Children and Family Futures
Strengthening Partnerships, Improving Family Outcomes

State of Vermont, Joint Legislative Child Protection Oversight Committee
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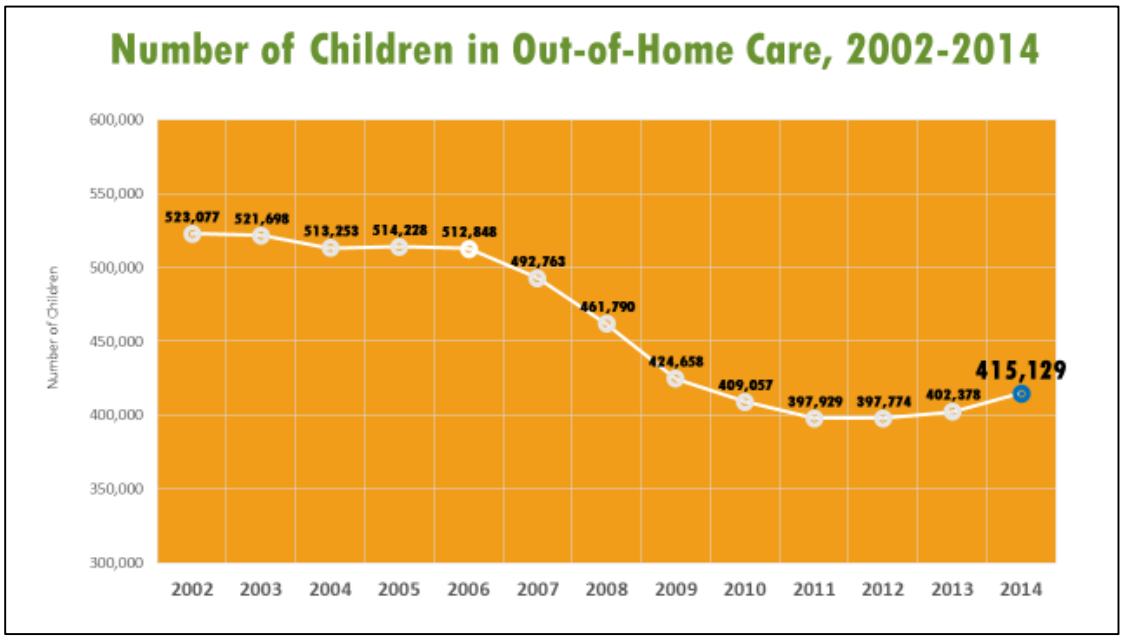
The trend of increasing numbers of children in out-of-home care that you are experiencing in Vermont is reflective of the trend as a nation as a whole with the total population on a two-year uptick after nearly two decades of declining numbers since the peak in 1999.[1]



Disturbingly, these numbers also reflect a slight increase over the past several years in the number of infants (children under age 1) who are being placed in protective custody.

