Journal of Substance Abuse Treatment 71 (2016) 63–67

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

Medication-assisted treatment improves child permanency outcomes for opioid-using families in the child welfare system

Martin T. Hall, Ph.D., M.S.S.W. [a,*], Jordan Wilfong, M.S.W. [a], Ruth A. Huebner, Ph.D. [b,1], Lynn Posze, M.A. [c], Tina Willauer, M.P.A. [c]

[a] Kent School of Social Work, University of Louisville, Louisville, KY
[b] Eastern Kentucky University and Graduate Faculty, University of Kentucky, Lexington, KY
[c] Sobriety Treatment and Recovery Teams, Kentucky Department for Community Based Services, Frankfort, KY

ARTICLE INFO

Article history:
Received 5 May 2016
Received in revised form 25 July 2016
Accepted 14 September 2016
Available online xxxx

Keywords:
Opioids
Medication-assisted treatment
Child welfare

ABSTRACT

Parents who use opioids and are involved in the child welfare system are less likely to retain custody of their children than parents who use other drugs. No previous studies have described medication-assisted treatment (MAT) utilization and child permanency outcomes for this population. The Sobriety Treatment and Recovery Team (START) model is a child welfare–based intervention focused on families with co-occurring substance use and child abuse / neglect issues. This study examined the prevalence and correlates of MAT utilization among parents in the START program with a history of opioid use, and compared child outcomes for families who received MAT services to those who did not. Of the 596 individuals with a history of opioid use in the START program, 55 (9.2%) received MAT. Receipt of MAT services did not differ by gender, age, county of residence, or drug use, though individuals who identified as White were more likely to participate in MAT. In a multiple logistic regression model, additional months of MAT increased the odds of parents retaining custody of their children. To address barriers to MAT, results-focused educational interventions may be needed for the child welfare workforce, as well as programs to improve collaboration and decision-making between the child welfare workforce, court personnel, and drug addiction treatment providers.

1. Introduction

Over 2 million Americans have substance use disorders from prescription opioids, and nearly 500,000 from heroin (Substance Abuse and Mental Health Services Administration, SAMHSA, 2013). Opioid use increases the likelihood of developing life-altering problems such as transmission of HIV and hepatitis, incarceration, post-traumatic stress disorder, and parenting deficits (Schilling, Dornig, & Lundgren, 2006), as well as homelessness and premature death (World Health Organization, 2004).

Among families involved with child welfare, between 50% and 80% of abused or neglected children have substantial safety risks due to parental substance use disorders (Semidei, Radel, & Nolan, 2001; Young, Boles, & Otero, 2007). Furthermore, parents with substance use disorders do not regularly reunify with their children after they are placed in foster care (Bishop et al., 2000), with one study showing a reunification rate as low at 10% (Ryan, Marsh, Testa, & Louderman, 2006). Finally, reunification rates are lower for parents with opioid use than parents with alcohol use (Choi & Ryan, 2007; Grella, Needell, Shi, & Hser, 2009) or cocaine use (Choi & Ryan, 2007).

Previous research on drug addiction treatment for parents involved with the child welfare system focused on how service completion impacts reunification outcomes (Green, Rockhill, & Furrer, 2007). Results from these studies have been mixed; some conclude that treatment completion increased reunification rates (Green et al., 2007; Smith, 2003), while others found that even when treatments helped parents reach sobriety, reunification rates were unaffected (Gregoire & Schultz, 2001). However, research in this area generally does not discriminate between type of substance use problem, thus creating difficulties assessing intervention outcomes based on specific drugs used (Smith, 2003).

Medication-assisted treatment (MAT) is an established intervention for individuals with opioid use disorders (Maremmani, Pani, Pacini, & Perugi, 2007; Roman, Abraham, & Knudsen, 2011). The World Health Organization (2004) has identified MAT as the most effective treatment for opioid use disorders, and the effectiveness of MAT increases when people receive treatment for longer time periods (Simpson, 1993). However, a recent national study found that around 1.3 million individuals with opioid use disorders could benefit from MAT but are not receiving it (Jones, Campopiano, Baldwin, & McCance-Katz, 2015). Barriers to the implementation of MAT include: lack of availability, stigma,

* Corresponding author at: Kent School of Social Work, 303 Patterson Hall, University of Louisville, Louisville, KY 40292. Tel.: +1 502 852 3490.
E-mail address: martin.hall@louisville.edu (M.T. Hall).
[1] Former: Kentucky Department for Community Based Services, Frankfort, KY.

http://dx.doi.org/10.1016/j.jsat.2016.09.006
0740-5472/

absence of a prescribing physician, and exclusive commitment to the 12-step model of treatment (Roman et al., 2011).

Research on drug addiction treatment for parents with opioid use disorders who are involved in the child welfare system – especially the use of MAT – is lacking, though mothers who receive MAT may be more likely to retain custody of their infant children (Lundgren, Fitzgerald, Young, Amodeo, & Schilling, 2007). This is notable because the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96–972) mandates that states make reasonable efforts to reunify families before terminating parental rights (Wulczyn, 2004). Though *reasonable efforts* are somewhat undefined, the laws are clear that whenever possible, children should be raised by their parents. The law is also clear on the timeline for doing so; the Adoption and Safe Families Act (ASFA; Public Law 105–89) of 1997 requires a termination of parental rights for children living in foster care for 15 of the most recent 22 consecutive months. These mandates require timely and effective interventions that address opioid use and help parents retain custody of their children.

