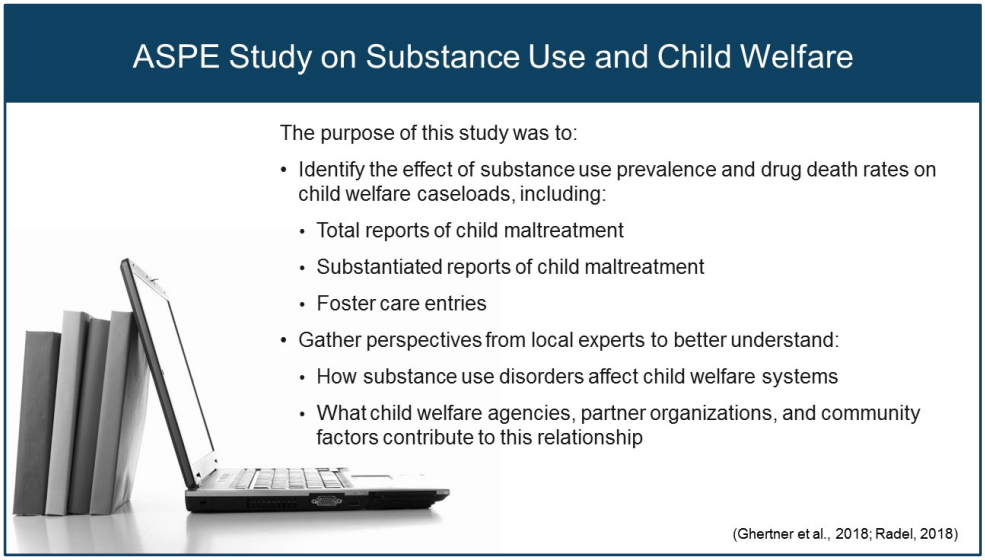
Slide 14



Highlight some of the trends that are specific to the rise in women's use of opioids.

For more specific information on the use of opioids in pregnancy, please see the module titled *Special Topic: Understanding Prenatal Substance Exposure and Child Welfare Implications*.

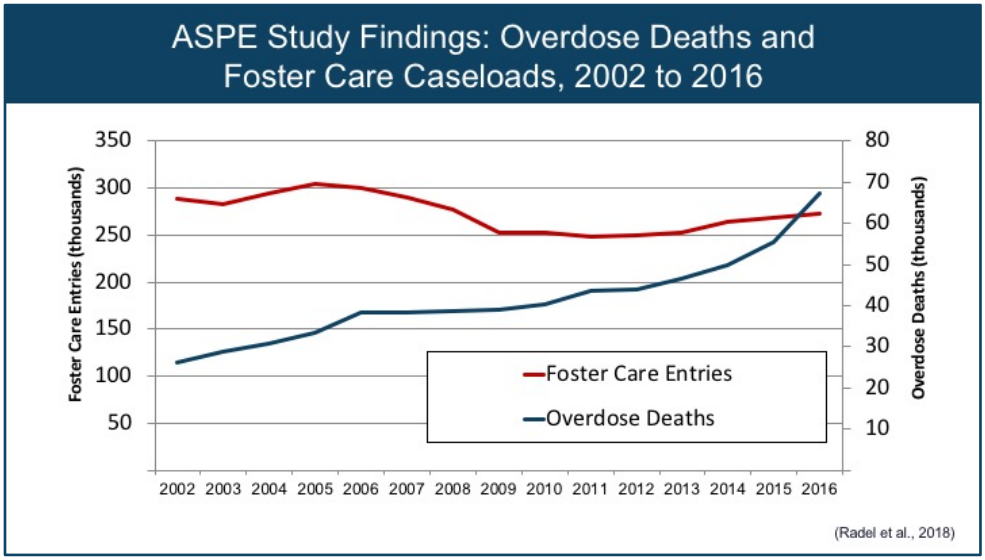
Slide 15



This slide provides some background information on the purpose and methods of this recent study.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) conducted a mixed-methods study, released in early 2018. The study investigated how substance use relates to child welfare caseloads and how parental substance use affects child welfare systems. They looked at rates of drug overdose deaths and rates of hospital stays and emergency department visits related to substances to measure substance use prevalence. They also conducted interviews and focus groups in states with high rates of opioid sales and drug overdose but variable changes in foster care rates.

Slide 16



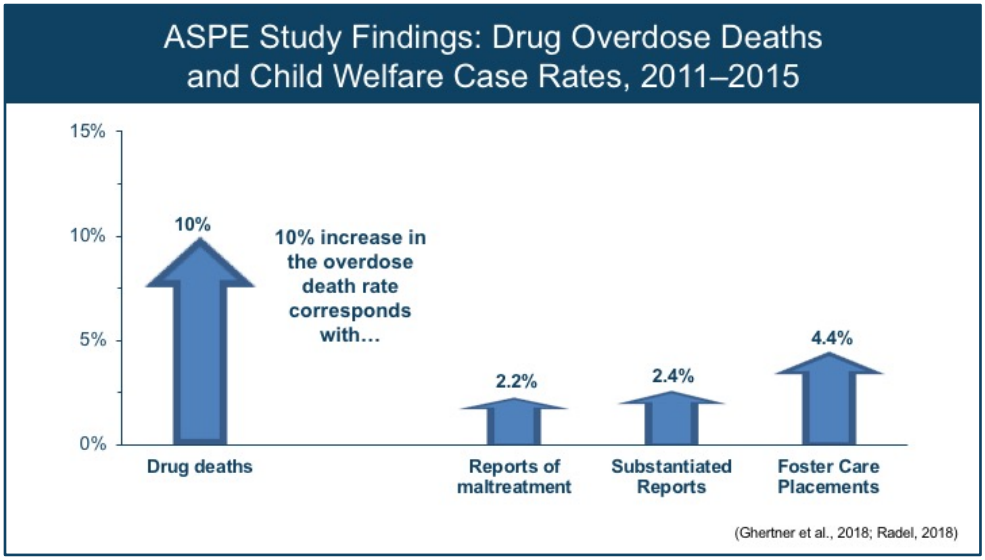
This slide highlights the ASPE study comparison of the rate of overdose deaths and foster care entries within the U.S. from 2002 to 2016.

Overall, the study found that foster care entries and overdose deaths are related at the national level. These data points show that prior to 2012, foster care entries were generally declining, while overdose deaths rose. Following 2012, foster care entry rates began increasing at the same time that drug overdose deaths began climbing at a faster rate.

There is variation in this relationship within the U.S.—some parts of the country show a stronger relationship, including:

- Appalachia
- Parts of the Pacific Northwest
- Parts of the Southwest
- Oklahoma
- New England

Slide 17



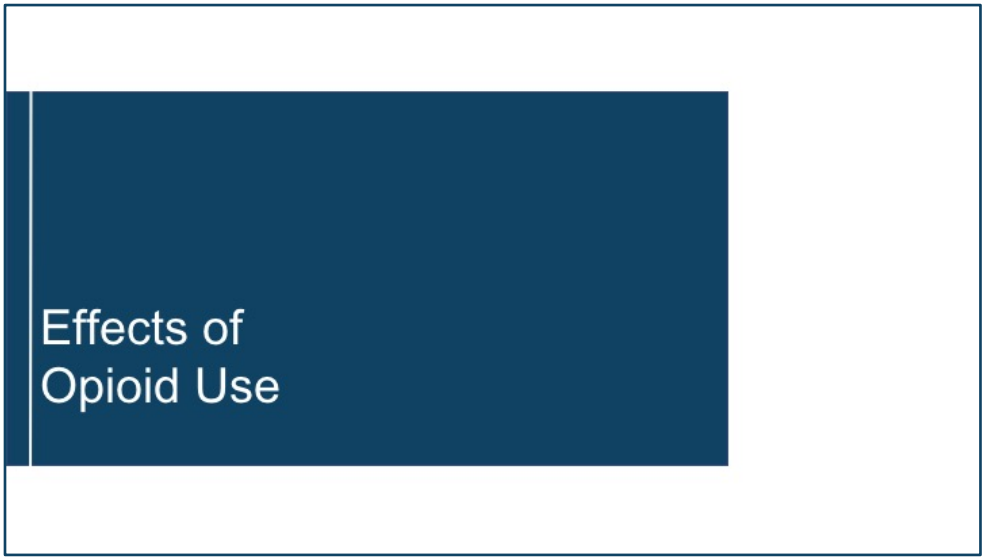
This slide shows additional data from the ASPE study on the relationship between drug overdose deaths and child welfare case rates.

Nationally, the rates of drug overdose deaths and drug-related hospitalizations have a positive relationship with child welfare caseload rates (including rates of child protective services reports, substantiated reports, and foster care placements).

Generally, counties with higher overdose death and drug hospitalization have higher child welfare caseload rates. In addition, these substance use indicators correlate with more complex and severe child welfare caseload rates. As cases became more severe—from report, to substantiation, to placement into foster care—the relationship with substance use increased.

A 10 percent increase in overdose death rates correlated with a 2.2 percent increase in rates of maltreatment reports, a 2.4 percent increase in substantiation rates, and a 4.4 percent increase in foster care entry rates.

