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# Medication-Assisted Treatment for Opioid Use Disorder in the Child Welfare Context: Challenges and Opportunities

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This brief describes four key challenges related to the use of medication-assisted treatment (MAT) in child welfare contexts for parents with opioid use disorder. It draws on results from a mixed methods study examining how substance use affects child welfare systems across the country. Key challenges discussed include the following:

- **Limited availability of appropriate treatment.** Quality treatment programs for parenting women are in short supply in many communities. In addition, limits on insurance coverage, including Medicaid coverage in some locations, often prevent sufficient treatment duration.
- **Misunderstanding of MAT.** MAT is not always well understood by stakeholders, who may encourage tapering of MAT prematurely and do not insist that medications be accompanied by necessary psychosocial and recovery support services, undermining clients' opportunities for success. Divergent understanding and views of MAT also mean that parents with opioid use disorder receive mixed messages about appropriate treatment, which may undermine referral and treatment engagement efforts.
- **Limited interaction between child welfare agencies and MAT providers.** The opioid crisis has prompted new entrants to the substance use disorder treatment community who are not familiar with child welfare agencies, are often unaccustomed to the needs of child welfare system clients, and may be resistant (even with appropriate client consent) to providing the feedback on parents' treatment progress needed for child welfare proceedings.
- **Need for alignment of systems and stakeholders with different perspectives and objectives.** Child welfare outcomes related to safety, permanency, and well-being depend on multiple stakeholders who may have different perspectives on MAT and different objectives regarding client outcomes.

The brief also describes opportunities to address each of the challenges described. Opportunities include new funding to expand MAT for opioid use disorder, funding soon to be available under the Family First Prevention Services Act that states may use to fund evidence-based treatment for substance use disorders to prevent children's entry into foster care, and additional steps that could enhance the availability of MAT and improve outcomes for children and families involved with the child welfare system in part because of parents' opioid use.

## INTRODUCTION

This brief is one of a series presenting findings of a mixed methods study describing how the current opioid epidemic, particularly parental opioid misuse, affects the child welfare system. This brief focuses on key challenges and opportunities related to implementation of medication-assisted treatment (MAT) for opioid use disorder in child welfare contexts. MAT is a treatment approach that practitioners have observed and researchers have documented to produce the best treatment outcomes for individuals with opioid use disorder (Connery, 2015). This brief describes four primary challenges that affect the use of MAT in child welfare contexts and identifies opportunities for communities to address these challenges through existing resources or approaches.

# HOW WE CONDUCTED THE STUDY

The research team conducted statistical analysis of nationally representative data regarding substance use and child welfare caseloads at the county level. The team also conducted over 180 interviews in 11 communities across the U.S. to understand the observations and experiences of child welfare administrators and practitioners, substance use treatment administrators and practitioners, judges and other legal professionals, law enforcement officials, and other service providers. For an overview of the findings of the study, see the brief *Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study*. For more information about the study's methods, see the brief *Substance Use, the Opioid Epidemic, and Child Welfare Caseloads: Methodological Details from a Mixed Methods Study*. All briefs from this study may be found at https://aspe.hhs.gov/child-welfare-and-substance-use.

Staff from Mathematica Policy Research collected and analyzed the qualitative data for the study under contract to ASPE.

This brief is largely based on the qualitative component of ASPE's mixed methods study. Readers should note that the qualitative component of this study was not nationally representative and was not designed to identify all the potential barriers and challenges related to implementing MAT for parents with opioid use disorder in child welfare contexts. It also may not reflect available services and stakeholder attitudes in every community. The sites included in the study were all ones that had experienced high levels of drug overdose deaths and drug-related emergency room visits and hospitalizations (including opioids and other illicit substances). The communities that were selected represent many regions of the country, are demographically diverse, and include a range of urban, suburban and rural counties.

# BACKGROUND

### Substance Use, Treatment, and Child Welfare

Parental substance use is a factor in many child welfare cases and has long been recognized as a significant barrier for reunification of parents and children (U.S. Department of Health and Human Services, 1999; Young and Gardner, 2002). The issue of parental substance use has received renewed attention in light of the current opioid epidemic. Another brief in this series found that counties with higher rates of drug overdose deaths and drug-related hospitalizations also had higher rates of child maltreatment reports and foster care placements.[1] Brook and colleagues (2010) found that children from families in which illicit drugs were being misused remained in foster care nearly twice as long before reunification than did children in families without drug involvement (median lengths of stay of 456 days and 245 days, respectively). Using qualitative methods, Jedwab and colleagues (2018) found a consensus among caseworkers that reunification was generally slower and more challenging in cases involving substance use than in cases without it. Caseworkers observed that cases in which substance abuse was a prominent factor required more time before reunification, a more gradual reunification process, and more post-reunification follow-up.

Parents who misuse substances may be inattentive or abusive to their children while intoxicated, may place children in unsafe situations, and may engage in a range of activities that place their children at risk. Children may accidentally ingest substances themselves, be exposed to toxic chemicals used in their production, and, in the case of opioids, may be born dependent on the substance and undergo withdrawal after birth. In addition, families involved with the child welfare system typically have a range of problems beyond a parent's inattention while under the influence of substances. Poor parenting skills, destructive family dynamics, and inadequate skills for coping with life's daily stresses, not to mention the setbacks to recovery that will inevitably occur, all must be addressed to ensure a safe and stable environment for children in

[1] See *The Relationship between Substance Use Indicators and Child Welfare Caseloads.*

the home of the recovering parent(s). These all must be accomplished while also addressing the parent's substance use and, for children in foster care, within the time frames prescribed by law for making permanency decisions.

Substance use disorder treatment has been successful in improving child welfare outcomes. Research has found that family reunification is more likely when parents complete substance use treatment (Choi et al., 2012; Grella et al., 2009). Two recent reviews of existing evidence found that treatment is more likely to lead to successful family reunification when comprehensive services that are matched to an individual's specific needs are provided and when recovery management and other social and family supports are integrated into the treatment plan (Huebner et al., 2017; Murphy et al., 2017).

