Planning for Safe Care:
What Your Family Drug Court Needs to Know about Serving
Pregnant Women with Opioid Use Disorders and Their Infants

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Director

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Strengthening Partnerships

Improving Family Outcomes

An Initiative Funded by the

Substance Abuse and Mental Health Services Administration (SAMHSA)

and the

Administration for Children, Youth and Families (ACYF), Children’s Bureau

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ncsacw@cffutures.org
The Office of Juvenile Justice and Delinquency Prevention Office of Justice Programs (2016-DC-BX-K003)

Points of view or opinions expressed in this presentation are those of the presenter(s) and do not necessarily represent the official position or policies of OJJDP or the U.S. Department of Justice.
Learning Objectives

- Understand best practices in the treatment of
  - Opioid use disorders for parenting and pregnant women
  - Infants prenatally exposed to opioids

- Learn how the Child Abuse and Prevention Treatment Act (CAPTA) provisions on prenatally substance exposure can improve outcomes for families
I. Some Data: Scope of the Issue
II. Windows of Opportunity
   ▪ Child Abuse and Prevention Treatment Act (CAPTA), Substance-Exposed Infants Provisions
III. Family Drug Court: Stage for Transformation
   ▪ Adult Drug Court Family-Centered Approach Case Studies
   ▪ Expanding the FDC Partnership
IV. Resources
V. Discussion
Drugs of the Decades
Age-Adjusted Rates of Death Related to Prescription Opioids and Heroin Drug Poisoning in the United States, 2000–2014*

*Data from Centers for Disease Control and Prevention 2015

Highest risk after a period of abstinence, inpatient treatment or incarceration
Number of Children in Out of Home Care 2000-2015

Parental Alcohol or Other Drug Use as a Contributing Factor for Reason for Removal in the United States, 2000 to 2015

Note: Estimates based on all children in out of home care at some point during Fiscal Year

Source: AFCARS Data, 2000-2015
Parental Alcohol or Drug Use as a Contributing Factor for Reason for Removal by State, 2015

National Average: 34.4%

Note: Estimates based on all children in out of home care at some point during Fiscal Year

Source: AFCARS Data, 2015
Age of Children who Entered Out of Home Care by Age, 2015

Note: Estimates based on all children who entered out of home care during Fiscal Year
Source: AFCARS Data, 2015
### Estimated Number of Infants* Affected by Prenatal Exposure, by Type of Substance and Infant Disorder

<table>
<thead>
<tr>
<th>Substance</th>
<th>Affected Infants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>600,000</td>
<td>15%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>360,000</td>
<td>9%</td>
</tr>
<tr>
<td>Illicit Drugs</td>
<td>200,000</td>
<td>5%</td>
</tr>
<tr>
<td>Binge Drinking</td>
<td>80,000</td>
<td>2%</td>
</tr>
<tr>
<td>Heavy Drinking</td>
<td>16,000</td>
<td>0.4%</td>
</tr>
<tr>
<td>NAS</td>
<td>24,000</td>
<td>(6 per 1,000 births)</td>
</tr>
<tr>
<td>FASD</td>
<td>28,000</td>
<td>(.2-7 per 1,000 births)</td>
</tr>
</tbody>
</table>


From Medicaid data, the mean length of stay for infants with NAS was 16.4 days at an average cost of $53,000.

Rate of Neonatal Abstinence Syndrome Over Time

*2013 Data in 28 States from the Center for Disease Control publicly available data in Health Care and in 28 states

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4520760/
Children Under Age 1 Entering Foster Care, 2013

Children Under 1 Entering Foster Care Rate per 1000 Children in Region

- 8.0 - 10.0
- 10.1 - 12.0
- 12.1 - 14.0
- 14.1 - 16.0

Source: AFCARS Data, 2013
**Neonatal Abstinence Syndrome**

An expected and **treatable condition** that follows prenatal exposure to opioids.

Symptoms begin within 1-3 days after birth, or may take 5-10 days to appear and include:

- Blotchy skin; difficulty with sleeping and eating; trembling, irritability and difficult to soothe; diarrhea; slow weight gain; sweating; hyperactive reflexes; increased muscle tone.