Slide 18



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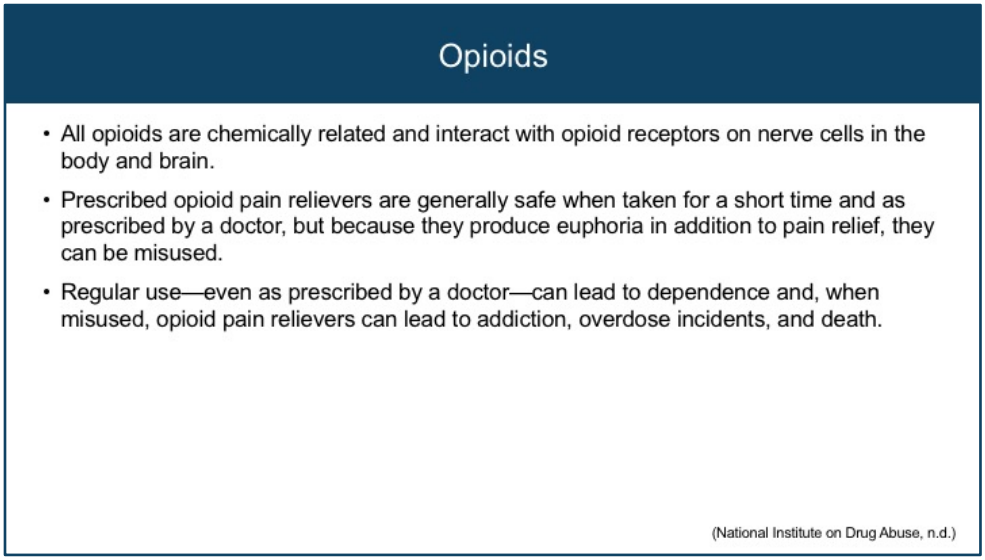
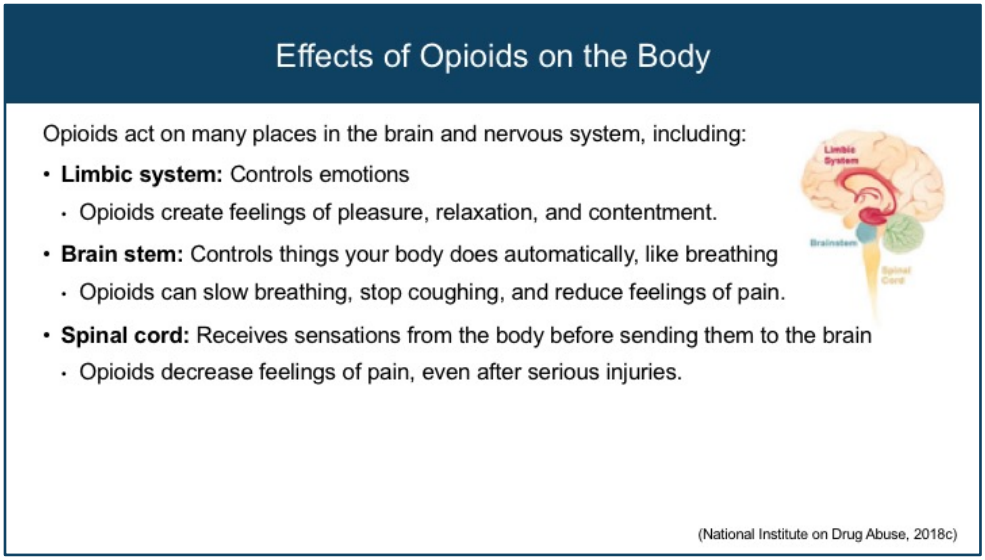


A person's opioid use can lead to a substance use disorder, including the misuse of prescription opioids. Misuse of an opioid occurs when it is taken in a different way or in a larger quantity than prescribed, or taken without a doctor's prescription.

Slide 20



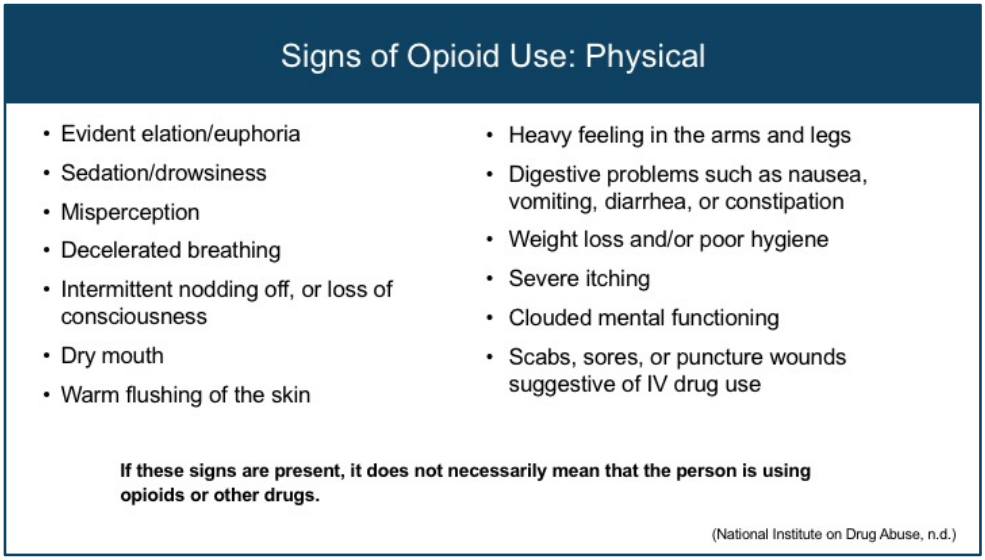
Opioids look like chemicals in your brain and body that attach to tiny parts on nerve cells called opioid receptors.

When opioids attach to these receptors, they block pain signals sent from the brain to the body and release large amounts of dopamine throughout the body. This release can strongly reinforce the act of taking the drug, making the user want to repeat the experience.

The main takeaway is that opioids cause people to feel pleasurable effects (relaxed, pain free).

The next few slides highlight the physical, behavioral, and psychosocial signs of opioid use.

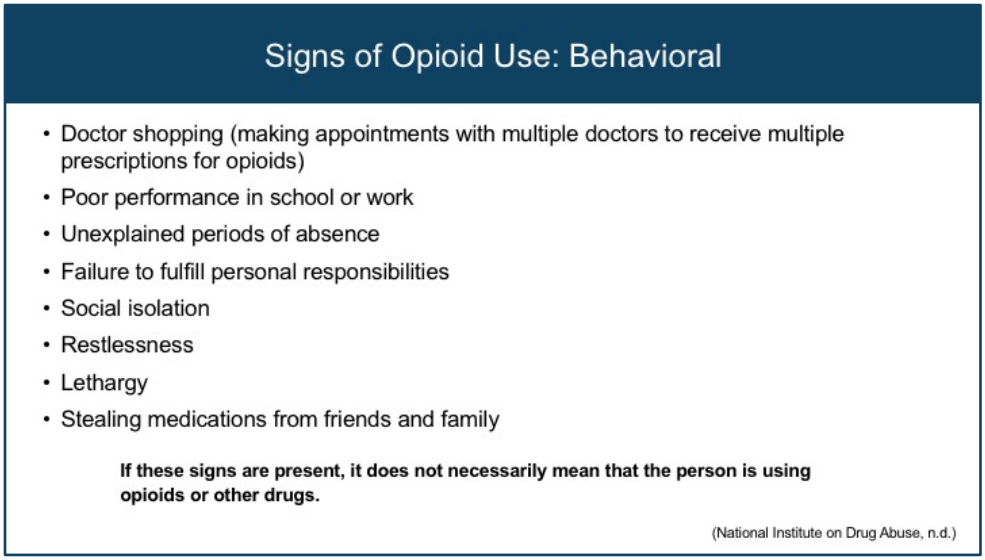
Slide 21



These are some of the physical symptoms of opioid use; not all physical symptoms are included in this list.

The presence of these symptoms does not necessarily mean a person is using opiates. If there are some concerns that present physical symptoms may indicate opiate use, a further conversation about your observation is important.

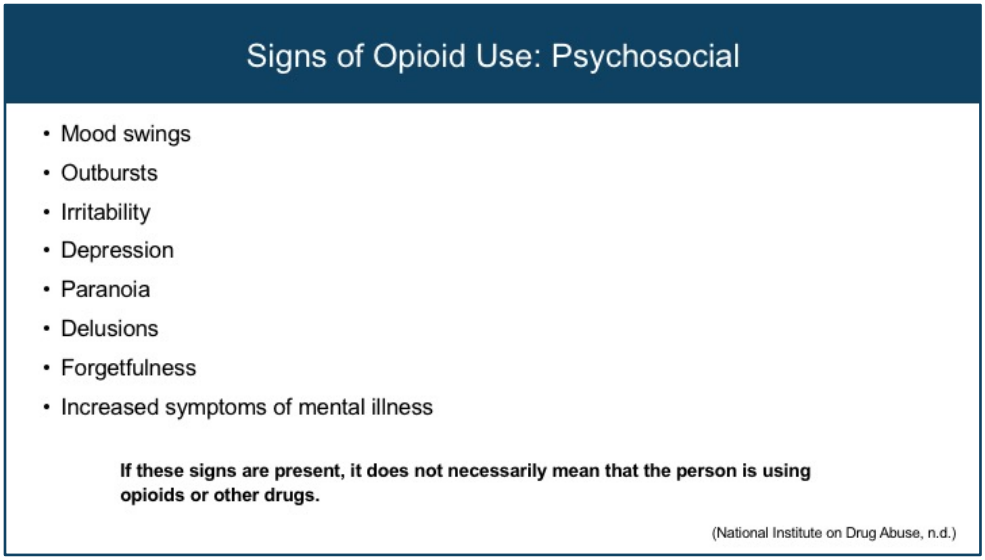
Slide 22



These are some of the behavioral signs of opioid or other drug use.