Many studies linking treatment to child welfare outcomes focus on treatment for substance use disorders generally. To date, the research on the role of MAT in child welfare practice is limited. The use of MAT to treat opioid use disorder has been associated with better substance use outcomes, though more evidence is still needed to understand whether and how it improves child welfare outcomes such as family reunification. One study has examined the outcomes of MAT specifically with clients involved with the child welfare system. In a study of the Sobriety Treatment and Recovery Team model in Kentucky, Hall and colleagues (2016) found that clients with a history of opioid use who received a year of MAT increased the odds of retaining custody of their children by 120 percent, compared with those who did not receive MAT. However, fewer than 10 percent of opioid-using clients in the program received MAT, a factor the authors attribute largely to stigma against MAT.

### What Is Medication-Assisted Treatment?

MAT is an approach to the treatment of substance use disorders that combines the use of medications with counseling and behavioral therapies to address the range of psychosocial factors that contribute to the condition. While MAT can also be used to treat alcohol use disorder, this brief focuses on the use of MAT to treat opioid use disorder.

Research has documented that this combination of medication with counseling and recovery support is more effective than substance use treatment without medications in treating opioid use disorder. Available research evidence indicates that MAT improves treatment adherence, reduces the risk of overdose death, and reduces the risk of contracting associated infectious diseases, such as HIV and hepatitis B and C, among other outcomes (Connery, 2015).

#### Child Welfare Outcomes of Medication-Assisted Treatment

A program in Kentucky found that clients with a history of opioid use who received a year of MAT increased the odds of retaining custody of their children by 120 percent, compared with those who did not receive MAT (Hall et al., 2016).

Methadone, buprenorphine, and naltrexone are the three drugs approved by the Food and Drug Administration to treat opioid use disorder (see the box on page 2). Methadone may be provided only though opioid treatment programs that are regulated, certified, and accredited through the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services and the Drug Enforcement Administration. SAMHSA partners with private accrediting agencies to fulfill the accreditation function. Buprenorphine can be provided either by an opioid treatment program or by office-based providers, who may be primary care providers (physicians, nurse practitioners, and physician assistants) who have received training on the medication as well as a waiver issued by SAMHSA in coordination with the Drug Enforcement Administration. These waivers are called DATA waivers after the Drug Abuse Treatment Act of 2000, which permits qualified practitioners to treat opioid use disorder with

certain narcotic controlled substances that have been approved by the Food and Drug Administration for that purpose. Statutory and regulatory provisions limit the number of patients a provider can treat with buprenorphine. Naltrexone can be provided by any physician or health care provider who has the authority to issue prescriptions and who is operating within their scope of practice, without special certification or training. In addition to these drugs, naloxone is a medication that rapidly reverses opioid overdose. It is used to treat overdose but does not address the underlying substance use disorder.

Medications that block withdrawal symptoms, minimize cravings, and prevent euphoria address important physiological aspects of substance use disorders. But these disorders are not simply physical diseases. Important psychological aspects of the conditions must also be addressed through counseling, cognitive behavioral therapies, and other recovery support services in order for patients to successfully address their substance dependence. SAMHSA's guidance on MAT notes that "to achieve clinical stability and abstinence from illicit drug use, many patients need psychosocial counseling and support services beyond the medication itself…Counseling helps people with [opioid use disorder] change how they think, cope, react and acquire the skills and confidence needed for recovery."[2] By law and regulation, opioid treatment programs must provide counseling, and practitioners with DATA waivers must have the capacity to refer clients for counseling, which may include any of a number of types of behavioral therapy.[3] Research is limited, however, regarding which psychosocial interventions are most helpful to MAT patients (Dugosh et al., 2016).

For more information on MAT and for guidelines on how MAT can be used with pregnant women and parenting mothers, see the resources section of this brief. While pregnant women are not typically involved with the child welfare system unless the family has older children, child welfare agencies encounter many women shortly after the birth of a child, and a pregnant woman's use of either illicit drugs or the drugs used in MAT may trigger a child protective services report by the hospital where she delivers. For this reason, we include them in the discussion here. Both methadone and buprenorphine are safe for use by pregnant women and are considered the standard of care for pregnant women with opioid use disorder (SAMHSA, 2018a).

### Medication-Assisted Treatment Prescriptions

The Food and Drug Administration has approved three medications to treat opioid use disorder: methadone, buprenorphine, and naltrexone. Methadone and buprenorphine (which are themselves opioids) both reduce the patient's cravings and suppress symptoms of withdrawal, essentially by tricking the brain into thinking it is still getting the abused drug but without the euphoric effects of most commonly abused opioids. Naltrexone blocks the euphoria as well as other effects (including pain relief) by preventing the opioids from attaching to the opioid receptors in the brain. The result is that even if a person relapses and uses an opioid, its euphoric effects are limited, which may help motivate the patient to reengage in treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). The three medications are available under various trade names and formulations.

The next sections of this brief identify challenges associated with providing MAT in the context of child welfare practice that were identified in the qualitative component of our study and then outline opportunities for improvement suggested by study

[2] Treatment Improvement Protocol No. 63 (SAMHSA 2018b), pp. 3-83 and 4-4.

[3] Regulations on this topic are laid out in 42 CFR Part 8. Legal authority is at 21 USC 823 and 42 USC 290aa(d), 290bb-2a, 290dd-2, 300x-23, 300x-27(a), and 300y-11.

participants and identified through analysis of recent federal legislation.

# LIMITED AVAILABILITY OF APPROPRIATE TREATMENT

Our interviews revealed that one of the primary barriers to successful family reunification for parents with opioid use disorder was the availability of quality MAT.

***Challenge.*** **The availability of MAT varied, with most communities reporting limited capacity.** Most of the communities we visited had at least one MAT provider, usually an outpatient facility or medical practice that prescribed buprenorphine. However, few of these providers oriented their services in ways that were well suited to the child welfare clientele. For instance, most did not accept Medicaid in payment for office visits, no child care was available, and generally there was little effort to provide psychosocial services in conjunction with the medication. Most communities studied in this effort did not have an opioid treatment program that could dispense methadone, which was considered a significant gap by many of those interviewed, especially since methadone treatment is less expensive than buprenorphine.