Timing of onset is related to characteristics of drug used by mother and time of last dose.

Most opioid exposed babies are exposed to multiple substances.


Neonatal Abstinence Syndrome: Treatment

Non-Pharmacological Treatment
- Swaddling
- Breastfeeding
- Calm, low-stimulus environment
- Rooming with mother

Pharmacological Treatment
- Individualized based on severity of symptoms
- Standardized scoring tool to measure severity of symptoms

Assessment of risks and benefits

The concurrent goal of treatment is to soothe the newborn’s discomfort and promote mother-infant bonding.
### Short-Term Effects of Prenatal Exposure by Substance

<table>
<thead>
<tr>
<th></th>
<th>Nicotine</th>
<th>Alcohol</th>
<th>Marijuana</th>
<th>Opiates</th>
<th>Cocaine</th>
<th>Methamphetamine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal Growth</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Anomalies</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>?</td>
</tr>
<tr>
<td>Neurobehavior</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

### Long-Term Effects of Prenatal Exposure by Substance

<table>
<thead>
<tr>
<th></th>
<th>Nicotine</th>
<th>Alcohol</th>
<th>Marijuana</th>
<th>Opiates</th>
<th>Cocaine</th>
<th>Methamphetamine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growth</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Behavior</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Cognition</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Language</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>?</td>
<td>+</td>
<td>?</td>
</tr>
<tr>
<td>Achievement</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>?</td>
<td>-</td>
<td>?</td>
</tr>
</tbody>
</table>

Complex Interplay of Factors

Interaction of various prenatal and environmental factors:

- Family characteristics
- Prenatal care
- Exposure to multiple substances: alcohol and tobacco
- Early childhood experiences in bonding with parent(s) and caregiver(s)
- Other health and psychosocial factors have a significant impact

“...across a number of models with and without covariates, Environmental risk accounted for more variance in developmental trajectories than did prenatal exposure.”

Windows of Opportunity
Substance-Exposed Infants: Primary Changes in Child Abuse Prevention and Treatment Act (CAPTA)

1974  
Child Abuse Prevention and Treatment Act (CAPTA)  
- Federal funding to support prevention, assessment, investigation, prosecution, and treatment activities related to child abuse and neglect  
- Current funding provides several grant programs:  
  - State Grants: a formula grant to improve CPS  
  - Discretionary grants: competitively awarded funds to support research, technical assistance, and demonstration projects  
  - Community-based Grants (CSCAP): funding to all states for support of community-based activities to prevent child abuse and neglect  
  - Children’s Justice Act Grants: to States and territories to improve the assessment, investigation, and/or prosecution of child abuse and neglect cases with particular focus on sexual abuse and exploitation of children, child fatalities, and children who are disabled or with serious health disorders

2003  
The Keeping Children and Families Safe Act of 2003  
- Amends CAPTA and creates new conditions for States to receive their State grant  
  - Congressional report states: “To identify infants at risk of child abuse and neglect so appropriate services can be delivered to the infant and mother to provide for the safety of the child” and  
  - “the development of a safe plan of care...to protect a child who may be at increased risk of maltreatment, regardless of whether the State had determined that the child had been abused or neglected as a result of prenatal exposure.”  
- To receive State grant, Governor must assure they have policies and procedures for:  
  - Appropriate referrals to address needs of infants born with and identified as Fetal Alcohol Spectrum Disorder  
  - Health care providers to notify CPS; notification not to be construed to establish a definition of what constitutes abuse or neglect or require prosecution for any illegal action  
- A Plan of Safe Care for infant and immediate screening, risk and safety assessment, and prompt investigation

2010  
The CAPTA Reauthorization Act of 2010  
- Conditions for receipt of State grant were updated to clarify definition of substance-exposed infant and added Fetal Alcohol Spectrum Disorder:  
  - “Born with and identified as being affected by a legal substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a Fetal Alcohol Spectrum Disorder”  
- Added reporting requirements to Annual State Data Reports to include:  
  - Number of children referred to child welfare services identified as prenatal drug exposed or FASD  
  - Number of children involved in a substantiated case of abuse or neglect determined to be eligible for referral to Part C of the Individuals with Disabilities Education Act (children under age 5)  
  - Number of children referred to agencies providing early intervention services under Part C