If these signs are present, it does not necessarily mean that the person is using opioids or other drugs. Asking further open-ended questions to learn more about the behavioral signs is important.

Slide 23

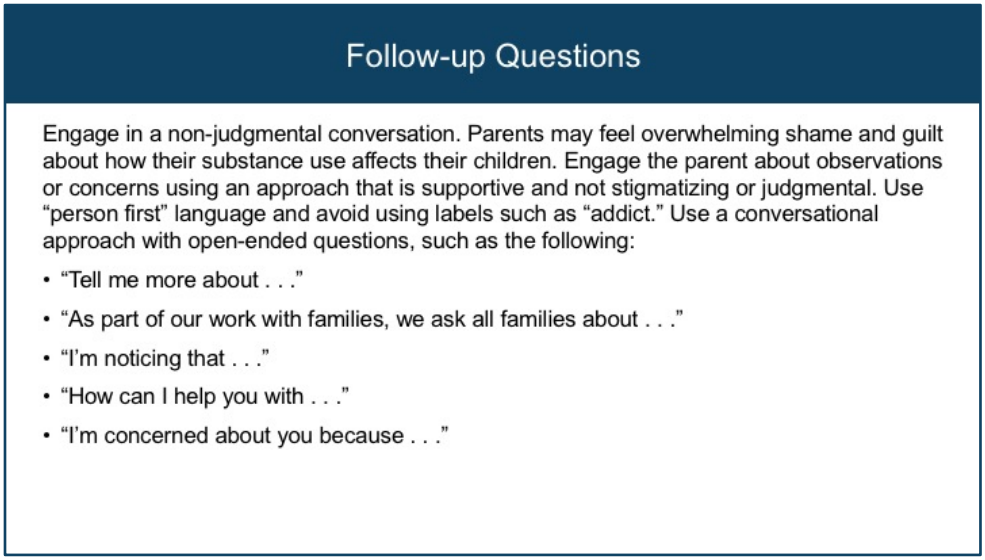


These are some of the psychosocial signs of opioid or other drug use. This is not meant to be a complete list.

If these signs are present, it does not necessarily mean that the person is using opioids or other drugs. Asking further open-ended questions to learn more about the behavioral signs is important.

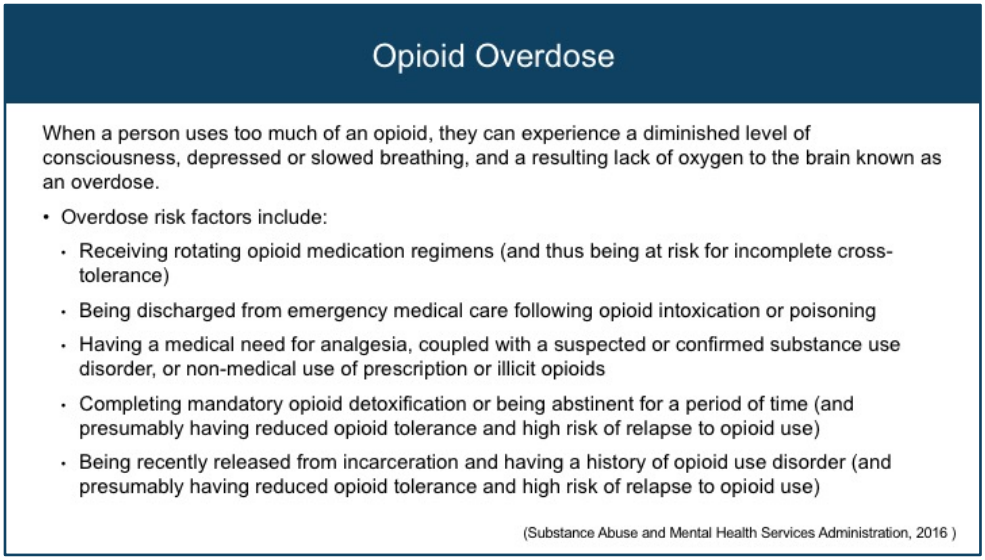
*****Ask participants to list other signs that haven't been covered in these slides. Make a list of all of the signs identified by the group.**

Slide 24



Gather information from a variety of sources, including reviewing corroborating reports, observing signs and symptoms, looking at drug testing results, and asking follow-up questions. Follow-up questions may lead to a more formalized screening.

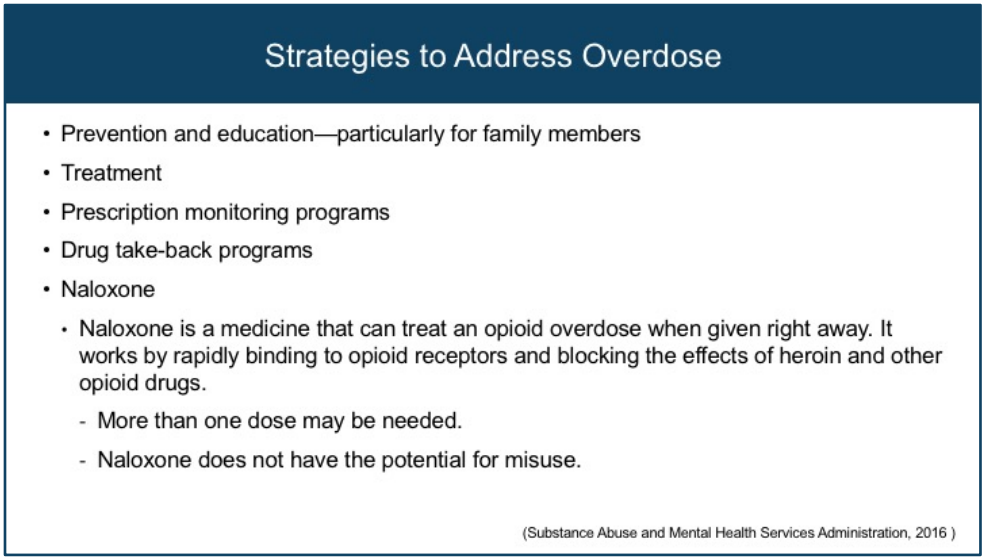
Slide 25



Know the risk associated with overdose when working with a person who is using substances.

Overdose often occurs when someone takes an opioid that has been combined with other substances, such as fentanyl, has a period of abstinence and goes back to use, or takes too much of an opioid.

Slide 26



Family members should be aware of the signs of opioid use and the potential for overdose. Provide access to education in your community for family members.

Work to engage parents in treatment. Sign releases of information with the treatment providers to share information and best understand the treatment plan and your clients' progress in treatment.

Encourage families to safely dispose of unused medications through community drug take-back programs.

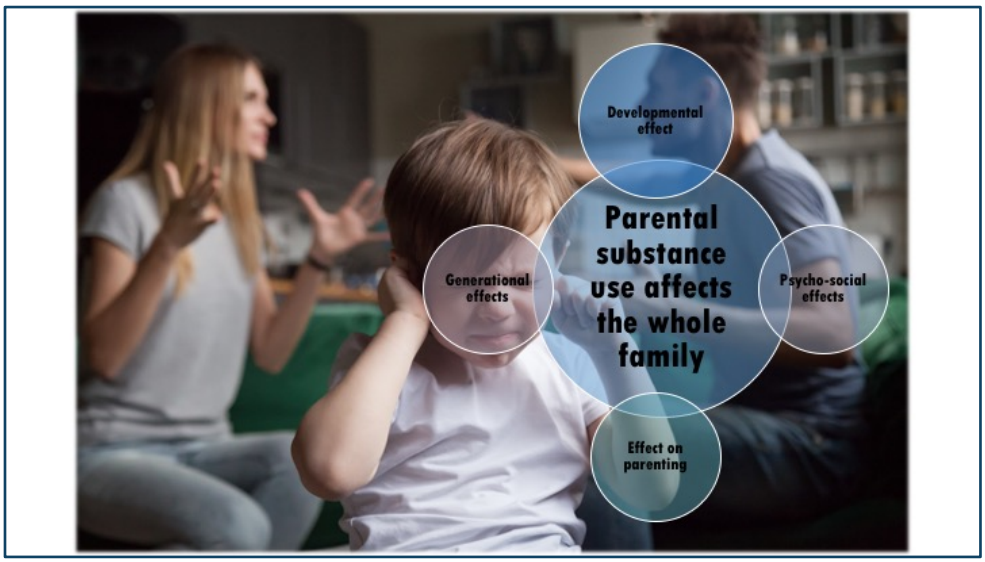
Prescription monitoring programs exist in many states to track prescriptions across healthcare providers and facilities to reduce "doctor shopping" and giving multiple prescriptions to the same person.

Naloxone is a medication that can treat opioid overdose when given quickly to someone having a suspected overdose. If naloxone is available in your community, inform families and encourage family members to obtain naloxone.

For more information, see *Module 7: Collaborating to Serve Parents With Substance Use Disorders*.

