

Child Welfare Opiate Engagement Project

The Ohio General Assembly has adopted more than a dozen bills in response to the opiate epidemic, aiming to promote improved prescribing practices and boost community-level treatment. But, to date, the legislature has yet to address the fallout to children of opiate abusers.

Nationally, between 60 percent and 80 percent of substantiated child abuse and neglect cases involve a parent or guardian abusing substances.^{1, 2}

In Ohio, parents abusing heroin or opium-based painkillers such as Vicodin and OxyContin are a growing problem. Just the cost of placing their children in foster care is now conservatively estimated to be \$45 million annually³—one of several costs on track to continue growing if no changes are made.

Among the nearly 86,000 cases entering Ohio's child welfare system annually, families dealing with opiate and/or cocaine abuse, including crack abuse, consume the most resources.⁴

- Half the children whose parents are not involved in cocaine and/or heroin leave foster care within four months. If the parents are using cocaine and/or heroin, half the children leave care within nine months.
- For parents, half the non-heroin, non-cocaine cases close within two months. Half the heroin and cocaine cases close within six months, with 18 percent remaining open two years or longer. Adding to the burden, heroin and cocaine cases reopen faster and more frequently.

Child welfare cases involving parents abusing heroin, cocaine or both have risen from about 15 percent to more than 25 percent of the caseload during the last five years, with heroin cases growing faster than cocaine during the last three years.⁵

Another troublesome trend: 70 percent of children age 1 or younger placed in Ohio's foster system are children of parents with substance use disorders involving opiates and cocaine.⁶ Children raised in substance-abuse environments are vulnerable to the toxic stress common within families struggling with addiction. The toxic stress results in problems—some lasting a lifetime—that include depression, anxiety, PTSD and behavioral and learning difficulties, as well as significant attachment problems.^{7 8 9}

This epidemic has one more issue calling for urgent action. Due to the negative impacts of temporary care on children, when a child welfare agency removes a child from a home, the agency must abide by time limits imposed by the 1998 Adoption and Safe Families Act. Reunification of parents and children is most often in the best interest of the children. But, dependency treatment can be a lengthy process, and parents who cannot recover within 15 to 22 months may permanently lose custody.¹⁰ Currently, more than 25 percent of foster placements involving children of opiate- and/or cocaine-dependent parents last 15 or more months, pushing against the time limits.¹¹

Best Practices

Opiate abuse and the associated problems and costs have increased in every segment of Ohio, from rural to suburban to urban and across the socioeconomic spectrum. Fortunately for Ohio and its public agencies, there are evidence-based best practices they can adopt or use more widely. The four practices described below coordinate services to increase the effectiveness of programs. They eliminate duplication. They yield better outcomes for children of parents with the disease of addiction and for the parents themselves—in shorter time. And, in the long run, they save taxpayer money.

Family Dependency Treatment Courts

Ohio has 16 Family Dependency Treatment Courts (FDTCs)¹ that focus on treatment and rehabilitation of parents whose children are in the child protection system. The courts address the parent’s substance use disorder as the root cause of child neglect and abuse.

Family drug courts are among the most effective programs for inducing parents to enter and complete substance abuse treatment, improving other outcomes and saving public funds.^{12 13}

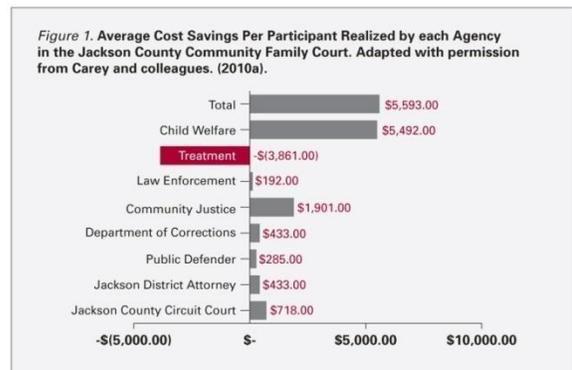
Compared to nearby traditional courts, independent impact evaluations^{14 15 16} of 12 FDTCs from Maine to Arizona and in the United Kingdom showed:

- Participants completed addiction treatment at a higher rate in all but one court. In eight courts, the completion rate was between 21 and 37 percent higher.
- Children of parents with substance use disorders were released from foster care substantially sooner in all but one court. Eight courts saw significant reductions ranging from two to nearly 7 months.