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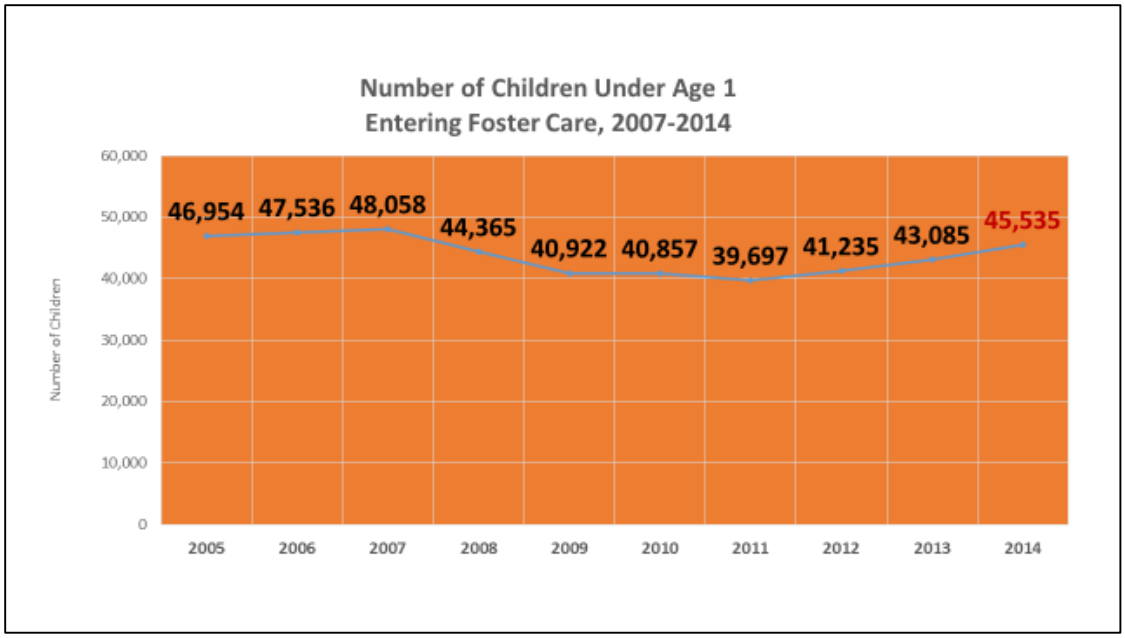
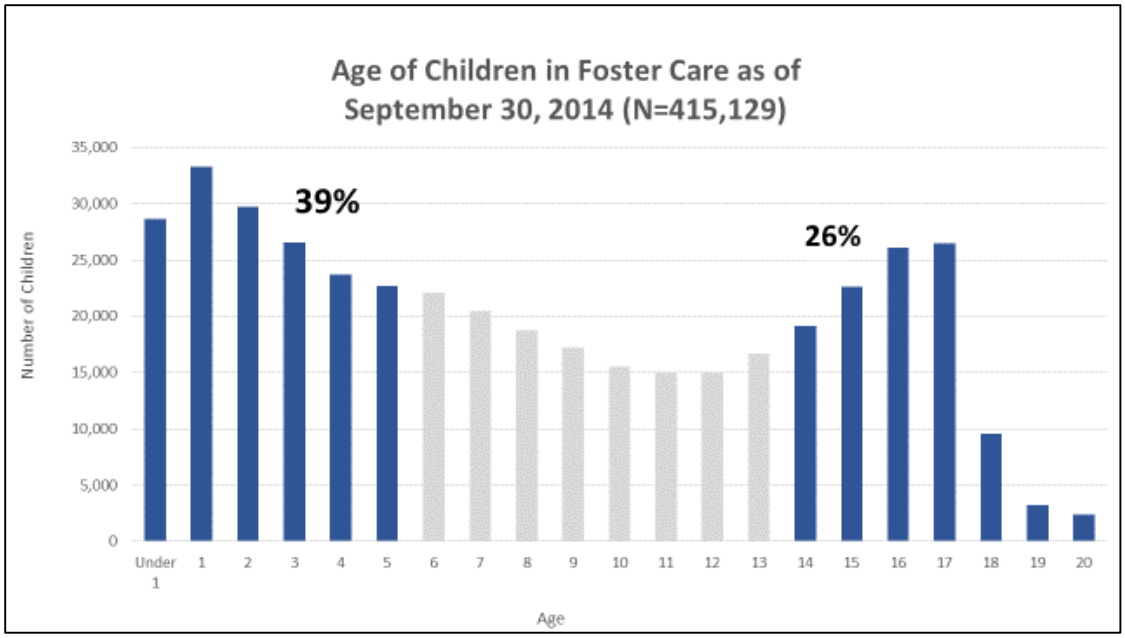