Slide 27

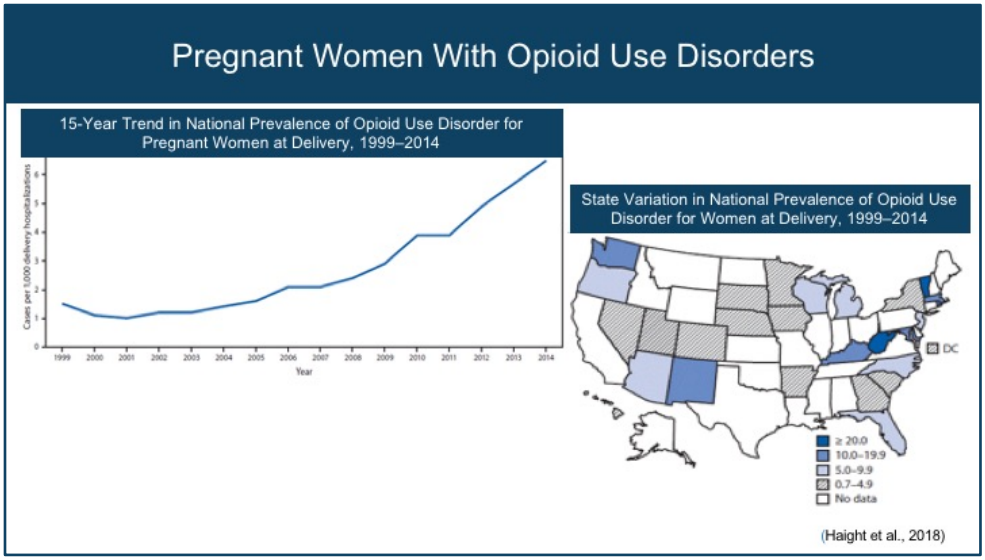
Slide 28



This slide summarizes the ways that parental substance use can affect the family.

*****Ask participants if they have any other examples of effects of parental substance use on the family.**

Slide 29



The national rate of opioid use disorders are increasing among reproductive-age and pregnant women; opioid use during pregnancy is associated with adverse maternal and neonatal outcomes.

National opioid use disorder rates at delivery more than quadrupled during 1999–2014. The rates significantly increased in 28 states.

Increasing trends might represent actual increases in prevalence or improved screening and diagnosis.

Although universal verbal screening for substance use is recommended by the American College of Obstetricians and Gynecologists, it is often not standard practice, which can lead to underestimates.

Slide 30

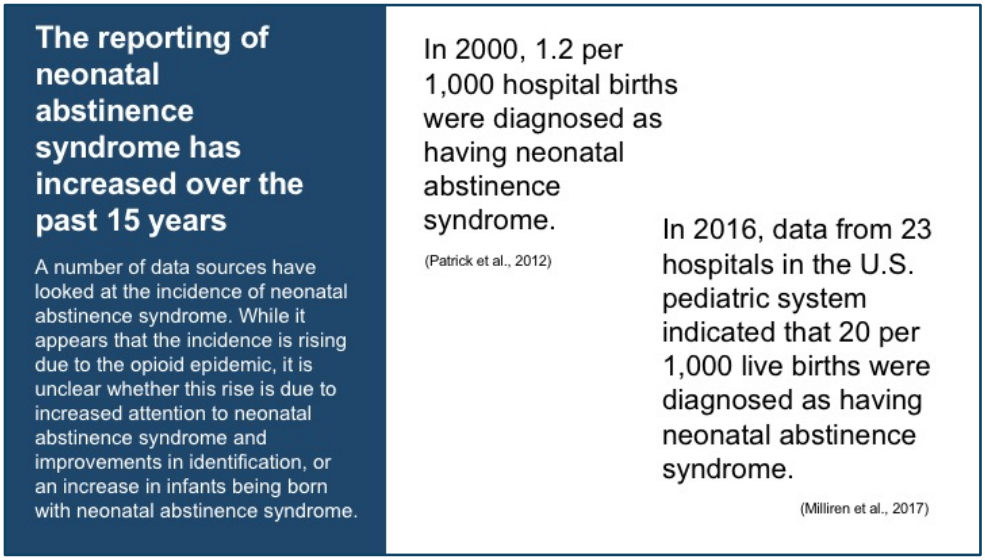
There is not a lot of clarity about the use of these terms. Neonatal abstinence syndrome is a broader term about the withdrawal symptoms from prenatal substance exposure, and neonatal opioid withdrawal syndrome is specific to opioid withdrawal.

However, in practice neonatal abstinence syndrome is often used as the term to indicate opioid withdrawal. Neonatal abstinence syndrome can be overlooked or misdiagnosed as infant seizures, feeding abnormalities, etc., so the importance of universal screening of mothers for substance use disorders is important. If a child welfare worker has concerns about a parent or caregiver's substance use, regardless of the infant's diagnosis, it is important to screen the parent or caregiver and connect them to a substance use disorder provider for a full assessment when indicated by the screening tool.

Neonatal abstinence syndrome is composed of physiologic signs and behaviors that indicate a dysfunctional regulation of the central and autonomic nervous systems; it varies in how it is expressed in affected infants.

Neonatal abstinence syndrome can be the result of a mother who took an opioid pain medication as prescribed or was part of a medication-assisted treatment program for individuals with a prior substance use disorder. Neonatal abstinence syndrome or neonatal opioid withdrawal syndrome are medical terms to describe medical symptoms or behaviors—these terms do not necessarily define risk to children.

Slide 31



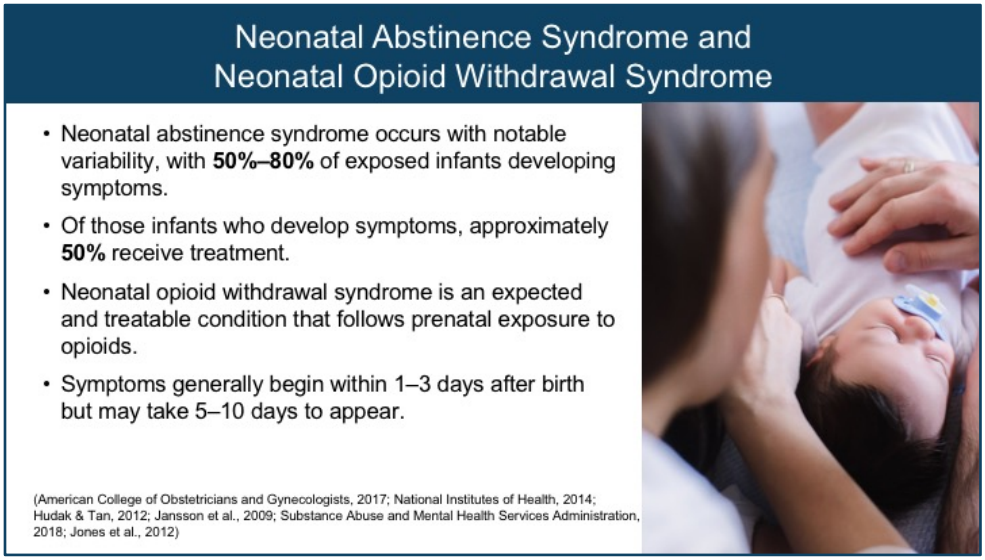
Data on the incidence of neonatal abstinence syndrome is limited to publicly available, state-level data, with rates varying widely across states.

Between 2000–2009, the incidence of neonatal abstinence syndrome increased threefold from 1.2 to 3.4 per 1,000 hospital visits (Patrick et al., 2012). From 2009 to 2012, neonatal abstinence syndrome incidence continued to increase, from 3.4 to 5.8 per 1,000 hospital visits. This represents an increase in incidence of 383% (Patrick et al., 2015).

The CDC examined publicly available data from 1999 to 2013 and found similar results, with neonatal abstinence syndrome incidence increasing from 1.5 to 6.0, representing a 300% increase (Ko et al., 2016). The rates of neonatal abstinence syndrome continue to rise, with data from 2016 that included 23 hospitals in the U.S. pediatric system indicating an incidence of 20 per 1,000 live births. (Milliren et al., 2017).

While the data aren't perfect, it is important to note the increases and continue to identify policies and provide appropriate services for these infants that are evidence-based and include their parents or caregivers.

Slide 32



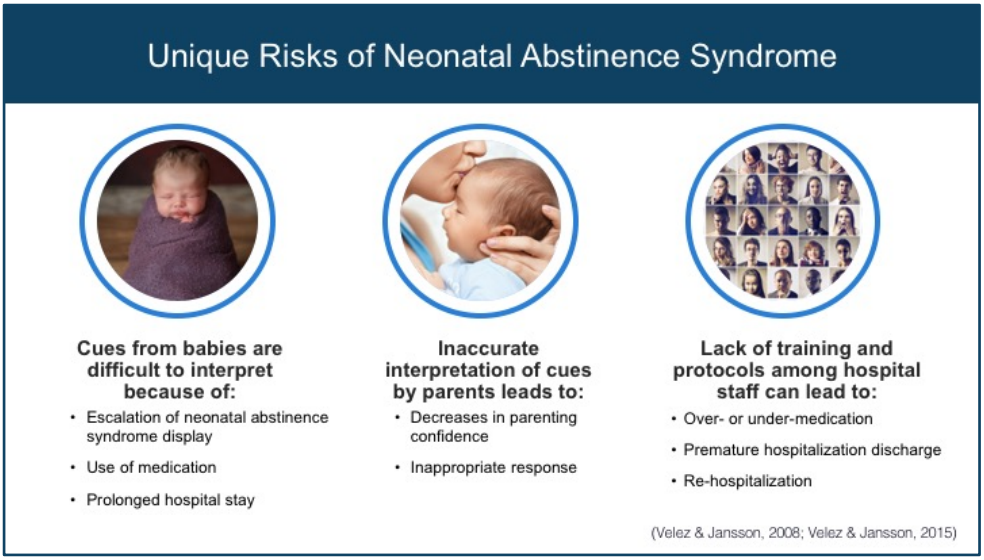
Not all infants exposed to opioids experience neonatal abstinence syndrome or neonatal opioid withdrawal syndrome, and we do not know all the factors that lead to the development of these syndromes. The timing of onset of neonatal abstinence syndrome is related to the characteristics of the substance used by the mother and the time of last dose. Most infants exposed to opioids are exposed to multiple substances.