- More families were reunified in 11 courts; 17 to 46 percent more in eight of the courts.
- Among the seven courts that reported terminations of parental rights, all saw a decrease, ranging from 2 to 27 percent.

By design, parents in family drug courts have greater participation in drug treatment programs compared to participants in traditional courts, resulting in higher treatment costs. Total costs for FDTC programs ranged from about \$7,000 to nearly \$14,000 per family.

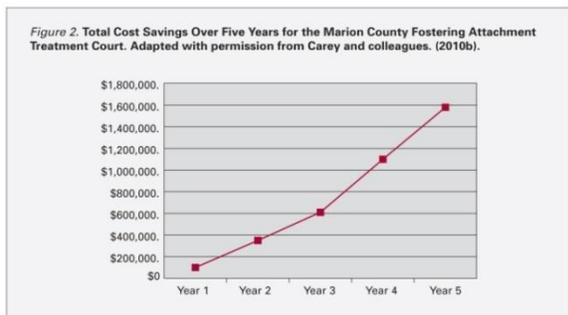
But, the overall savings due to reduced use of foster care, the courts, jails and probation officers is substantial. The specialized courts saved taxpayers an average of \$5,022 per family in Baltimore, \$13,104 per family in Marion County, Oregon.^{17 18 19}



SAVINGS BY AGENCY, JACKSON COUNTY, OR

¹ Belmont, Delaware, Clermont, Coshocton, Fairfield, Franklin, Hardin, Lorain, Lucas, Mahoning, Marion, Morrow, Ottawa, Summit, Trumbull and Union counties. Cuyahoga County is in the process of obtaining Supreme Court of Ohio certification.

The savings a family drug court provides a community may grow and accrue as participants maintain sobriety and other improvements over time and as more families with addiction problems participate in the program. Taxpayer savings increased ten-fold during the first five years the family drug court was in operation in Marion County, Oregon.



LONG-TERM SAVINGS, MARION COUNTY, OR

Evidence suggests that adult drug courts, which have been in use longer and are more widely studied, are more effective for participants whom traditional courts find most challenging. Studies show adult drug courts are equally effective regardless of which type of drugs are used by people with substance use disorders and despite the presence of other risk factors, such as mental illness and unemployment. Early studies are showing that family drug courts are having the same successes.²⁰

Medication Assisted Treatment

Few people with opiate addiction recover permanently without Medication Assisted Treatment (MAT). In fact, opiate addiction treatment without MAT results in relapse rates of 80 to 95 percent, according to the federal Center for Substance Abuse Treatment.^{21 22} It is important to note that these medications are designed to be prescribed in conjunction with behavioral therapy, not as stand-alone treatment.^{23 24}

Patients who participate in behavioral therapy combined with the appropriate MAT have a long-term recovery rate of at least 50 percent, on par with chronic, relapsing diseases such as diabetes and hypertension.

MAT employs naltrexone, buprenorphine or methadone in combination with counseling and support services. NOTE: All medication must be safely stored out of the sight and reach of children and kept in childproof containers whenever possible.

The medications in conjunction with psychological and behavioral counseling are designed to:

- Improve chances of abstaining from opiate abuse
- Reduce cravings and preoccupation
- Retain patients in treatment and maintain the therapeutic relationship
- Decrease negative behaviors associated with addiction, including lying, neglect and law-breaking
- Reduce addiction-related consequences, including unemployment, homelessness and incarceration

Naltrexone, an opioid antagonist, is used in mild cases of opiate addiction. The drug blocks the effects of opiates, producing no high or pain relief. It has no abuse potential. A long-acting injectable form, called Vivitrol, was approved for treatment of opiate dependence in 2010. The older, oral form has been shown to decrease relapse rates in highly motivated and supervised patients by 80 percent.