Child welfare caseworkers often viewed the capacity of their local substance use disorder treatment providers as limited. In some of the communities hardest hit by the opioid epidemic, caseworkers told us that clients with opioid use disorder had to wait weeks before they could have an initial appointment and that the nearest methadone clinic (to which enrolled clients typically must report daily) was hours away. In addition, although MAT drugs were covered by state Medicaid programs in the sites we visited, physicians prescribing MAT in office settings often did not accept Medicaid for the required office visits, for which they typically charged $500 to $1,000 per month, an amount out of reach for most child welfare clients. Limitations on treatment duration and/or changes in clients' insurance coverage also may be factors in premature tapering of MAT drugs. Relatively few of the interviewees mentioned experiences with naltrexone, although professionals in one site noted some success with this drug among their child welfare clients.

The Substance Abuse Prevention and Treatment Block Grant requires that publicly supported treatment providers prioritize for treatment women with children, and persons who inject drugs. However, as an example of the shortages evident in areas heavily affected by opioid use disorder, caseworkers in one of the communities we visited said that treatment providers were unable to give their clients priority because nearly every treatment patient was a parent.

Our findings are generally consistent with existing research on the availability of MAT. In 2017, less than 4 percent of licensed physicians had approval to prescribe buprenorphine, and in 2016, approximately 47 percent of counties lacked a physician with a buprenorphine waiver (President's Commission, 2017). One study found that in 2012, clusters of counties in the Southeast had the largest gaps between opioid use disorder rates and capacity for treatment in opioid treatment programs accepting Medicaid (Abraham et al., 2018). Another study found significant gaps in treatment capacity in 2012 at the state and national levels (Jones et al., 2015). With respect to pregnant women specifically, a survey of obstetricians in the six states encompassing Appalachia found only three practices (6.3 percent) that prescribed methadone or buprenorphine (Miller et al., 2017). Most obstetricians in the region referred clients with opioid use disorder to just a few academic hospitals for treatment. Recognizing treatment shortages for patients with opioid use disorder, the Department of Health and Human Services recently expanded the patient limit for buprenorphine providers from a maximum of 100 patients to 275 patients as a strategy to expand treatment capacity.

Identifying reasons for treatment shortages was beyond the scope of this study. Other research has generally identified several key reasons for the limited availability of MAT. These reasons include financing and reimbursement barriers, regulatory issues, negative attitudes about MAT, and workforce challenges, including a shortage of physicians with waivers to prescribe buprenorphine (Hinde et al., 2017; SAMHSA–Health Resources and Services Administration, 2014). Windham (2018) found that 91 percent of individuals with an opioid use disorder diagnosis who were covered by employer-sponsored health insurance accessed

some substance use disorder treatment services in 2014-2015. However, only 51 percent had a claim for MAT, and most of these claims were related to buprenorphine prescriptions.

***Opportunity.*** **Support more outpatient providers in obtaining waivers to prescribe buprenorphine and combine MAT with recovery supports tailored to parents.** States and local communities can do much to support primary care and other outpatient providers in obtaining DATA waivers to prescribe buprenorphine. Providers should develop connections with existing mental health and substance use treatment providers that are able to provide the psychosocial supports needed by many families involved with or at risk of involvement with the child welfare system. A number of funding opportunities provided by agencies in the Department of Health and Human Services, particularly SAMHSA and the Health Resources and Services Administration, include efforts to increase the availability of MAT. In addition, child welfare agencies could partner with MAT providers to implement treatment services that address issues of child safety planning, improve parenting skills, and focus on issues related to managing family dynamics as part of recovery services and supports. At the federal and state levels, numerous efforts to address these barriers are underway, including grants to states to expand the availability of MAT, training for providers, and referral networks to assist patients in finding appropriate treatment.[4]

***Challenge*****. Limited availability of psychosocial supports and family-centered treatment.** Across all sites in our study, caseworkers described limited availability of the psychosocial supports and family-centered services for parents with opioid use disorder. Family-centered treatment includes services addressing family relationships and parenting roles, and may include family therapy, parenting interventions, child care, and developmental services for children. In the context of residential treatment programs, the term also refers to programs that allow children to reside with parents in treatment. According to our respondents, in child welfare settings, where parents are already facing substantial impediments to stability, these family-centered services aid in treatment engagement and retention and facilitate long-term behavioral change. Thus, they are critical to successful family reunification.

Particularly in rural areas we visited, but also in some cities distant from major metropolitan areas, caseworkers described shortages or even complete absence of mental health clinics and substance use disorder treatment providers. For example, in one rural community we visited, the only MAT provider within the county was a buprenorphine clinic. No professional mental health or counseling services were available. Caseworkers and judges lamented this deficiency and attributed low reunification rates in part to the lack of services to address aspects of substance use disorder beyond the physical dependence. Services to address parenting issues, adults' and children's trauma, and co-occurring mental health issues and domestic violence were among those mentioned as most relevant to these families involved with the child welfare system. While a few residential treatment programs addressed these issues, in this community most outpatient treatment programs, and particularly MAT providers, did not include these components.

These findings are consistent with other recent research that found a lack of support for small, non-specialist physicians prescribing buprenorphine (Hinde et al, 2017). Among the stakeholders interviewed in that study, physicians were resistant to prescribing MAT because they could not provide the additional support services needed or didn't know where to refer patients for such services.

Despite the recognized need to provide these services, respondents viewed the implementation of MAT as uneven in their communities and noted that services addressing the psychosocial aspects of addiction were often lacking. According to many caseworkers, court professionals, and public health workers we spoke with, these services are particularly important to parenting women, for whom recovery needs to include establishing a safe environment for their children as well as abstaining

[4] A summary of SAMHSA's efforts to expand access to MAT for opioid use disorder may be found at https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/state-grant-programs.

from substance use. We were told that substance use disorder treatment programs may not be able to engage and retain patients whose entry is motivated by parenting concerns unless the programs actively address parenting issues. While each of the communities participating in our study had at least one family-centered program in its service area, these programs were primarily small residential treatment programs with very limited patient capacity. Furthermore, some of these programs prohibited admission of clients using methadone or buprenorphine. None of the communities we visited identified a MAT program with a focus on family counseling and supports.