How infants are cared for seems to make a big difference in the duration of symptoms, and many infants respond well to nonpharmacological treatment (examples of this are mothers rooming in with babies, skin to skin contact, etc.—decreasing or eliminating the need for medication).

Symptoms of these syndromes include:

- Blotchy skin
- Difficulty with sleeping and eating
- Trembling
- Irritability
- Difficult to soothe
- Diarrhea
- Slow weight gain
- Sweating
- Hyperactive reflexes
- Increased muscle tone

Slide 33



There are a number of reasons that neonatal abstinence syndrome presents risks to the mother-infant dyad, including:

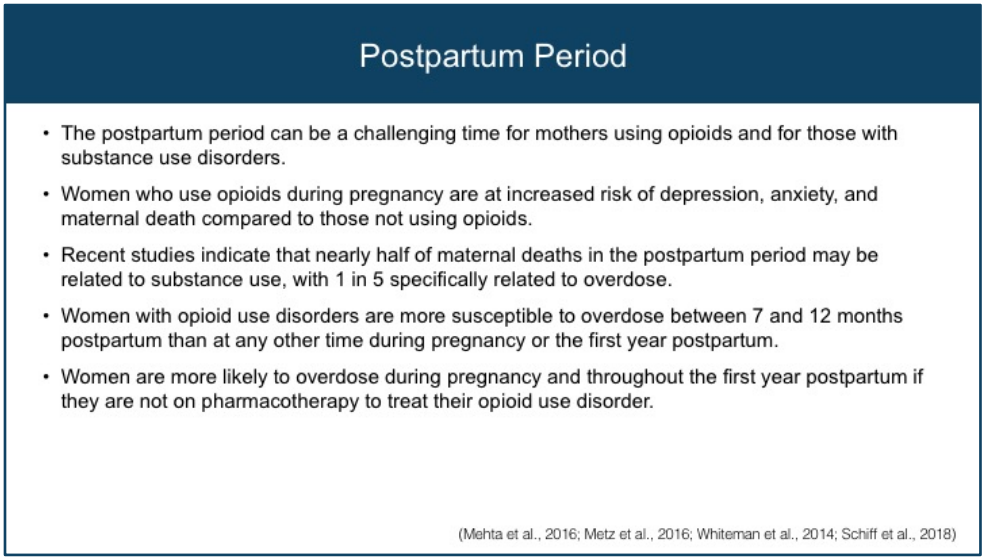
- Babies not exhibiting certain cues due to their neonatal abstinence syndrome and parents not understanding what the baby needs
- Challenges for parents in interpreting these cues as well as a lack of confidence in their ability to parent—particularly among first-time parents
- A lack of training about substance use disorders and effects of prenatal substance exposure among hospital staff, creating stigma and inconsistent support to the infant/parent

The disorganized rather than adaptive behaviors displayed by each infant undergoing the effects of in-utero exposure may impair basic functions such as feeding, sleeping, and the ability to be alert and communicate clear cues to caregivers. Understanding and responding to neurobehavioral dysfunction of the newborn may help to promote the infant's self-organization and self-regulating abilities.

Child welfare workers need to consider these challenges when creating case plans for these infants to ensure that their parents/caregivers are receiving services that address their ability to bond and care for infants with these unique challenges. Parents and caregivers with substance use disorders will likely need treatment as well as recovery supports that address their parenting role in order to safely meet the needs of these infants.

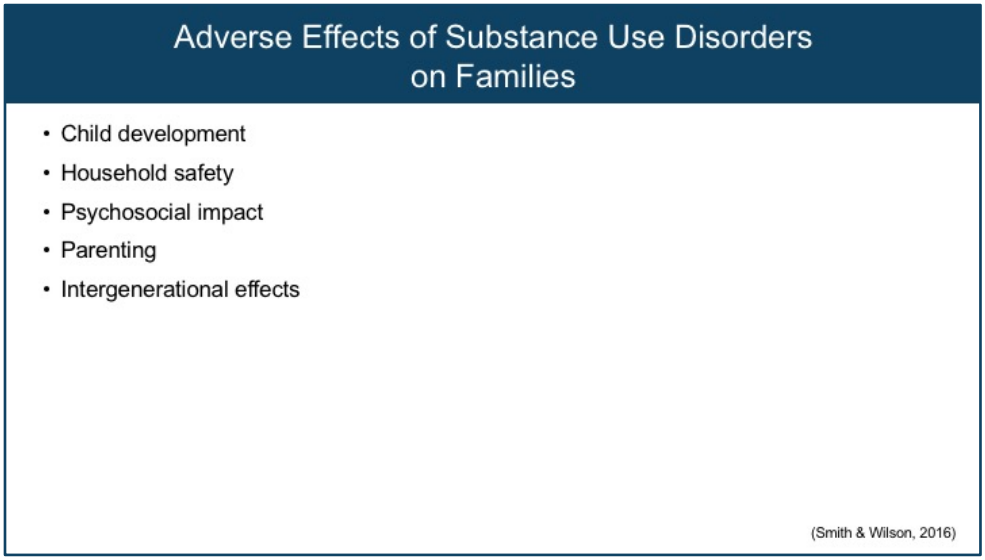
Remember that some infants are experiencing neonatal abstinence syndrome as a result of their mother engaging in medication-assisted treatment during pregnancy or being prescribed a medication during pregnancy for a medical condition. The environmental risks for these populations may be very different.

Slide 34



Some studies have shown that nearly 50% of maternal deaths in the postpartum period are related to substance use and overdose.

Slide 35

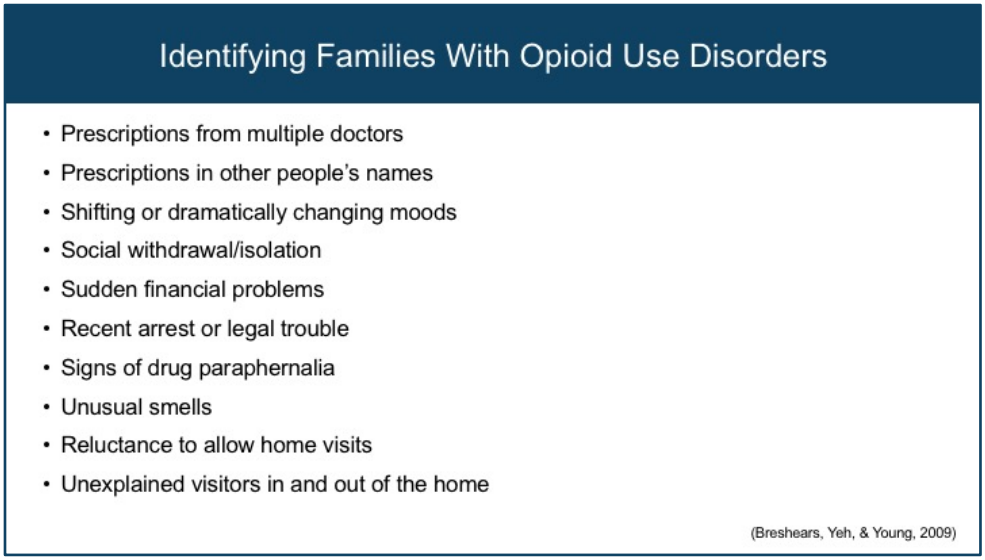


The life of a person with a substance use disorder is often out of balance, and the negative effects of use and misuse can have an enormous impact on his or her family and friends. The following shows how substance use disorders negatively affect a family's functioning across several domains.

- Child Development
    - Children may present with fetal alcohol syndrome or neonatal abstinence syndrome. Infants exposed to substances may experience a range of social, emotional, and behavioral effects as a result of exposure.
- Household Safety
    - Parents may neglect the child's basic needs (e.g., empty cupboards, no adult supervision). Parental use may include manufacturing substances or selling drugs. Children may be exposed to harsh chemicals (i.e., those used in methamphetamine labs) or to dangerous and traumatic situations.
- Psychosocial Impact
    - Children may struggle with communication difficulties, overstimulation, or emotional regulation. The postnatal environment may contribute to insecure attachment or other social-emotional concerns.
- Parenting
    - Parent-child relationships may lack trust. Children may feel as though they must be the parent, resulting in feelings of anxiety and stress.
    - Parents may lack the skills to parent effectively, due to their own history as children of substance users.
    - Parents may use harsh discipline.
- Intergenerational
    - Multiple generations of the family may be affected by substance use disorders.

- Parents may lack basic family support, due to generational substance use disorders.
- The family may present with issues of chronic neglect, due to the effects of long-term substance use disorders.

Slide 36



Review additional areas that workers might see or become aware of when working with families where opioids or other drugs may be present.

This is not a complete list, and some of these signs may not indicate drug use. All of this information should prompt further open-ended discussions with families.

As was discussed earlier, examples of open-ended questions include:

"Tell me more about . . ."