Buprenorphine, also known as Suboxone, a partial opioid agonist, prevents withdrawal symptoms when an opiate abuser stops taking

painkillers or heroin quickly binding to opiate receptors and then slowly disassociating from them. The medication is typically used in cases of moderate dependence. Patients who take buprenorphine stay in treatment longer and have more opiate-free drug screens. There are two product lines of buprenorphine. The mono product (i.e., Subutex) contains only buprenorphine. The combo product (i.e., Suboxone, Zubsolv) contains buprenorphine and naloxone. The combo product was formulated to decrease the ability of patients to divert or abuse the medication.

Methadone, a full opioid agonist, is the oldest and best studied of the treatment medications and is used for severe cases of dependency. A Schedule II narcotic, methadone prevents withdrawal symptoms by binding to opiate receptors and suppressing opioid craving. The drug can only be dispensed in a certified Opiate Treatment Program. Methadone reduces cravings and is evidenced to be most effective with treatment retention among the three types of MAT.

Patients who become stable on methadone are more likely to see increases in employment, social stability and have stable housing and improved overall health. Certified Opiate Treatment Programs are, however, limited in Ohio, leaving patients in parts of Ohio without access to the most effective treatment.

Patients in treatment often cycle from methadone to buprenorphine to naltrexone and then to medication-free treatment, or transition from any of the MAT prescriptions to a drug-free state, given sufficient time, motivation and support. Some patients remain on maintenance therapy with a particular medication during their lifetime of recovery as is common with

chronic disease management for conditions other than addiction, too.

The costs of appropriate MAT are significant, but lack of or inadequate treatment creates an even greater burden to society, states, communities and individuals.

For each person with addiction, the costs may include losses to local economies due to lost work time, jail or prison costs, repeated treatment attempts, and overdose deaths, not to mention traumatic impacts to their children's healthy development, academic progress and lifetime health and success.

In order to expand MAT, education and training should be offered to professionals in behavioral health, child welfare, primary healthcare and the criminal justice systems.

Sobriety Treatment and Recovery Teams

Based on Toledo's ADAPT program, the Sobriety Treatment and Recovery Teams (START) program begun in Cuyahoga County in 1997 is a model now used in New York City as well as in two urban, one rural and one Appalachian site in Kentucky.

Studies in Ohio and Kentucky show that parents in START are nearly twice as successful in achieving sobriety as those not involved in the program.²⁵ The Kentucky study also showed that 41 percent of children of families treated in the state's standard system were placed in foster care compared to 20 percent of children of START families. Early New York data²⁶ indicate START parents are more likely to enter treatment and START children less likely to enter foster care.

START provides specialized interventions to families referred to the child welfare system

who have confirmed drug addiction problems. Participation is triggered when a pregnant mother tests positive for substance use in the second or third trimester or an infant tests positive at birth. Mothers who use drugs during pregnancy are more likely to use them after giving birth and, in turn, their children are more likely to be placed in foster care.²⁷

Each START social service worker is paired with a family advocate who understands their needs. Most advocates are in recovery and many have been clients of child and family welfare agencies.

The team approach provides stronger engagement and more frequent contact with both the family and treatment providers. Other partners in the network include drug treatment, healthcare and housing providers, neighbors, friends, relatives and other informal sources of support.

START staff is encouraged to rely heavily on informal supports for monitoring children's safety, providing emergency care and, in some cases, ongoing care. In all cases and situations, START relies on the informal network members to support and monitor a family's welfare after formal services have ended.

Every dollar spent on START substance abuse treatment and family mentors in Kentucky saves \$2.52 in foster placement costs.²⁸

In traditional programs, placement of children of drug-dependent caregivers in foster homes averaged 383 days.²⁹ For families involved in START in Cuyahoga County, placement averaged 300 days.³⁰

Screening and Assessment for Family Engagement, Retention and Recovery

The Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR) program promotes child safety and family well-being by streamlining and coordinating child welfare services, treatment services and actions by the courts overseeing the children and parents.

The SAFERR model,³¹ developed jointly by the National Center on Substance Abuse and Child Welfare and the Substance Abuse and Mental Health Services Administration, provides tools for building cross-system collaboration at the local, regional and state levels. The model supports improved multi-system approaches to communication and protocols, screening and assessment, along with case management and treatment interventions.

In Ohio, Butler County has used and adopted segments of SAFERR in local programs. An evaluation³² of Butler County's Multidisciplinary Treatment Team (MTT) showed that 13.4 percent of families in the MTT program required placement in foster care compared to 32.1 percent for families in the family drug court program.