In addition, while MAT is the standard of care for pregnant women with opioid use disorder (American College of Obstetricians and Gynecologists, 2017), respondents reported that few MAT providers in their communities accept pregnant patients. An analysis of national treatment data showed that fewer than half of pregnant patients with opioid use disorder who were admitted to treatment received MAT, a figure that declined between 1992 and 2012 (MacAfee et al., 2017).

***Opportunity.*** **Support treatment options for pregnant women and parents with opioid use disorder.** Increasing the availability of treatment options for parents and pregnant women with opioid use disorder is essential to mitigating the risk of maltreatment and improving child welfare outcomes. A range of guidance is available regarding preferred content of treatment programs focusing on women and parents (e.g., SAMHSA, 2018a; SAMHSA, 2016; SAMHSA, 2015). For instance, SAMHSA has outlined a continuum of family-based services, with the most advanced type being "family-centered treatment," in which each family member has a treatment plan and receives individual and family services (SAMHSA, 2015). Detail about making opioid use disorder treatment programs family centered may be found in documents listed in the resources section of this document.

By law, pregnant and parenting women are a priority population of SAMHSA's Substance Abuse Prevention and Treatment Block Grant. States must require and advertise a treatment admissions preference for pregnant women in programs funded by this grant. A range of grant announcements for increased treatment funds could be used by state and local governments to target services for these women. As states identify priority populations under MAT expansion grants, states could specify (but as yet generally have not specified) parents generally, parents involved with the child welfare system, and/or pregnant women as priority populations. Doing so could ensure timely treatment opportunities when parents come to the attention of the child welfare system.

***Opportunity.*** **Implement optional prevention components of the Family First Prevention Services Act (FFPSA).** The FFPSA (Division E, Title VII, of Public Law 115-123) permits states, beginning in 2019, to add certain service components to their state title IV-E foster care and permanency plans in order to prevent the need for out-of-home care. These components include evidence-based services to treat parents' substance use disorders and/or mental health conditions and in-home, skill-based parenting programs. Services in the plan may be delivered to children that the state determines are at risk of out-of-home placement, as well as their parents, for up to 12 months. Half of the costs will be covered by the federal program. States choosing to provide prevention services under title IV-E will need to become informed purchasers of substance use prevention and treatment services for their clients. The program's introduction provides an opportunity to help child welfare agency directors and staff understand what they should seek in services for clients in order to maximize their opportunities for recovery. For example, paying substance use disorder treatment providers for their time to participate in child welfare team meetings and providing feedback to the child welfare agency and court on parents' progress in treatment would likely improve the quality of collaboration. In addition, child welfare agencies could insist that treatment they pay for include family oriented components such as family counseling and/or therapy groups for older youth.

# MISUNDERSTANDING OF MEDICATION-ASSISTED TREATMENT

Views regarding MAT varied widely both between sites and among professionals within a site. In most sites MAT had gained acceptance in recent years, though some professionals in several sites expressed reservations regarding its potential role in helping clients achieve abstinence and recovery and be able to safely care for their children. In some sites, professionals serving families differed substantially in their understanding of the role of MAT. While this study did not interview health care providers, the attitudes and practices of obstetricians regarding MAT for pregnant women with opioid use disorder is an additional component of the situation.

### Duration of Medication-Assisted Treatment

"The longer patients take medication, the less likely they are to return to opioid use…There is no known duration of therapy with buprenorphine (or methadone or naltrexone) after which patients can stop medication and be certain not to return to illicit opioid use. Those who stay in treatment often abstain longer from illicit opioid use and show increasing clinical stability. Long-term treatment outcomes up to 8 years after buprenorphine treatment entry show lower illicit opioid use among those with more time on medication" (SAMHSA 2018b).

***Challenge.*** **Medication-assisted treatment is not always well understood by child welfare stakeholders, which can limit parents' recovery options and lower the likelihood of family reunification.** Interviews in communities around the country hard hit by the opioid crisis revealed that many child welfare and related professionals do not have a clear understanding of the practice of MAT. Some stakeholders did not understand that MAT is a well-studied, effective, evidence-based treatment that significantly improves treatment outcomes. A number of respondents did not understand important aspects of MAT, including how long individuals with opioid use disorder were likely to continue on medications or what other psychosocial supports are needed for MAT to be effective in clients with significant impairment and complex needs. They often did not understand that MAT is recommended for pregnant women with opioid use disorder and is considered the best option for healthy fetal development, despite the risk of neonatal abstinence syndrome.

A number of interviewees—including some of those who were supportive of MAT—expected that MAT patients would rapidly be stepped down from buprenorphine or methadone and be completely off medication before reunification. While this approach may be feasible in some cases, these expectations are not realistic for most parents with children in the child welfare system. SAMHSA guidance suggests that the duration of patients' MAT needs may range from under 12 months to years, or even a lifetime, depending on the individual circumstances (SAMHSA, 2018b). Recovery timelines are typically much longer than the timelines within which children in foster care must be placed in a permanent, stable household.

MAT is often viewed by child welfare and court professionals as simply medication without other psychosocial interventions or recovery supports. These views are reinforced by the fact that in many communities MAT is provided solely as medication. Many professionals we interviewed perceived that MAT was simply one of the three available medications, rather than a comprehensive program including behavioral therapies and recovery supports in addition to medication.

While some clients with opioid use disorder may be stabilized with medications alone, the parents involved with the child welfare system typically have a range of interrelated problems for which counseling and recovery supports are essential. Caseworkers we interviewed emphasized that families with child welfare involvement often have numerous other psychological conditions, making

their treatment and recovery pathways more complicated. Research shows that individuals with opioid use disorder are likely to have other substance use disorders and co-occurring mental health issues (Jarlenski et al., 2017; Martins et al., 2012; Wu et al., 2011; Grella et al., 2009). Research has also found that women with serious mental illness are more likely than women without a mental illness to lose custody of their children, with one study finding them four times more likely to lose custody (Park et al., 2006). These findings suggest that for a large portion of parents with child welfare involvement who have opioid use disorder, receiving buprenorphine, methadone, or naltrexone alone will not be enough to treat their addiction or keep their children safe.