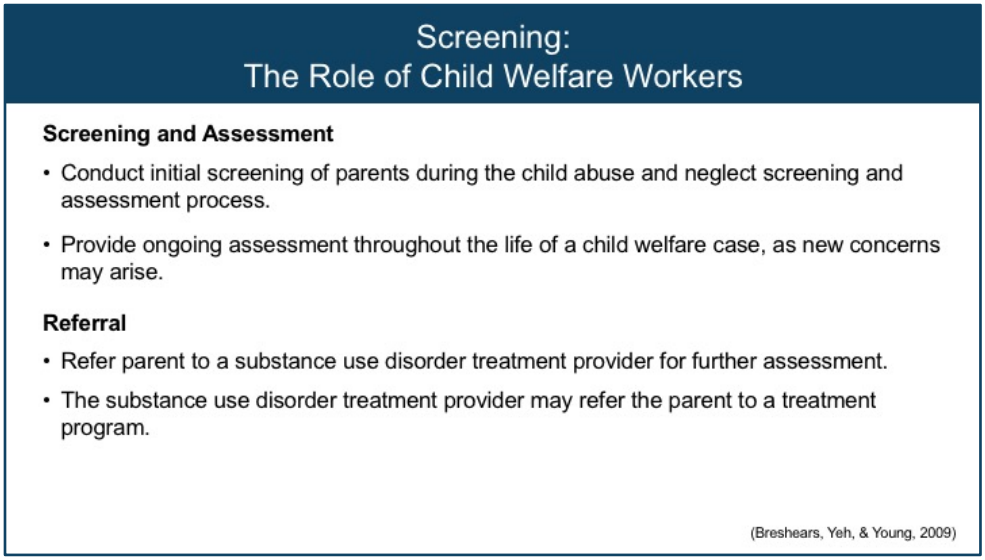
"As part of our work with families, we ask all families about . . ."

"I'm noticing that . . ."

"How can I help you with . . ."

"I'm concerned about you because . . ."

Slide 37



What is the role of child welfare workers in screening for substance use disorders?

When a report of child abuse or neglect has to be investigated, emergency response workers or investigators are generally the first ones to see the parents.

This is a time to conduct the initial screening of parents for potential substance use disorders, including parents who use opioids. The child welfare worker may observe overt signs and symptoms as part of the initial screening and assessment for child abuse and neglect.

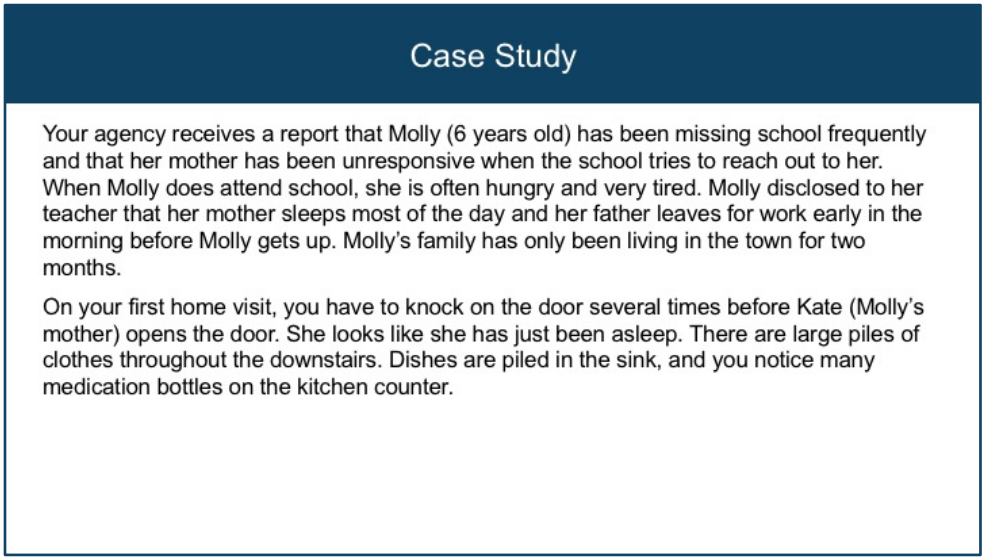
Sometimes, concerns around parental substance use become more apparent after the initial investigation or assessment. Child welfare assessment of families is a process, not an event. If additional concerns arise, further screening may be necessary.

The purpose of substance use disorder screening is to determine the presence of substance use and identify the need for a further clinical substance use disorder assessment.

Using a valid screening tool such as the UNCOPE, AUDIT, AUDIT-C, or ASSIST can provide information about the need for a substance use disorder assessment by a treatment provider.

*****Discuss your agency's protocol on screening related to substance use disorders.**

Slide 38



Make a list of the information to gather.

How would you engage Kate in a discussion?

What information do you want to know?

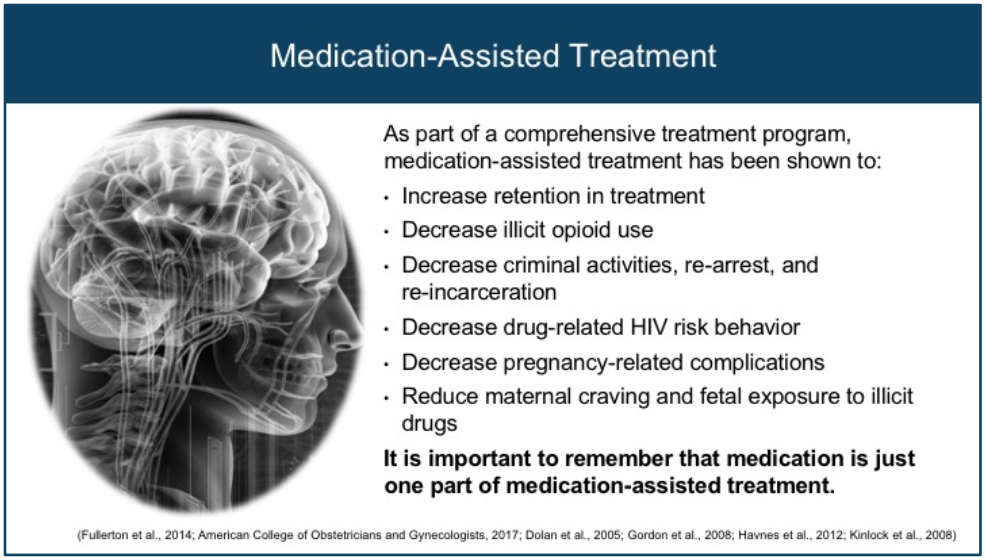
*****Tell participants to practice asking questions based on observable indicators of opioid use or other substance use. This can be done with the whole group if the group is small. Asking questions can be challenging, and it can be helpful to practice asking open-ended engaging questions. Refer participants back to the open-ended questions that were highlighted earlier in the training. Identifying a family's strengths is also important.**

Slide 39

This next section will focus on medication-assisted treatment. Medications should not be delivered in isolation but should instead be part of a larger treatment plan.

For further information about treatment, please review *Module 2: Understanding Substance Use Disorders, Treatment, and Recovery*.

Slide 40



Discuss the following reasons why it is important to use medication-assisted treatment to support positive outcomes for both the mother and the infant:

- Increases retention in treatment
- Decreases illicit opioid use
- Decreases criminal activities, re-arrest, and re-incarceration
- Decreases drug-related HIV risk behavior
- Decreases pregnancy-related complications
- Reduces maternal craving and fetal exposure to illicit drugs

It is important to remember that, in medication-assisted treatment, medication is just one part of the overall treatment. Medication supports individuals in attending to other elements of their treatment and recovery plan, including therapy, mental health counseling, employment counseling, and a myriad of other services to support their treatment and recovery.

Slide 41

Medications Used to Treat Opioid Use Disorders

Medication	Primary Use	Formulation	Treatment Setting	Maximum Client Capacity	Administration	Use In Pregnant Women
Methadone (Dolophine®, Methadose®)	• Agonist—Suppresses cravings and withdrawals • Detoxification • Maintenance	• Liquid • Tablet/diskette • Powder	• SAMHSA Certified Opioid Treatment Program (OTP)	----	• Daily at Opioid Treatment Program (OTP) • Some individuals may qualify for take-home prescriptions lasting up to 30 days	• In use for over 40 years • National Institutes of Health consensus panel recommended methadone as the standard of care for pregnant women
Buprenorphine (Subutex®)	• Partial Agonist—Suppresses cravings and withdrawals; partial stimulation of brain receptors • Detoxification	• Tablet	• Physicians or psychiatrists granted a DATA waiver (CARA 2016 expanded to NP and PAs) • Some SAMHSA Certified OTPs	• 100* *CARA 2016 expanded to 275 patients for some physicians	• Daily • Individuals can be prescribed a supply to be taken outside of the treatment setting	• Maternal Opioid Treatment Human Experimental Research (MOTHER) study: No significant difference between buprenorphine and methadone regarding serious maternal or neonatal adverse events
Buprenorphine-Naloxone Combination (Suboxone®; Zubsolv®)	• Maintenance	• Sublingual tablets	• Prescription	----	• Daily	• Buprenorphine without naloxone recommended

(Center for Substance Abuse Treatment, 2006)

Review the information on the three most common medications used to treat opioid use disorders: methadone, buprenorphine, and buprenorphine\naloxone combination.

There are a number of medications that can be used to treat opioid use disorders.

For pregnant women, physicians and opioid treatment providers should consider the risks and benefits of each medication, including the potential for the infant to develop neonatal abstinence syndrome, the necessary length of stay in the hospital setting, and the likelihood of relapse or return to use, to determine the appropriate course of action; evidence on the risks and benefits of each medication is still emerging.