Participants in both programs significantly reduced their use of cocaine, marijuana and heroin, with 55 percent in family drug court completing drug treatment and 32 percent in the MTT program completing treatment, compared to a control group's 26 percent.

SAFERR helps child welfare, drug treatment and court staff:

- Create and guide teams that improve services by sharing information and coordinating services.
- Develop clear expectations for the team’s mission, authority and accountability.
- Identify and address state policies that block efficient practice.
- Select screening and assessment tools and strategies for daily practice.
- Support and oversee implementation of improved practices.
- Monitor and evaluate success and problems.

Expected outcomes:

- Families are identified more accurately and earlier.
- When entering or participating in substance abuse treatment, potential child maltreatment is identified more accurately and earlier.
- The systems communicate effectively in screening and assessment and in monitoring progress in services.
- Staff will make more informed, timely and shared decisions regarding reunification, after care or continuing services, and filing petitions for termination of parental rights.
- Families will enter and remain in treatment and child welfare services at higher rates.
- Work processes are streamlined.
- Child maltreatment risks are reduced.

- Family stability, reunification and well-being are increased.

Reports indicate that several critical elements were found to increase the success of the model, including co-location of staff for cross-agency communication and services, promoting improved access to services, as well as understanding of each other’s systems.³³

Because families involved in child welfare or substance abuse programs are often involved in welfare, criminal justice and mental health systems, SAFERR suggests extending the same strategies promoting communication and coordination of services. Case managers and court officials who are making decisions on services need clear input from all systems working with a family in order to best address the constellation of problems.

The Child and Family Services Improvement Act Regional Partnership Grant program represents the broadest federal effort ever launched to improve the well-being, permanency and safety outcomes for children at risk of or in out-of-home placement due to parental/caregiver drug abuse. These projects apply elements of the SAFERR model and have supported the development of defined outcomes for improving best practice approaches that can be used as benchmarks to measure progress. Ohio’s Lucas and Butler counties have been among the funded sites for these partnerships.³⁴

Summary and Recommendations

Ohio's opiate epidemic is of such grave concern that during his first 100 days in office, Governor Kasich created a Cabinet-level Opiate Task Force. Since that time, new policies, investments and initiatives have begun. These include:

- The Ohio Medicaid Expansion that makes more Ohioans, including caregivers, eligible for drug treatment services.
- Continued expansion of Family Dependency Treatment Courts (FDTC) through the Supreme Court of Ohio, which provides four years of grant funding to local courts that implement a FDTC. This expansion was recently supported by an additional \$4.4 million grant opportunity to local courts through MHAS for any specialized drug court.
- A Medication Assisted Treatment (MAT) pilot providing \$5 million to selected locations that coordinate with providers and local drug courts including FDTCs.
- A Federal Mental Health Block Grant providing \$350,000 to support housing for recovering individuals.
- \$4.2 million to selected hospitals to support the Maternal Opiate Medical Support (MOMS) Project.

Although all of these efforts indirectly impact the child welfare system, this paper outlines how opiate use is directly impacting the child welfare system, the children and families the system serves and what steps need to be taken to serve them better. Just as the medical community, treatment providers and the courts have had to change their approach to working with persons addicted to opiates, Ohio's Public Children Services Agencies need to change in order to reach better outcomes.

Each best practice we recommend below requires child welfare to provide more intensive and time-consuming case management. This can only happen by adding caseworkers and training. To accomplish this, we need the support of our federal, state and local leaders.

- I. Encourage implementation of the Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR) model: Support cross-system collaboration at the local, regional and state level based on the SAFERR model, including increased capacity for technical assistance and training to support the development process. Consider ways to decrease barriers for co-locating staff that build on successful Ohio experiences, such as the Regional Partnership Grants and Protect Ohio. Encourage the development of Memoranda of Understanding between courts, treatment providers, and child welfare agencies that are built on the foundations of the SAFERR model.
- II. Increase the number of Family Dependency Treatment Courts: Ohio has 16 Family Drug Treatment Courts and should increase the number across the state. The Supreme Court of Ohio with support of the Ohio Department of Mental Health and Addiction Services (OhioMHAS) and the Ohio Department of Job and Family Services (ODJFS) submitted a grant application to the Office of Juvenile Justice Delinquency Prevention for \$300,000 over a 24-month period to