***Opportunity.*** **Forge consensus among stakeholders about how to incorporate MAT into child welfare case plans.** While education on MAT can be targeted to specific stakeholder groups, it is also important for different stakeholders in the same community to come to a consensus on the benefits of MAT and how it should be implemented for parents involved in the child welfare system in their jurisdiction or region. These stakeholders may include child welfare agency administrators and staff, judges and court personnel, attorneys working on behalf of various parties to child welfare cases, and court appointed special advocates. When caseworkers and courts understand the scope of appropriate MAT for their clients, they are better able to advocate for appropriate services as well as monitor participation and measure progress. They can assure that parents receive not only a buprenorphine prescription but also an appropriately designed case plan with therapies and services that provide real opportunities to reunite safely with their children. In one community we visited, caseworkers, judges, prosecutors, treatment providers, and clinicians in the local hospital had developed a common understanding about MAT and often consulted on cases. Interviewees reported that conflicts among agencies about clients' care had been reduced as a result.

Family treatment courts are one promising model for incorporating MAT and were highly regarded in the communities we visited for their constructive, collaborative approach. Several of the communities we visited had established family treatment courts which "provide children and parents with the skills and services necessary to live productively and establish a safe environment for their families." (National Drug Court Institute, 2018). To do so, these courts partner with the child welfare agency and service providers to manage cases of abuse or neglect and to link families with service providers. In the communities participating in our study, family treatment courts were known for helping clients to succeed rather than watching them fail.

Even where family treatment courts had not been established, some family court judges had informally taken this more therapeutic approach and believed that the success rate had improved. Some communities have used grants under the Administration for Children and Families' Regional Partnership Grant Program and the family treatment court grants administered by the Department of Justice's Office of Juvenile Justice and Delinquency Prevention to develop collaborative approaches involving a range of partners. Drug-endangered children's coalitions and perinatal quality collaboratives are other possible venues for such activities.

### Benefits of Family-Centered Treatment with Support Services for Child Welfare Clients

"These services make what should happen so much more clear to everybody. They give the parent the best shot and they protect the kid the most…If [parents can't succeed] with this, we're going to have to go to termination [of parental rights], but if you go to termination with this case, everybody involved, every legal party in the case, knows that this parent had the absolute best shot to get into recovery…and if they can't do it with [these services], [the child] probably shouldn't go home…for right now this is not going to work."

–Local Child Welfare Director

***Challenge.*** **Some stakeholders did not perceive MAT as a legitimate form of therapy for opioid use disorder.** A number of stakeholders interviewed during this study viewed the use of methadone or buprenorphine as another form of addiction. For example, one child welfare caseworker stated that he would prefer to have clients "completely sober" and not on any MAT prescription. Other caseworkers and judges believed that, through MAT, clients were simply substituting one drug of abuse for another and made no distinction between a client stabilized on MAT and one using illicit substances. In their experience, buprenorphine was often used alongside other substances whose effects it does not inhibit, such as methamphetamine or benzodiazepines. Some viewed buprenorphine as a primary drug of abuse, little better than heroin or prescription opioids, even when used as directed and without misuse of other substances.

These respondents also perceived that buprenorphine was regularly diverted and used by individuals without prescriptions, which may be a common perception among buprenorphine prescribers as well (Lin et al., 2018). Studies have found relatively high rates of such diversion (Li et al., 2016; Kenney et al., 2017). However, while buprenorphine does have abuse potential (Li et al., 2016), as a partial opioid agonist it provides limited euphoric effects, particularly relative to the effects of other regularly misused opioids. Research suggests that some users of diverted buprenorphine, rather than using it to get high, do so to ease withdrawal symptoms until their preferred drug can be obtained, while others use it to treat their opioid use disorder themselves without visiting a treatment provider (Daniulaityte et al., 2015; Li et al., 2016; Walker et al., 2018).

For children in foster care, the judge is the ultimate arbiter of custody and decides whether improvements in parents' parenting behaviors are sufficient to ensure child safety. Judges are not uniform in their understanding or support of MAT. Indeed, a 2013 national survey of drug courts found that nearly half had policies prohibiting the use of MAT (Matusow et al., 2013). The increased awareness of MAT's effectiveness and targeted communication efforts likely have more recently led to a greater acceptance of MAT in many courtrooms. Most of the judges we spoke with were supportive of MAT. However, in some communities, child welfare caseworkers and substance abuse counselors reported working closely to successfully stabilize parents on MAT regimens, only to have judges deny reunification because the parents remained on MAT. Similarly, patients following their obstetricians' guidance in taking buprenorphine or methadone may then have their infant placed in foster care because the baby tests positive for the prescribed drug and/or displays symptoms of withdrawal, even if the parent has been compliant with the treatment regimen and appears committed to recovery.

### Communication Challenges

"There's been a long history where …physicians or methadone clinics [in our community] won't cooperate with child welfare or the courts. They won't provide any reports, or records, or [drug test results], or just oversight" to indicate whether the client is compliant.

–Substance use treatment administrator

These divergent opinions among professionals frequently pulled families in opposite directions, making it impossible for them to comply with conflicting directives as they tried to establish and maintain recovery and reunite with children in foster care.

While reservations about MAT were not uncommon in the sites included in our study, nearly all the communities also had professionals who asserted that MAT represents the best chance for parents with opioid use disorder to make meaningful changes in their lives and reunite with their children in foster care. For example, in one community, child welfare caseworkers emphatically stated that they had only seen successful reunification in cases involving opioid use disorder when parents were engaged in MAT. In another community, judges expressed support of MAT as part of a comprehensive treatment plan.

***Opportunity.*** **Target education and messaging about MAT to courts and child welfare caseworkers.** Messages about MAT should consistently convey that MAT includes not just medication but a program of counseling and recovery supports. Educational efforts can help to encourage common expectations about the provision of MAT and outcomes from it, and can clarify research evidence for providers. Such messaging should be incorporated particularly into efforts to educate practitioners within the substance use treatment field and allied professionals working with clients who have substance use disorders. At the federal level, SAMHSA has some efforts underway along these lines, including a new Treatment Improvement Protocol (No. 63) on medications for treating opioid use disorder (SAMHSA, 2018b) as well as guidance on best practices in treating opioid use disorders during pregnancy (SAMHSA, 2018a). For additional guidance, see the resources section of this brief.