Slide 42

Medications Used to Treat Opioid Use Disorders

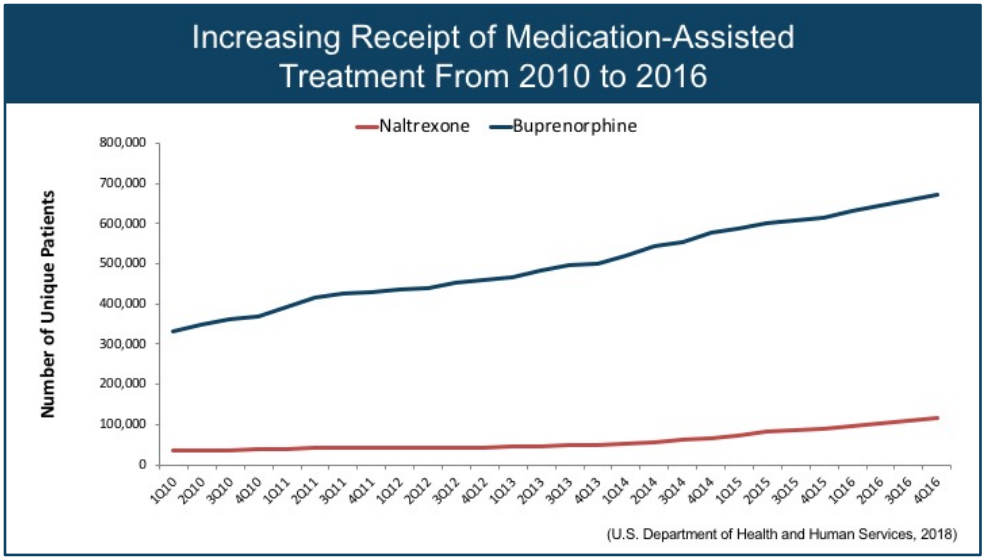
Medication	Primary Use	Formulation	Treatment Setting	Maximum Client Capacity	Administration	Use In Pregnant Women
Naltrexone Extended-Release (Vivitrol®)	• Antagonist—Blocks effects of opioids • Maintenance	• Injection (primarily)	• Any healthcare provider licensed to prescribe medications	----	• Monthly, following medically-supervised detoxification	• Insufficient research to support use
Naloxone (Narcan®)	• Antagonist—Displaces opiates from brain receptors and reverses respiratory depression • Reverse overdose	• Injection	• First responders, family members	----	• When overdose is suspected or signs of overdose are observed	

(Center for Substance Abuse Treatment, 2006), SAMHSA, 2015; SAMHSA, 2016)

Review the information on these additional medications.

Naloxone (Narcan®) is not used on its own in long-term treatment. Instead, it is used to reverse opioid overdose.

Slide 43

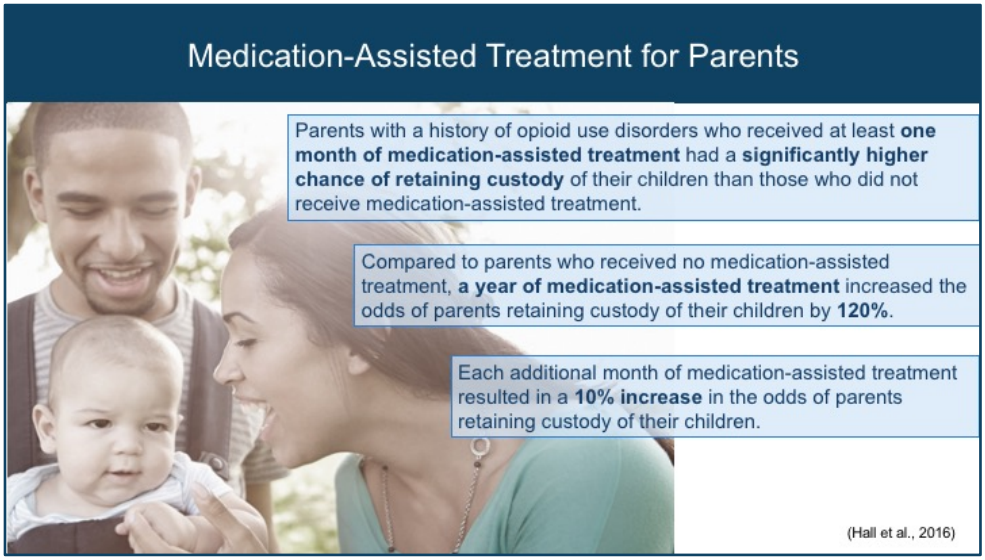


This graph shows a significant increase in patients receiving medication-assisted treatment from 2010 to 2016. Review the information below about medication-assisted treatment, including basic information, the benefits, and the myths.

- Medication-assisted treatment (MAT):
    - Methadone (Dolophine®, Methadose®), buprenorphine (Suboxone®, Subutex®, Probuphine® , Sublocade™), and naltrexone (Vivitrol®) are used to treat opioid addiction.
    - Acting on the same targets in the brain as heroin and morphine, methadone and buprenorphine suppress withdrawal symptoms and relieve cravings. Naltrexone blocks the effects of opioids at their receptor sites in the brain and should be used only in patients who have already been detoxified.
    - All medications help patients reduce drug seeking and related criminal behavior and help them become more open to behavioral treatments.
- Benefits of MAT:
    - Medication-assisted treatment decreases opioid use, opioid-related overdose deaths, criminal activity, and infectious disease transmission.
    - Medication-assisted treatment increases social functioning and retention in treatment.
    - Treatment of opioid-dependent pregnant women with methadone or buprenorphine improves outcomes for their babies.
- Medications are not widely used:
    - Less than half of privately-funded substance use disorder treatment programs offer medication-assisted treatment, and only 1/3 of patients with opioid dependence at these programs actually receive it.
    - Nearly all U.S. states do not have sufficient treatment capacity to provide medication-assisted treatment to all patients with an opioid use disorder.

- Myths about MAT:
    - Methadone and buprenorphine DO NOT substitute one addictive substance for another. When someone is treated for an opioid use disorder, 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 an opioid use disorder, allowing the patient's brain to heal while working toward recovery.
    - Diversion of buprenorphine is uncommon; when it does occur, it is primarily used for managing withdrawal. Diversion of prescription pain relievers, including oxycodone and hydrocodone, is far more common; in 2014, buprenorphine made up less than 1 percent of all reported drugs diverted in the U.S.
    - The length of time in methadone treatment varies from person to person.

Slide 44



Medication-assisted treatment is associated with positive child welfare outcomes. This slide highlights some of the findings from a 2016 study on medication-assisted treatment for families in the child welfare system.

This study examined the prevalence and correlates of medication-assisted treatment utilization among parents in the Sobriety Treatment And Recovery Teams (START) program with a history of opioid use, and compared child outcomes for families who received medication-assisted treatment services to those who did not. The START model is a child welfare based intervention focused on families with co-occurring substance use and child abuse/neglect issues.

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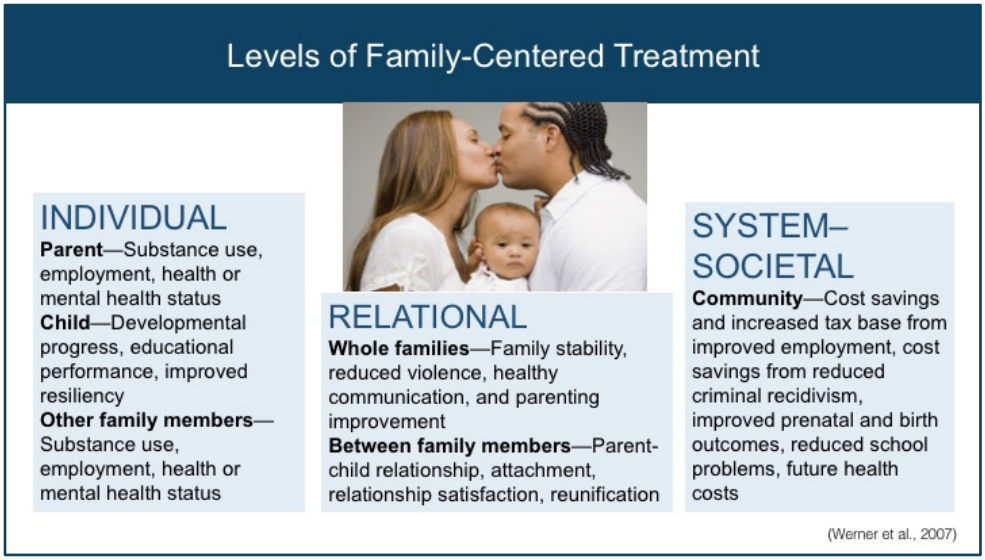
When child welfare workers and substance use treatment providers working with families with substance use disorders recognize that substance use is a brain disease rather than a personal failing or chosen behavior, it can help to reduce stigma.

Reducing stigma ensures that clients are seen as whole people. Child welfare workers and substance use treatment providers can identify client strengths and recognize opportunities to improve parenting and support the parent-child relationship so that families can stay together safely.

Viewing the family as a system requires a shift in thinking for child welfare workers, who have traditionally focused on their mission of safety and well-being of the child, and substance use treatment providers, who have traditionally focused on the treatment and recovery of the parent. Child safety and parental recovery are critically linked to one another and must be addressed holistically to ensure the best outcomes for the entire family.

Slide 47



Currently, there is no universally accepted definition of “family-centered treatment.” Provider approaches may differ along a continuum, from *family involvement* (a minimum standard of service) to *family-centered services* (in which children or other family members may receive their own services) to *full comprehensive family-based treatment* (in which all members of the family have individualized case plans and share an integrated family plan).