Comprehensive Addiction Management Act of 2016  
- Further clarified population requirements for a health care provider:  
  - “Born with and identified as having symptoms resulting from prenatal substance abuse, specifically removing “illegal”  
- Required the Plan of Safe Care to include needs of both the infant and family/caregiver  
- Specified data reported by States, to the extent practicable, through National Child Abuse and Neglect Data System (NCANDS):  
  - The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder  
  - The number of infants for whom a Plan of Safe Care was developed  
  - The number of infants for whom referrals were made for appropriate services—including services for the affected family or caregiver  
- Specified increased monitoring and oversight:  
  - Children’s Bureau through the annual CAPTA report in the State plan  
  - States to ensure that Plans of Safe Care are implemented and that families have referrals to and delivery of appropriate services
1974

**Child Abuse Prevention and Treatment Act (CAPTA)**

- Federal funding to support prevention, assessment, investigation, prosecution, and treatment activities related to child abuse and neglect
- **Current** funding provides several grant programs:
  - **State Grants**: a formula grant to improve CPS
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2003

The Keeping Children and Families Safe Act of 2003

• Amends CAPTA and creates new conditions for States to receive their State grant

  • Congressional report states: “To identify infants at risk of child abuse and neglect so appropriate services can be delivered to the infant and mother to provide for the safety of the child” and...

  • “the development of a safe plan of care...to protect a child who may be at increased risk of maltreatment, regardless of whether the State had determined that the child had been abused or neglected as a result of prenatal exposure”

• To receive State grant, Governor must assure they have policies and procedures for:

  • Appropriate referrals to address needs of infants “born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure”

  • Health care providers to notify CPS; notification not to be construed to establish a definition of what constitutes abuse or neglect or require prosecution for any illegal action

  • A Plan of Safe Care for infant and immediate screening, risk and safety assessment, and prompt investigation
2010
*The CAPTA Reauthorization Act of 2010*

- Conditions for receipt of State grant were updated to clarify definition of substance exposed infant and added Fetal Alcohol Spectrum Disorder:
  - “Born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a Fetal Alcohol Spectrum Disorder

- Added reporting requirements to Annual State Data Reports to include:
  - Number of children referred to child welfare services identified as prenatally drug exposed or FASD
  - Number of children involved in a substantiated case of abuse or neglect determined to be eligible for referral to Part C of the Individuals with Disabilities Education Act (children under age 3)
  - Number of children referred to agencies providing early intervention services under Part C
2016

Comprehensive Addiction and Recovery Act of 2016 (CARA)

• Further clarified population requiring a Plan of Safe Care:
  • “Born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder,” specifically removing “illegal”

• Required the Plan of Safe Care to include needs of both the infant and family/caregiver

• Specified data reported by States, to the extent practical, through National Child Abuse and Neglect Data System (NCANDS)
  • The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder
  • The number of infants for whom a Plan of Safe Care was developed
  • The number of infants for whom referrals were made for appropriate services—including services for the affected family or caregiver

• Specified increased monitoring and oversight
  • Children’s Bureau through the annual CAPTA report in the State plan
  • States to ensure that Plans of Safe Care are implemented and that families have referrals to and delivery of appropriate services
2016 Primary Changes in CAPTA

- Further clarified population to infants “born with and affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder,” specifically removing “illegal”

- Required Plan of Safe Care to include needs of both infant and family or caregiver

- Specified data to be reported by States

- Specified increased monitoring and oversight for States to ensure that Plans of Safe Care are implemented and that families have access to appropriate services
CAPTA: State Policy Implications

Development of a state-level collaborative body to enforce or develop and oversee related laws and policies (e.g. child abuse/neglect statutes on prenatal substance exposure)

Defining the population of infants: affected by substance abuse, withdrawal symptoms or fetal alcohol spectrum disorder

Determining populations of families and the appropriate organization to implement and oversee the Plan of Safe Care

Strengthening of state data systems to meet the reporting requirements
CAPTA Practice Consideration
Plan of Safe Care Principles