## LIMITED INTERACTION BETWEEN CHILD WELFARE AGENCIES AND MEDICATION-ASSISTED TREATMENT PROVIDERS

Communication between substance use treatment providers, on the one hand, and child welfare caseworkers and courts, on the other, was generally recognized as essential to successful family reunification. However, many individuals we interviewed emphasized difficulties in collaborating across these silos. Observers and practitioners have long recognized challenges in establishing effective communication between child welfare agencies, courts, and substance use disorder treatment providers (U.S. Department of Health and Human Services, 1999; Young and Gardner, 2002). However, the opioid epidemic and efforts to expand the availability of MAT have changed the landscape of recovery services in many communities. New treatment providers have entered the field, necessitating renewed efforts to ensure collaboration between child welfare and substance use disorder professionals.

Federal regulations regarding the confidentiality of substance use disorder treatment[5] are often discussed as a barrier to cooperation, particularly when agencies are unaccustomed to collaborating within the structure of these regulations. As ongoing working relationships are established, however, most providers find that establishing procedures for obtaining clients' consent at intake for information sharing is feasible. Clients working toward reunification typically want information on treatment progress shared with child welfare staff and readily provide consent. Should consent later be revoked, in the absence of shared information, child welfare staff typically will assume treatment noncompliance. Problems may still arise, however, if substance use disorder treatment providers do not establish consent or if they use confidentiality rules as an excuse not to make the effort to communicate when consent has been established.

***Challenge.*** **Many MAT providers did not have experience working with child welfare agencies or courts.** Buprenorphine providers in the communities we visited were typically private-practice physicians with relatively little experience in substance use disorder treatment, particularly for low-income women with child welfare involvement. According to caseworkers and court professionals, these clinics did not often cooperate with child welfare agencies and courts in monitoring clients' progress in treatment. These programs were problematic because the child welfare and court professionals could not rely on the treatment provider for the reliable input about the parents' recovery status that they needed for decision-making. Some reasons for the lack of collaboration given in interviews were concerns over patient privacy, frustration with the volume and frequency of reporting requested by the child welfare agency, and differing perspectives on service objectives.

[5] Federal regulations regarding confidentiality of substance use disorder treatment patient records may be found at 42 CFR Part 2. SAMHSA resources regarding these confidentiality regulations are at https://www.samhsa.gov/health-information-technology/laws-regulations-guidelines.

***Opportunity.*** **As child welfare agencies increasingly become purchasers of substance use disorder treatment, they may demand feedback and accountability.** In contrast with the situation during previous drug epidemics, child welfare agencies participating in this study more frequently reported paying for clients' substance use disorder treatment out of child welfare agency budgets. Even more was paid for by states' Medicaid programs. As states begin implementing the FFPSA, still more child welfare agencies are likely to get involved in purchasing substance use disorder treatment services, and more will collaborate with Medicaid to coordinate which agency pays for which services. As the payer, state child welfare agencies could more thoughtfully require reasonable feedback on client engagement, treatment participation, progress, and prognosis. Such feedback would provide better information to inform child welfare decisions. In addition, recent changes to the federal child welfare programs authorized along with the FFPSA will, beginning in October 2018, permit child welfare agencies to pay the room and board costs of children residing with their parents in residential substance use disorder treatment programs, with partial federal reimbursement for those costs.[6] This change, too, has the potential to give child welfare agencies a larger role in shaping substance use disorder treatment programs used by families involved with their agencies.

***Challenge.*** **Treatment providers did not always have the same objectives as the child welfare system.** In some of the communities we visited, interview participants pointed to differing objectives as a key reason for a lack of collaboration between substance use treatment providers and the child welfare system. Treatment providers often focus exclusively on recovery goals for their patients (i.e., parents), whereas child welfare caseworkers and courts focus on child safety and family stability. These goals are not always in conflict: some treatment providers found the child welfare agency and family court helpful in motivating clients to engage in and stick with treatment. One substance use disorder treatment provider said, "[The child welfare agency] is like the muscle and sometimes that's how we will refer to them…if you need [a client] to do something and you can't just motivate them on your own…this is what you need…[the agency] can sometimes be that push because there's more to lose." A treatment provider in another state estimated that the treatment completion rates for clients with child welfare involvement were much higher than those of other clients, largely because the desire to reunite with their children was a strong motivator.

**Benefits of Communication**

"[The child welfare agency] is like the muscle and sometimes that's how we will refer to them…if you need [a client] to do something and you can't just motivate them on your own…this is what you need…[the agency] can sometimes be that push because there's more to lose."

–Substance use treatment provider

On the other hand, some respondents described conflicts arising because of the different missions. One treatment provider noted, "I don't want to be known [within the substance use disorder treatment agency] as the person you don't want to work with…because she's going to help them take your kids away…so the more I can stay out of [communicating with the child welfare agency], the better off I am at helping people find recovery." Other substance use disorder treatment providers complained about child welfare timelines being too short and arbitrary and felt that collaboration with the child welfare agency was too labor intensive, with frequent progress reports, joint staffings, and court appearances taking hours—time that was generally not billable to Medicaid, private insurance, or other health care financing streams that fund their agencies.

***Opportunity.*** **Tools are available to identify sources of conflict and build positive working relationships.** The National Center on Substance Abuse and Child Welfare, cosponsored by SAMHSA and the Administration for Children and

[6] 42 USC 672.

Families, makes a range of tools and training available to facilitate collaboration among service systems and courts working to serve families with substance use disorders. These resources include free online cross-training for child welfare, substance use disorder treatment, and court staff; tools to assist agencies in building collaborative practice across disciplines; and tools for developing cross-agency performance measures. Individualized technical assistance is also available to communities.

***Challenge.*** **Limited collaboration with treatment providers hindered child welfare caseworkers' and courts' understanding of how to work with parents with opioid use disorder.** Child welfare caseworkers and court professionals in many places lacked information about treatment outcomes, guidance on what to expect from clients' participation in MAT programs, and insight on how to differentiate appropriate progress from failure, for instance in responding to relapse. Child welfare caseworkers frequently perceived MAT providers as unconcerned with family outcomes. Without relevant information and training, these caseworkers tended to fall back on gut feelings or familiar rubrics for success that were not always a good fit for clients in MAT programs. Conversely, MAT providers were not familiar with child welfare services, often had little or no contact with clients' children, and did not always see clients' children or parenting issues as especially relevant to clients' recovery.