address the scale and scope of Ohio's family dependency treatment courts. If Ohio obtains the grant, after the initial 24-month period of funding, Ohio may be invited to apply for additional funding up to \$2 million for an additional three-year time period to implement its plan to address scale and scope issues for family dependency treatment courts. In the meantime, \$4.4 million to expand the state's existing drug courts, including FDTs, is available through OhioMHAS. The Supreme Court of Ohio typically selects one to two courts per year for the start-up funding and expects recipient courts to earn SCO certification. The high court seeks two dockets for 2015.

- III. Establish time-limited prioritization of drug treatment counseling and recovery services for child welfare cases as required by 122nd-HB 484, Ohio's Adoption and Safe Families Act. The act demands that children services agencies, drug and alcohol treatment providers and juvenile courts assure timely assessments, services and permanency decisions for children of substance-abusing parents.
- IV. Increase access to Medication Assisted Treatment (MAT): Medication Assisted Treatment (MAT) is not just a best practice but the standard of care for this population. All three forms of Medication Assisted Treatment (agonist, partial agonist and antagonist) should therefore be available for all parents in the child welfare system where opiate addiction has been determined. MAT significantly decreases relapse rates and greatly increases the likelihood of success in transitioning patients into long-term recovery. Medications combined with behavioral therapy are the gold standard in promoting long-term chronic disease management and recovery for people with opioid dependency and addiction. MAT should be available for all parents in the child welfare system where opiate addiction has been determined. To accomplish this, education and training should be offered to professionals in behavioral health, child welfare, primary healthcare and the criminal justice systems to support an increased understanding of the importance of MAT. In addition, policies and resources should support availability of and timely access to MAT for child welfare-involved parents with opioid addiction. The Governor's Cabinet Opiate Action Team has created a small pilot with streamlined Medicaid pre-authorization procedures, and this could be replicated for Medicaid-eligible parents in the child welfare system.
- V. Expand access to recovery support and intensive child welfare case management: Evaluations show that Sobriety Treatment and Recovery Teams (START) programs using the Annie E. Casey Foundation model of pairing a child protective services caseworker with a parent mentor helped reunify children and parents twice as effectively as traditional programs. The model should expand to additional counties.

Child Welfare Opiate Engagement Project Committee Members

Name	Organization
Timothy Dick, Co-Chair	Clermont County Children Services
* Orman Hall, Co-Chair	Governor's Cabinet Opiate Action Team
Crystal Ward Allen	Casey Family Programs
Gayle Channing Tenenbaum	Public Children Services Association of Ohio
Maureen Corcoran	Vorys Healthcare Advisors
* Sandy Starr	Ohio Department of Mental Health and Addiction Services
* Dr. Mark Hurst	Ohio Department of Mental Health and Addiction Services
* Matt Loncaric	Ohio Department of Mental Health and Addiction Services
* Brad DeCamp	Ohio Department of Mental Health and Addiction Services
Pat Rideout	Cuyahoga County Division of Child and Family Services
Cynthia Weiskittel	Cuyahoga County Division of Child and Family Services
Sharla O'Keefe	Morrow County Job and Family Services
Dr. Lorra Fuller	Scioto County Children Services
Deanna Nichols-Stika	Wayne County Children Services
Cheri Walter	Ohio Association of County Behavioral Health Authorities
Lori Criss	The Ohio Council of Behavioral Health & Family Services Providers
* Roger Ward	Ohio Department of Job and Family Services
* Jennifer Justice	Ohio Department of Job and Family Services
* Mary Haller	Ohio Department of Medicaid
* Patrick Beatty	Ohio Department of Medicaid
* Dr. Mary Applegate	Ohio Department of Medicaid
Christine Raffaele	Supreme Court of Ohio
Melinda Sykes Haggerty	Ohio Attorney General's Office
Veronica Paulson	Ohio Attorney General's Office
Elizabeth Ranade-Janis	Office of Criminal Justice Services
Rick Frank	Ohio Hospital Association

* Subject Matter Experts

Endnotes

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