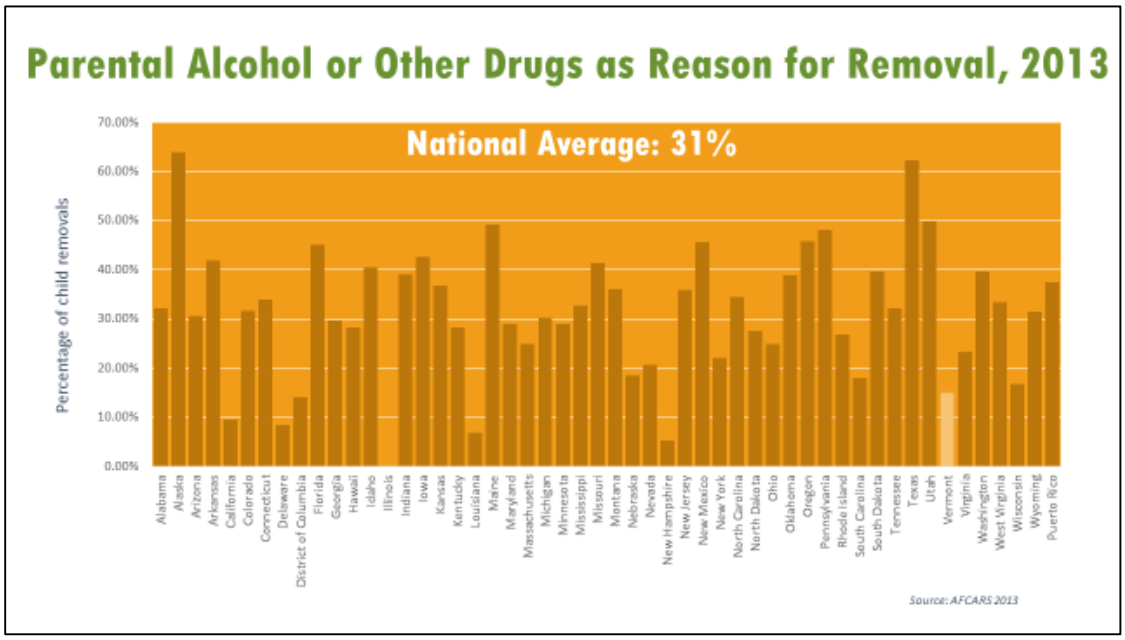
And these trends are resulting in an increasing shift toward younger children (those under age 6) making up a larger percentage of children in out-of-home care. There has always been a bi-modal age distribution with children under age 6 and teenagers, but this pattern has shifted recently toward younger children reaching nearly 40% of kids in care.



A frequent question in states like Vermont is whether these young children are entering care as a result of parents with opioid use disorders. The answer, unfortunately, is that we can't say for sure. While Vermont is one of the few states that have conducted a systematic review of cases to determine those with parental substance use disorders, which documented an 80% prevalence rate, the vast majority of states cannot answer that question.

One might suggest however, that there are few other underlying factors that would disrupt the ability of a parent to care for their infant more than a substance use disorder does—particularly in areas of the country that are experiencing a profound opioid use epidemic. I will speak to these types of risk factors in a moment.

What we do know from the same AFCARS data set is that, at present, states have widely varying approaches to collecting and recording parents' substance use as factors in the cases of child removal. These data range from less than 10% to almost 70% with a mean across states of 31%. The rate reported in Vermont in the most recent year these data are available is 15%.



However, the Vermont Department for Children and Families has taken three important and noteworthy actions:

1) A systematic review of cases to better determine the prevalence rate;

2) Partnering with Lund Family Center to provide access to substance abuse assessment and engagement professionals; and,

3) The implementation of a standardized screening protocol to better identify parental substance use disorders among families and make appropriate referrals to substance use assessments of treatment needs.

All three of these actions are programmatic responses that would be recommended by our organization to any state that is seeking to improve its response to the needs of families in this population. They are among the seven ingredients that we have found lead to better outcomes for children and families:

1) Having a system of identifying families in need of substance abuse treatment
2) Timely access to assessment and treatment services
3) Increased management of recovery services and compliance with treatment
4) Family-centered services that improve parent-child relationships
5) Increased judicial oversight
6) Systematic response for participants implementing contingency management
7) Collaborative non-adversarial approach grounded in efficient communication across service systems and the court

This alarming rate of young children coming into care is especially troubling as children ages 0-3 are especially vulnerable. Infancy and toddlerhood is a time of rapid development across all domains of functioning. The brain of a newborn is about one-quarter the size of an adult's and by the age of three, the brain has developed to about 80 percent of its adult size.[2] It is imperative that the development of that child take place in a stable environment with a caregiver who becomes attached to the child and a child who becomes attached to the caregiver.