• Inter-disciplinary
• Family-centered, including a preference that infants and mothers remain together when possible
• Ideally developed prior to the birth of the infant
Plan of Safe Care Principles

Brings together:

- Child Welfare Risk, Safety and Strengths Assessment (e.g. investigation)
- Hospital Discharge Plan
- Infant Care Plan
- Substance Use Treatment Case Plan
- Prenatal Care Plan
Plan of Safe Care Principles

- Facilitates identification of the family’s overall needs and engagement into the appropriate services including
- Specifies to whom the infant will be discharged
- Identifies a lead agency for development and ongoing monitoring based on a determined frequency to ensure child and family well-being
Although the Safety Plan may address some of the components in a Plan of Safe Care, they have different purposes and may not:

- Include parents’ or infants’ treatment needs
- Include other identified needs that are not determined to be immediate safety concerns
- Involve systems outside of child welfare
- Continue beyond the child welfare assessment if the case is not promoted for ongoing services

“...a safety plan is designed to control safety threats and have an immediate effect...[it] stay[s] in effect as long as the threats to child safety exist and the family remains unable to provide for the child’s safety...”

- Child and Family Services Review (CFSR) E-Training Platform
  https://training.cfsrportal.org/section-2-understanding-child-welfare-system/3016
### CAPTA Practice Consideration

#### Plan of Safe Components

<table>
<thead>
<tr>
<th>Domain</th>
<th>Types of Needed Services and Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary and OB/GYN Health</td>
<td>- Pregnancy and post-partum obstetrical, gynecological and family planning</td>
</tr>
<tr>
<td></td>
<td>- Pain management</td>
</tr>
<tr>
<td></td>
<td>- Breastfeeding coaching</td>
</tr>
<tr>
<td></td>
<td>- Co-occurring mental health, particularly maternal depression</td>
</tr>
<tr>
<td>Domain</td>
<td>Types of Needed Services and Supports</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Substance Use and Mental Health Disorders</td>
<td>▪ Access to and retention in substance use treatment services and ongoing recovery support</td>
</tr>
<tr>
<td>Prevention, Intervention and Treatment</td>
<td>▪ Mental health services</td>
</tr>
<tr>
<td></td>
<td>▪ Treatment provider that is knowledgeable about the child welfare systems and offers gender-specific,</td>
</tr>
<tr>
<td></td>
<td>family-centered and trauma-informed services</td>
</tr>
<tr>
<td>Parenting/Family Support</td>
<td>▪ Coordinated care management for parents and children</td>
</tr>
<tr>
<td></td>
<td>▪ Domestic partner and family violence intervention</td>
</tr>
<tr>
<td></td>
<td>▪ Infant care, parent-infant bonding, nurturing parenting coaching, safe-sleep</td>
</tr>
<tr>
<td></td>
<td>▪ Child care</td>
</tr>
<tr>
<td></td>
<td>▪ Income support and safety net</td>
</tr>
</tbody>
</table>
## Supports for Infant

<table>
<thead>
<tr>
<th>Domain</th>
<th>Types of Needed Services and Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>▪ Linkage to a medical home, pediatrician or primary care provider</td>
</tr>
<tr>
<td></td>
<td>▪ High-risk infant follow-up care as needed</td>
</tr>
<tr>
<td></td>
<td>▪ Referral to specialty health care as needed</td>
</tr>
<tr>
<td>Child Development</td>
<td>▪ Coordination of early care, developmental and education programming</td>
</tr>
<tr>
<td></td>
<td>▪ Services provided by staff knowledgeable in child development and in working with infants with prenatal substance exposure</td>
</tr>
<tr>
<td></td>
<td>▪ Developmental screening and assessment</td>
</tr>
<tr>
<td></td>
<td>▪ Referral to developmental pediatrician as needed</td>
</tr>
</tbody>
</table>
Family Drug Courts: Stage for Transformation

“If OTPs and other MAT providers cannot establish a foothold in drug courts, they are unlikely to do so elsewhere in the criminal justice system.”