Despite this variation, some common principles underlie family-centered treatment, including:

- It is comprehensive and includes clinical treatment for substance use disorders, clinical support services, and community supports for parents and their families.
- It focuses on the entire family unit as opposed to the individual parent with a substance use disorder. Women/parents define their families, and treatment identifies and responds to the effects of substance use disorders on every family member.
- Treatment is based on the unique needs and resources of individual families.
- Families are dynamic, and thus treatment must be dynamic.
- Conflict within families is inevitable, but resolvable. Treatment offers whole family services that build on family members’ strengths to improve family management, well-being, and functioning.
- Meeting complex family needs requires coordination across systems.
- Services must be gender responsive and specific and culturally competent.
- Family-centered treatment requires collaboration across professionals and an environment of mutual respect and shared training.
- Safety of all family members comes first.
- Treatment must support the creation of healthy family systems.

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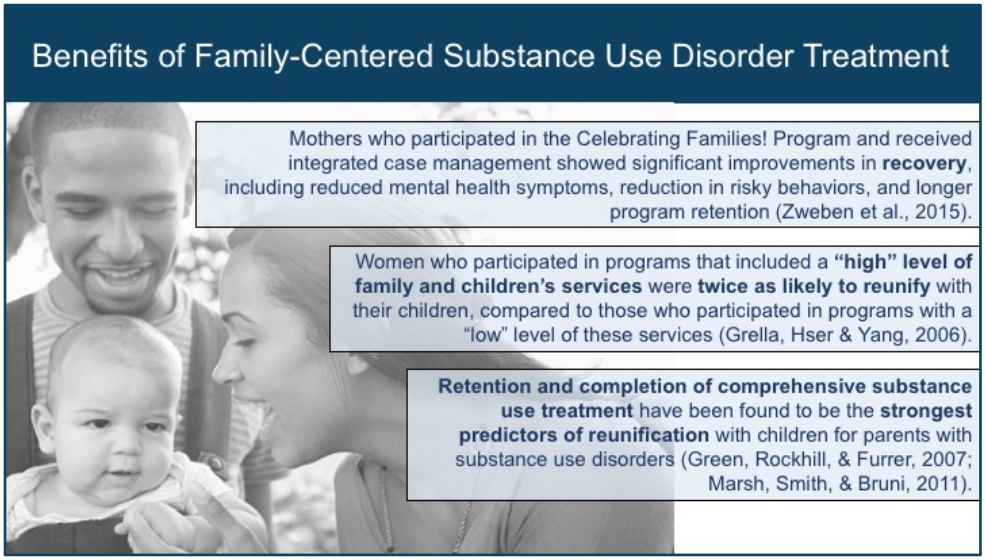
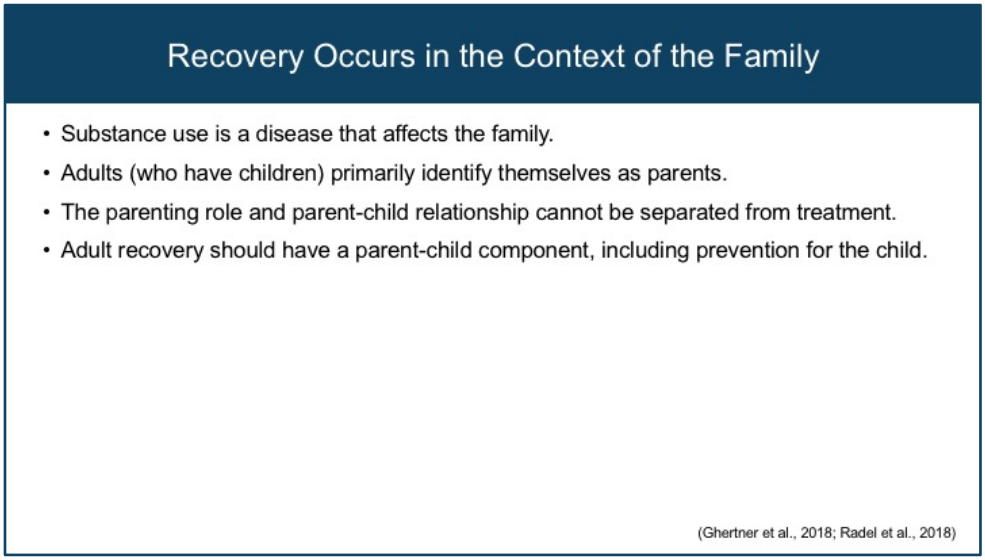


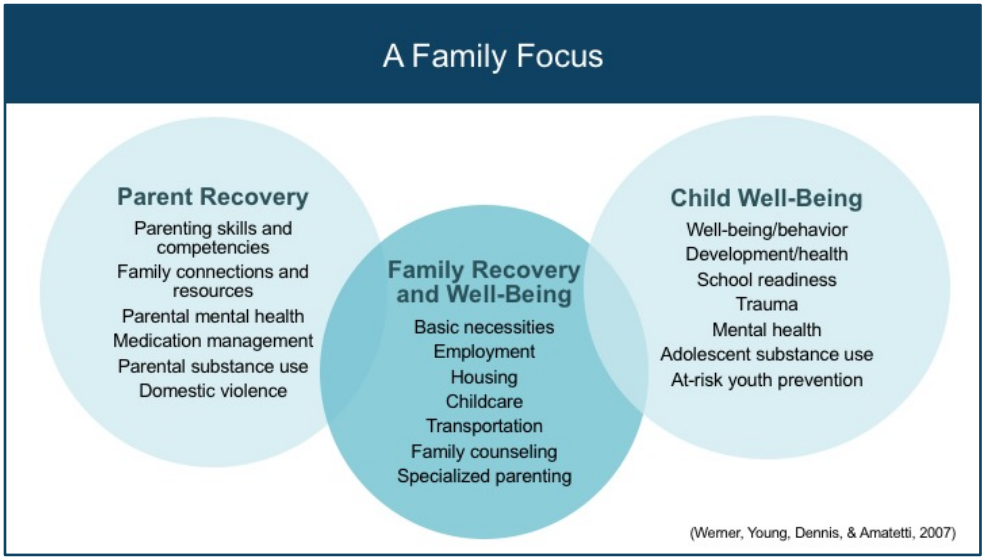
Review the outcomes of family-centered treatment.

Slide 49



Family-centered treatment is an important step to family recovery. We know that recovery occurs within the context of relationships.

Slide 50

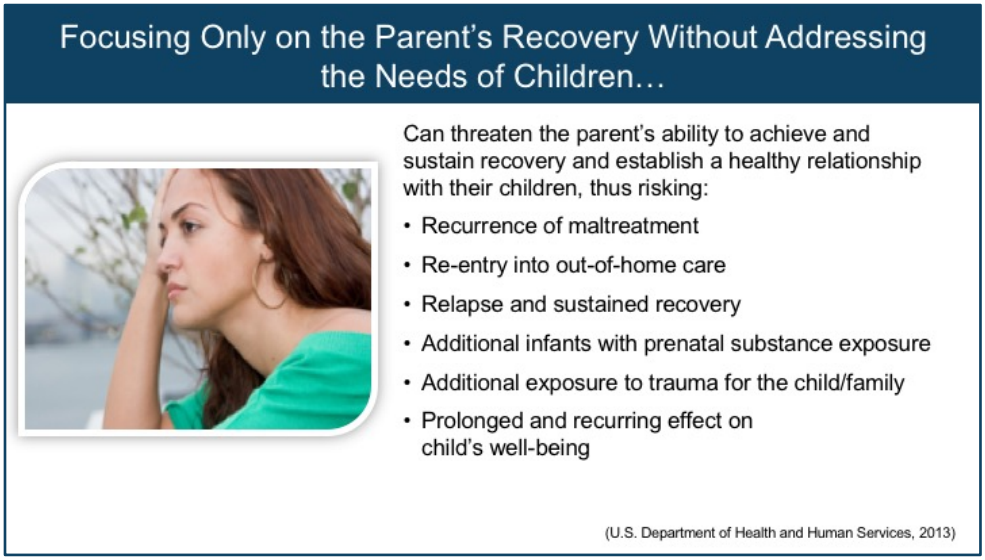


When serving a family holistically, the focus is on the parent's recovery, the child's well-being, and the family's recovery and well-being as a whole.

- Services to support the parent's recovery should address:
  - Parenting skills and competencies
  - Family connections and resources
  - Parental mental health
  - Medication management
  - Parental substance use
  - Domestic violence
- Services that support child well-being must address:
  - Well-being/behavior
  - Development/health
  - School readiness
  - Trauma
  - Mental health
  - Adolescent substance use
  - At-risk youth prevention
- Supporting the entire family's recovery and well-being means providing:
  - Basic necessities
  - Employment
  - Housing
  - Childcare

- Transportation
- Family counseling
- Specialized parenting

Slide 51



Focusing only on the parent's recovery issues without addressing the needs of the child and the family as a whole can threaten the parent's ability to achieve and sustain recovery, to parent effectively, and to establish a healthy and positive relationship with their child(ren); thus risking:

- Recurrence of maltreatment
- Re-entry into out-of-home care
- Relapse and sustained recovery
- Additional infants with prenatal substance exposure
- Additional exposure to trauma for the child/family
- Prolonged and recurring effect on child's well-being

Slide 52

National Center on Substance Abuse and Child Welfare

A Program of the

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

and the

Administration on Children, Youth and Families
Children's Bureau
Office on Child Abuse and Neglect

www.ncsacw.samhsa.gov

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