It seems clear, however, that the children under age 1 who are entering care are not just those identified with substance exposure at birth or during the prenatal period.

Rather, I would suggest that parents of infants and toddlers, who are being reported to DCF with allegations of neglect, or more infrequently child abuse allegations, resulting in children being placed in protective custody, may be those parents who are not stable in treatment and, if appropriate, are not receiving medication assisted treatment.

My understanding is that, despite the substantial increase in the availability of treatment in Vermont, there is currently a wait list for medication assisted treatment of 300 to 400 persons.

It's important to recognize however that ***both*** *pre*- and *post*-natal factors contribute to the risk of child maltreatment and can affect the child's cognitive, behavioral and emotional development.

Prenatal factors include:

- Exposure during pregnancy to opioids, amphetamines, alcohol, tobacco and other substances, or more likely a combination of substances (alcohol is a known teratogen associated with neurodevelopmental disorders and tobacco use is well-established as a factor associated with small for gestational age infants)

- Whether the mother has access to and engages in routine prenatal care and other services; and,

- Whether the mother has access to and engages in substance use treatment.[3]

Time and time again, studies have demonstrated the impact of prenatal exposure to alcohol and tobacco. A report to Congress by the Institute on Medicine found:

"Of all the substances of abuse (including cocaine, heroin and marijuana), alcohol produces by far the most serious neurobehavioral effects in the fetus.[4]"

The attention currently focused on our country's opioid use epidemic is warranted, particularly in regard to the number of young people who are dying of drug overdoses. However, in responding to the serious problem of prenatal substance exposure, it is imperative to keep our eye on the ball in terms of alcohol and tobacco exposure and their known risks to a child's development.

Postnatal risk factors for young children include:

- Impaired parenting skills and capacity
- Quality of attachment between mother and infant and the father and infant
- The presence of co-occurring issues, such as domestic violence and mental health disorders.[5]

Of course, these postnatal factors do not always occur solely in the postnatal environment; often these risks exist prior to the birth of the infant. Studies have demonstrated this complex relationship:

"[The] sum combination of biological effects of prenatal drug exposure and postnatal home environment characteristics appears to influence child development.[6]"

These post-natal child neglect and abuse risk factors are commonly grouped into three general categories

1) Family Factors including a history of interpersonal violence, social isolation and lack of social support.[7]

2) Child factors, importantly the child's age, with infants and children under the age of 6 at higher risk for maltreatment, as are children with special needs, including children with developmental, learning and physical disabilities.[8]

3) Parent Factors including substance use, mental health issues, age of the parent, parent's coping skills and parents' history of childhood trauma and maltreatment.[9]

The task for DCF is sorting out these complex relationships among the family members as well as the potential immediate risk and safety factors that may affect this group of highly vulnerable children.

But, without ready access to quality substance use disorder treatment for these families, DCF must act to ensure the safety of children.

I had the pleasure of spending a few days in Vermont last month and offer a few additional points regarding access to quality treatment and my observations and assessment based on multiple discussions with various staff members.

1. Medication Assisted Treatment for opioid use disorders is one component of substance use treatment. According to the American Society of Addiction Medication 2014 National Practice Guidelines, "psychosocial treatment is recommended in conjunction with any pharmacological treatment of opioid use disorder [and] at a minimum should include psychosocial needs assessment, supportive counseling, links to existing family supports, and referrals to community services."[10]

It is not clear that this full complement of services is readily available to DCF-involved families, which would aid in reducing the trauma that children experience by their separation from birth parents and their placement in kinship or stranger foster care. There is a Federal priority for access to treatment for pregnant and parenting women; it appears that in Vermont, the priority for pregnant women is in place. However, those parents who are not pregnant may not have ready access to treatment which could prevent their child's removal.