Almost All
(98%) surveyed drug courts reported participants with an opioid use disorder

Approximately a Quarter
(20-25%) reported blanket prohibitions against medication assisted treatment

Approximately Half
(56%) reported offering medication assisted treatment

Statement of Assurance: ...the treatment drug court(s) for which funds are sought will **not deny any eligible client for the treatment drug court access** to the program because of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monoprodct formulations, naltrexone products including extended-release and oral formulations, disulfiram, and acamprosate calcium). [2015]
9 Components of Successful MAT Programs In Drug Court Settings

- **Counseling and other services**, plus medication, are essential.
- Courts are selective about treatment programs and private prescribing physicians.
- Courts **develop strong relationships** with treatment programs and require regular communication regarding participant progress.
- Screening and assessment must consider all clinically appropriate forms of treatment.
- Judges rely heavily on the **clinical judgement** of treatment providers as well as the court’s own clinical staff.

Medication Assisted Treatment in Drug Courts, Recommended Strategies (2016). Legal Action Center, Center for Court Innovation, New York State Unified Court System’s Office of Policy and Planning
26% surveyed drug courts reported availability of medication assisted treatment for pregnant participants (2013)

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3602216/
Differentiating Different Populations of Pregnant Women

1. Using legal or illegal drugs, on an opioid medication for chronic pain or on medication (e.g., benzodiazepines) that can result in a withdrawal syndrome and **does not have a substance use disorder**

2. Receiving medication assisted treatment for an opioid use disorder (Buprenorphine or Methadone) or is **actively engaged in treatment** for a substance use disorder

3. Misusing prescription drugs, or is using legal or illegal drugs, **meets criteria for a substance use disorder**, not actively engaged in a treatment program
Supporting Pregnant Women with Opioid Use Disorders

• Screening during pregnancy
• Treatment during pregnancy
• Support at birth and beyond
# Prenatal Care Screening

<table>
<thead>
<tr>
<th>Routinely Screened Conditions*</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cystic Fibrosis (Caucasians)</td>
<td>1/2500 = 0.0004%</td>
</tr>
<tr>
<td>HIV</td>
<td>1/500 = 0.002%</td>
</tr>
<tr>
<td>Birth Defects</td>
<td>2%</td>
</tr>
<tr>
<td>Anemia</td>
<td>2-4%</td>
</tr>
<tr>
<td>Pre-eclampsia</td>
<td>2-8%</td>
</tr>
<tr>
<td>Gestational diabetes</td>
<td>2-10%</td>
</tr>
<tr>
<td>Post partum depression</td>
<td>10-15%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Use**</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>9.4%</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>15.4%</td>
</tr>
<tr>
<td>Illicit drugs</td>
<td>5.4%</td>
</tr>
</tbody>
</table>


Barriers to Screening

**Patient**
- Fear of discrimination or judgment
- Previous bad experience with health care provider
- Fear of Child Protective Services
- They don’t consider their use problematic

**Provider**
- “My patients don’t use drugs”
- “I don’t have time”
- “I won’t get paid”
- “I don’t know what to do if they screen positive”
Assessment during Pregnancy

- Early identification is key
  - Allows for early intervention and treatment that minimizes potential harms to the mother and her pregnancy
  - Maximizes motivation for change during pregnancy
- Universal screening is recommended
  - Alcohol (ACOG 2011)
  - Prescription opioids (ACOG 2012)
- Selective screening based on “risk factors” perpetuates discrimination and misses most women with problematic use
Opioids during Pregnancy

Stability for pregnant woman and fetus, prevent relapse
Treatment for Opioid Use Disorders in Pregnancy

**Standard of care:** Medication Assisted Treatment plus counseling

- Methadone or Buprenorphine

**Benefits**

- Stable intrauterine environment (no cyclic withdrawal)
- Increased maternal weight gain
- Increased newborn birth weight and gestational age
- Increase PNC adherence
- Decrease in illicit drug use - reduction of HIV/HCV acquisition
- Decrease risk of overdose
- Other supportive services

(2008). Mental Health Services Administration, SAMHSA. Medication-assisted treatment for opioid addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) 43. DHHS Publication No. 05-4048. 2005 Rockville Maryland


American Society of Addiction Medicine, National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (2015)