One promising approach is the Sobriety Treatment and Recovery Team (START) model, a child welfare-based intervention focused on families with co-occurring substance use and child abuse / neglect issues (Huebner, Willauer, & Posze, 2012). START uses a system-of-care approach to partner with local drug addiction treatment providers and the courts. Additionally, START child welfare workers receive special training in substance use and motivational interviewing, and are paired with a *family mentor*, an individual in sustained recovery from addiction who coaches and supports parents with child welfare and drug addiction treatment. The START worker and family mentor dyads maintain 12–15 cases, a lower number than is common in child welfare. This allows teams to deliver intensive, individualized services using both formal and natural supports to promote recovery and family well-being. START supports the use of MAT when it is indicated and geographically available. Previous research indicated that the children of parents receiving START entered state custody at roughly half the rate of similar families (Huebner et al., 2012); and 42.3% were reunified by case closure (Huebner, Posze, Willauer, & Hall, 2015).

The purpose of this study is to describe MAT use and related outcomes among opioid users in the START program. The study has two primary aims. First, we will describe prevalence and correlates of MAT utilization among child welfare parents with a history of opioid use that received services in the START program. We hypothesize that MAT is underutilized, even though the START program promotes its use. The second aim of the study will be to compare child outcomes for opioid users in the START program who received MAT services to those who did not. The primary outcome of interest will be permanency status – specifically, whether or not parents in the START program retained custody of their children at case closure. As such, this manuscript will be among the first to describe the relationship between MAT utilization and permanency status for families involved in the child welfare system.

2. Methods

2.1. Sample and procedure

Participants in this study were drawn from the START program in Kentucky. As noted, START is a child welfare-based intervention focused on families with co-occurring substance use and child abuse / neglect (CA/N). Families receiving START were required to meet the following criteria: (1) referred to the state's child protective services regional intake or child abuse hotline because of suspicion of CA/N; (2) a finding of CA/N was substantiated by child protective services investigative worker; (3) substance use was the primary child safety risk factor; (4) at least one child in the family was 5 years of age or younger; (5) prior child protective services cases, if applicable, were closed at the time the new case was referred; and (6) referrals to START from the child protective services investigative worker had to occur within 30 days of the initial hotline report.

The sample for the current study consisted of closed START cases with at least one adult family member reporting opioid use. This resulted in a sample of 596 adult opioid users representing 413 unique families. Adult opioid users in this sample were most often the biological parent(s) of children in the cases. However, other adults in the household (e.g., non-biological parents, grandparents) were included if they also received START services and reported opioid use. Of the 413 families, 172 (41.6%) consisted of families with 2 or more adults reporting opioid use, and in the remaining 241 families (58.4%), only one adult reported opioid use (because there were either no other adults in the household, or if other adults were present, they did not report opioid use). Families in the sample were residing in 5 counties within Kentucky, including urban, small city, and rural areas. Parents entered the START program between the years of 2007 and 2015.

2.2. Measures

2.2.1. Demographics

Self-reported demographic data for the following variables were included: gender, age, race (i.e., White, other races), and county of residence (Boyd, Daviess, Jefferson, Kenton, Martin).

2.2.2. Substance use

Current use of the following nine categories of psychoactive substances was assessed (yes or no): alcohol, marijuana, cocaine, opiates, methadone, benzodiazepines, barbiturates, methamphetamines, and amphetamines.

2.2.3. Household opioid use

Household opioid use was measured by dichotomizing the number of adult opioid users in the household (i.e., one adult opioid user versus two or more adult opioid users).

2.2.4. Medication assisted treatment

MAT utilization was assessed during parents' involvement in START. This included the use of methadone, buprenorphine, and naltrexone. The variable was initially dichotomized (yes or no) as having received any type of MAT. However, since a small number of clients received less than a month of MAT and studies suggest that greater length of time on MAT is associated with more favorable outcomes (Greenfield & Fountain, 2000), the variable was again dichotomized as either no MAT (0) versus more than 1 month of MAT services (1). Finally, months of MAT received during the START program was calculated.

2.2.5. Permanency outcomes

Of the 558 families who received START services, 416 cases had been closed. Five common permanency outcomes were identified at case closure: (1) child(ren) remained with at least one parent(s) who received START services ($n = 222$); (2) some children remained with parent(s) and some were placed elsewhere ($n = 14$); (3) child(ren) placed into permanent custody of a relative ($n = 122$); (4) parental rights were terminated and children were placed in foster care ($n = 55$); and (5) permanency was unresolved at START closure ($n = 3$). For the purposes of this analysis, the permanency outcome variable was reduced to two outcomes: (1) child(ren) remained with at least one parent who received START services ($n = 222$); or (2) all other possible outcomes ($n = 191$). The three families whose permanency status was unresolved at START closure were excluded, resulting in a final sample of 413 closed cases.

2.3. Data analysis

Data analysis consisted of two steps. First, individuals and families who received no MAT and those with at least 1 month of MAT were