***Opportunity.*** **Formalize collaboration across disciplines to improve both the likelihood of recovery and family stability.** Some of the communities we visited developed a shared approach to case coordination, holding cross-disciplinary meetings including treatment professionals and child welfare caseworkers. In these settings, treatment providers involved child welfare staff in treatment planning and provided regular updates. In other sites, treatment providers were invited to participate in family team meetings, during which families could create plans for safe care of their children and engage recovery supports to move toward stable sobriety. Though it was not common in the communities included in the study, cross-training between child welfare and substance use treatment staff is another strategy some communities have used effectively to improve understanding and working relationships across disciplines. Multidisciplinary training that satisfies the continuing education requirements across the range of professionals who work with these families in child welfare, SUD treatment agencies and the courts could help bridge the divide and improve agencies' abilities to understand each other's perspectives.

## ALIGNING SYSTEMS AND STAKEHOLDERS WITH DIFFERENT PERSPECTIVES AND OBJECTIVES

For many individuals with opioid use disorder, the success of MAT depends on decisions made by that individual and the treatment provider. However, for parents involved in the child welfare system, a multitude of actors are involved in child welfare decision-making processes, all with different roles, perspectives, and expertise. The previous section touched on collaboration with substance use treatment providers, but child welfare decisions involve other actors as well.

***Challenge.*** **Positive outcomes in child welfare depend on multiple stakeholders from different fields.** These stakeholders can include child welfare caseworkers and administrators, judges and court personnel, substance use treatment professionals, law enforcement officials, public health workers, and, of course, parents and children themselves. As described above, not all stakeholders have common understandings and perceptions of MAT. The clinical opinion of the treatment provider is just one of many views that inform decisions. The perspectives of other stakeholders without clinical experience have a great deal of influence over case determinations.

In addition, the different stakeholders' timelines and expectations are not always aligned. This misalignment has been a problem for substance use treatment, child welfare services, and the courts for decades (Young et al., 1998), and the emphasis on MAT has only made the situation more complex. It has long been observed that judicial decisions on child custody and reunification do not necessarily

closely follow measures of treatment success (Gregoire and Shultz, 2001). For example, courts are restricted by the statutory timelines for a stable, safe home for children required by the Adoption and Safe Families Act of 1997.[7] Substance use disorder treatment providers develop their own plans for treatment and recovery with patients, which may not take into consideration the milestones in the parent's child welfare case plans. In addition, treatment providers may have limited patient capacity and long wait lists, causing a parent's treatment to be delayed. Parents with opioid use disorder may not be willing to engage in MAT immediately, and when they are, a treatment provider may not have an opening available. And children themselves live according to a developmental timeline that puts pressure on all parties to quickly ensure safe and stable caregiving relationships.

Another complicating factor is the role of health insurance providers, particularly Medicaid. Insurance providers and state Medicaid plans differ in how they cover MAT. Some state Medicaid plans do not cover all three MAT drugs. Some require prior approval before entrance into certain types of treatment— particularly residential or other family-centered settings. Medicaid plans also differ in terms of how long they will cover treatment, and coverage is often not long enough to ensure stability and recovery. Historically, Medicaid coverage of residential substance use disorder treatment has been limited. The Centers for Medicare & Medicaid Services has recently issued guidance to allow states to request waivers to allow the use of Medicaid funds to provide a broader scope of substance use treatment services, including short-term inpatient and residential treatment.

If health coverage issues delay parents' treatment admission, shorten the length of stay in treatment, or limit the types of treatment they may undertake, parents may be at increased risk of not being able to provide a safe and stable environment for their children within the child welfare timelines. For instance, participants in one of the sites we visited noted that the state's Medicaid plan covered certain treatment modalities for only 30 days, even though a 90-day treatment duration is considered the minimum necessary for treatment to be effective (National Institute on Drug Abuse, 2018).

***Opportunity.*** **Develop cross-agency communication protocols and shared performance measures.** Collaborative practice involves more than general consideration of common goals and promises to work together. Efforts must be backed by specific actions and procedures to reinforce leadership expectations and document progress. Specific communication protocols make it clear to staff when and how information is to be exchanged. In mature partnerships, joint performance measures allow for progress to be assessed and hold both agencies accountable for improving client outcomes. The National Center on Substance Abuse and Child Welfare provides information resources and technical assistance to communities that seek to develop their collaborations to this level.

***Challenge.*** **Agencies and courts must consider a range of factors beyond substance use and progress toward recovery in making decisions.** When caseworkers and courts make recommendations and decisions that affect families and children, they must take a number of factors into consideration. How a parent is progressing on the path to recovery is just one of those factors. Though child safety is closely related to parental recovery from substance use disorder, recovery on its own may not be sufficient to ensure a safe home. For instance, parents complying with treatment may still have difficulty meeting children's basic needs, may exercise poor judgment by leaving children with inappropriate caregivers, or may use harsh disciplinary practices that leave children at risk even in the absence of active substance use. Any of these could appropriately lead to a negative reunification decision despite progress toward recovery goals.

***Opportunity.*** **Identify effective MAT approaches in the child welfare context.** While the research evidence on MAT is robust, only one study to date has specifically examined the use of MAT with child welfare clients (Hall et al., 2016). That study found that MAT treatment improved the likelihood that program participants retained custody of their

[7] Public Law 105-89.

children. However, few parents in the study who had a history of opioid misuse received MAT, illustrating its limited reach. We need to understand better the extent to which MAT can be effective in enabling family reunification, reducing the incidence of child maltreatment or repeated maltreatment, and achieving other child welfare outcomes. We also need to know more about what additional services may be needed for MAT to be successful for different types of families and in different contexts.