“Medically supervised tapered doses of opioids during pregnancy often **result in relapse** to former use. Abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor, fetal distress, or fetal demise.”
Postpartum

Critical Period
- Newborn care, breastfeeding, maternal/infant bonding
- Mood changes, sleep disturbances, physiologic changes
- Cultural norms, “the ideal mother” in conflict with what it is actually like to have a newborn

Neglected Period
- Care shifts away from frequent contact with Prenatal care provider – to pediatrician
- Care less “medical” (for mom) and shifts to other agencies (WIC)
- Insurance and income support realignment
- SUD treatment provider(s) – care may be on-going

Gaps in care – addressed through public health interventions – e.g., home visiting
Adult Drug Court (ADC) Case Study

- **Purpose:** Obtain in-depth knowledge of policies and practices of ADCs in broadening services beyond the individual client to the family

- **Three ADCs:**
  - 11th Judicial Circuit; Miami-Dade, FL
  - 13th Judicial District Drug Court; Billings, MT
  - Van Buren County Circuit Court; Paw Paw, MI

- **Qualitative Methods**
  - Semi-structured interview guide based on *Guidance to States: Recommendations for Developing Family Drug Court Guidelines*
  - Review of policy and procedural manuals

Treatment that Supports Families

- Encourages retention in treatment
- Increases parenting skills and capacity
- Enhances child well-being
- Is cost-effective

Family Centered Treatment is not Residential Treatment & Family Recovery is not Treatment Completion

**Parent Recovery**
- Parenting skills and competencies
- Family connections and resources
- Parental mental health
  - Medication management
- Parental substance use
- Domestic violence

**Child Well-being**
- Well-being/behavior
- Developmental/health
- School readiness
- Trauma
- Mental health
- Adolescent substance abuse
- At-risk youth prevention

**Family Recovery and Well-being**
- Basic necessities
- Employment
- Housing
- Child care
- Transportation
- Family counseling
- Specialized Parenting

*Family Centered Treatment for Women with Substance Use Disorders: History, Key Elements and Challenges*
Continuum of Family-Based Services

Adult Drug Court Case Study: Strategies for implementing a family-focused approach

• Strong judicial and coordinator leadership to guide change
• Cross-system partnerships
• Strengthen partnerships to expand array of evidence-based services
• Effective cross-system communication and information sharing
• Cross-system training
• Early identification of family’s needs
• Evidence-based services to children and parents
• Responses to behavior that are sensitive to the needs of children and parents
• Sustainability planning
• Outcomes monitoring
Expanding the FDC Partnership to Address the Needs of Pregnant Women and their Infants

- MAT and substance use treatment providers who are knowledgeable and experienced in working with pregnant women
- Mother’s medical providers – OB/GYN and others
- Infant’s medical providers – Pediatrician, Neonatologists and others
- Early Childhood
- Home Visiting Programs
& Discussion
Resources
Resources on Medication Assisted Treatment for Drug Courts

Legal Action Center
• MAT in Drug Courts, Recommended Strategies
• MAT Advocacy Toolkit
• MAT in Drug Courts: Recommended Strategies
• Attorney’s Guide: Addiction Medication and your Client
• Legality of Denying MAT in the Criminal Justice System

https://lac.org/resources/substance-use-resources/medication-assisted-treatment-resources/

• Includes recommendations to OTPs to improve access to MAT within the criminal justice system
• Guide for Collaborative Planning
• 7 guides to identify collaborative strengths and challenges
• Facilitator’s Guide
• Case Study

• Substance Exposed Infants In Depth Technical Assistance: 8 states
• Policy Academy: 10 states

Web-Based Resource Directory
Case Study: CHARM Collaborative

What Makes it Work
- Shared Understanding Among Partners
- Regular Meetings
- Information Sharing

Early Identification and Intervention
- MAT and substance use treatment services
- Prenatal Care
- Child Welfare 30-day pre-birth-assessment

Intense Level of Support
- Pregnancy
- Birth
- Post-Partum
Additional Resources

- Publications
- Webinars
- Online Tutorials
- Toolkits
- Video

http://www.ncsacw.samhsa.gov/


3. Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Legal Professionals

Please visit: http://www.ncsacw.samhsa.gov/
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