2. The National Institute on Drug Abuse's (NIDA) Principles of Effective Treatment[11] describes additional considerations for quality substance use treatment. These include:

   - Treatment needs to be readily available
   - Treatment needs and level of care must be determined with a comprehensive assessment
   - No single treatment is appropriate for everyone and treatment depends on each person's needs
   - Remaining in treatment for an adequate time is critical
   - Treatment needs must be continually assessed and modified
   - Ongoing monitoring is needed as relapse is expected

   The extent to which these quality markers are operational in Vermont, as well as the other principles set forth by The National Institute on Drug Abuse, is not currently known by DCF policymakers or practitioners.

3. Responsiveness to the Family, Child and Parent risk factors should take place in a family-centered approach to address all three categories of risk factors. Services should minimally include appropriate parenting programs, developed specifically for parents in early recovery and addressing parenting skills. These parenting interventions must strengthen and deepen the emotional bonds between parents and their children. The service needs of children, including developmental assessments and responses to any neurodevelopmental delays associated with prenatal substance exposure, must also be addressed.[12]

   The extent to which substance abuse treatment agencies have a family-centered approach and understand the unique needs of families who are in DCF caseloads is not clear at present, nor is the availability of developmental intervention to address children's needs.

The magnitude of factors faced by families with opioid and other substance use disorders requires a collaborative approach. It is clear that a single system or agency cannot be held solely responsible to appropriately assess the multiple risk factors, while at the same time serving as the sole entity responsible for addressing families' myriad needs. In our work in developing collaborative practice with various states and localities, several key lessons have emerged:

- Development of a structure is necessary to facilitate collaborative practice. A structure entails state- and local-level agencies who are organized in an effort to manage the planning and implementation of protocols and policies and are focused on making data-driven decisions to improve family outcomes.

- Development of protocols and policies are needed that clearly describe each system's role in the screening, assessment, engagement into substance use treatment and other services, ongoing delivery of services, and most importantly, include a shared focus on outcomes that cut across agencies' boundaries to ensure the well-being of children ***and*** their families.

- Each system's role in sharing information must be addressed in the protocols and policies. The information sharing protocols and policies must describe what information is needed at critical points in time, who needs the information, why the information is necessary, and how the information can be relayed. Challenges in sharing information, such as protecting client confidentiality, must be worked through and can be addressed through formal MOUs and protocols.

As mentioned, Vermont has taken several actions that I commend in its effort to keep families safe and stable. Yet, as I came away from my days in Vermont last month, there was one area of practice that I found particularly disturbing. I learned that there are agencies, attorneys, and advocacy organizations who are currently advising parents to not cooperate with DCF when their child has been reported for potential child abuse or neglect. Before learning about this practice, I stated at that time and I would repeat today:

> In the absence of cooperation of parents and their attorneys to actively engage parents with substance use disorders in treatment and to share information about their progress, or lack thereof, toward ensuring the well-being of their family and the safety of their children, I believe DCF must act as though those children are not safe.

A fundamental shift in practice is required across our nation that embraces ensuring the safety of children and providing permanent caregiver relationships for them, while simultaneously being focused on the well-being of families and the recovery of parents.

It is ultimately incumbent on DCF to ensure Vermont's children and families are safe, and it is incumbent on substance use treatment and other supportive agencies to partner with DCF toward this end. This committee can make a major contribution to that goal by ensuring that the resources to provide these needed partnerships are available, that legislative barriers are identified and rectified, and that reviews of progress against clear indicators of interagency outcomes are monitored consistently and in public.

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[5] Ibid
[6] Ibid
[7] Carnochan, S., Rizik, Baer, D., and Austin, M.J. (2013). Preventing the recurrence of maltreatment. *Journal of Evidence-Based Social Work. 10(3),* pp. 161-178.
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[9] Ibid
[10] American Society of Addiction Medication 2014 National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use. Retreived from http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/national-practice-guideline.pdf?sfvrsn=22 (accessed October 19, 2015).
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