***Challenge.*** **Caseworkers and courts do not consistently know how to assess when a client on MAT is stable and can safely reunite with children.** In the communities we visited, caseworkers and court professionals generally lacked an understanding of the long-term expectations for MAT patients and a framework for thinking about and measuring recovery. While treatment providers have milestones for patient treatment and recovery, treatment does not always follow fixed steps or timeframes. Patients undergoing MAT do not necessarily follow a linear path to recovery, and they can encounter setbacks that require returning to an earlier treatment phase. This fluidity in treatment—not unique to MAT—presents challenges for caseworkers and judges because they must make decisions on family reunification on a relatively strict timeline.

Many of the caseworkers and judges we spoke with expressed frustration with the uncertainty regarding how long parents must be in treatment, the point at which they would be stable enough to care for their children, and the risk of relapse. Misunderstanding of the duration of MAT is a significant factor in this frustration. However, our informants often described having little or no communication with treatment providers as to parents' status in treatment and having to rely on the parents themselves, who were considered unreliable informants in the absence of outside corroboration.

Even when they were able to communicate with treatment providers, agencies encountered problems including misunderstanding, lack of common frameworks for judging progress, and lack of financial support for the time and effort involved in collaboration and interagency communication. Because substance use disorder treatment providers did not receive payment for their time spent reporting progress to child welfare agencies, such reporting was a low-priority activity. In addition, when child welfare agencies and courts were accustomed to thinking about treatment success in terms of days, weeks, or months of abstention, they lacked guidance on how to translate reliance on MAT drugs into a measure of success.

Because of the diverging opinions of stakeholders involved in child welfare decisions, as well as the complexity of case determinations, the situation on the ground may be frustrating, confusing, and contradictory for both clients and service providers. Many caseworkers explained to us that without a clear road map to recovery and reunification, parents were left without a path forward, and cases increasingly ended with voluntary relinquishment or termination of parental rights.

***Opportunity.*** **Provide guidance on recovery metrics.** Agencies working in child welfare need better information on how to assess clients' progress toward recovery. This need was particularly an issue with MAT because the meaning and measure of abstinence was less clear to child welfare staff in this context than in the context of other treatment regimens with which they were more familiar. The lack of feedback from some MAT providers on treatment adherence exacerbated child welfare practitioners' frustration on this issue. Child welfare agencies and judges need straightforward ways of assessing and expressing clients' progress in treatment and its relationship to safety and reunification.

# CONCLUSION

The medication component of MAT prevents withdrawal without producing the euphoria or "high" associated with most other opioids. In doing so, it can provide the opportunity for effective recovery. However, families involved with the child welfare system typically have a range of problems beyond a parent's inattention while under the influence of substances. Poor parenting skills, destructive family dynamics, and inadequate skills for coping with life's daily stresses and the setbacks to recovery that will inevitably occur all must be addressed to ensure a safe and stable environment for children in the home of the recovering parent(s). Professionals who work with families in the child

welfare system need more information about MAT and its role in recovery from opioid use disorder. They also need to engage with MAT providers to make sure that clients receive appropriate recovery supports to maximize their chances of overcoming addiction and providing a safe and stable home in which their children can thrive.

## SELECT RESOURCES ON MEDICATION-ASSISTED TREATMENT AND FAMILY-CENTERED TREATMENT

*Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series No. 63*. Substance Abuse and Mental Health Services Administration (2018). HHS Publication No. (SMA) 18-5063. https://store.samhsa.gov/product/SMA18-5063FULLDOC

> This Treatment Improvement Protocol reviews the use of the three Food and Drug Administration–approved medications used to treat opioid use disorder—methadone, naltrexone, and buprenorphine—and the other strategies and services needed to support recovery for people with opioid use disorder.

*Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants*. Substance Abuse and Mental Health Services Administration (2018). HHS Publication No. (SMA) 18-5054. https://store.samhsa.gov/product/SMA18-5054

> This clinical guide provides comprehensive, national guidance for optimal management of pregnant and parenting women with opioid use disorder and their infants. The clinical guide helps health care professionals and patients determine the most clinically appropriate action for a particular situation and informs individualized treatment decisions.

*A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers*. National Center on Substance Abuse and Child Welfare (2016). HHS Publication No. (SMA) 16-4978. https://store.samhsa.gov/product/A-Collaborative-Approach-to-the-Treatment-of-Pregnant-Women-with-Opioid-Use-Disorders/SMA16-4978

> This guide promotes collaborative efforts among agencies and providers serving pregnant and postpartum women with opioid dependence and their infants. It presents a coordinated, multi-systemic approach grounded in early identification and intervention to assist child welfare professionals, medical professionals, substance use treatment providers, and other service providers to develop approaches to support families.

*Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR)*. Young, NK, Nakashian, M, Yeh, S, and Amatetti, S (2006). Department of Health and Human Services Pub. No. 0000. Substance Abuse and Mental Health Services Administration. https://ncsacw.samhsa.gov/resources/SAFERR.aspx

> This guide describes a collaborative model to help child welfare, substance abuse treatment, and family court professionals make better informed decisions when determining outcomes for children and families affected by substance use disorders. It provides strategies to help improve connections, communications, and collaborative capacities across systems. The guide includes information about confidentiality issues in substance use disorder treatment and establishment of consent for information sharing.

*Family-Centered Treatment for Women with Substance Use Disorders: History, Key Elements and Challenges*. Werner, D, Young, NK, Dennis, K, and Amatetti, S (2007). Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf

> This briefing paper looks at the role of family in the context of treatment for women with substance use disorders. First, a continuum of family-based services is presented. This continuum offers a framework for defining and

discussing different ways of approaching family involvement in treatment services. The remainder of the paper explores a comprehensive model of family-centered treatment, including key principles, components, modalities of delivery, and challenges to establishing and operating family-centered treatment programs.

*Family Treatment Court Planning Guide*. National Drug Court Institute (2018). https://www.ndci.org/wp-content/uploads/2018/03/18803_NDCI_Planning_v7.pdf

This guide, assembled by the national association that represents drug courts and a knowledgeable technical assistance provider, provides practical advice to communities about where to start and what steps to take in planning and implementing a family treatment court. Text and worksheets address a wide range of topics that include making the case for such a court in your community, developing planning, steering and operational teams, long term strategic planning, services planning, policies for program eligibility and responding to a range of client behaviors, and securing necessary resources.

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