SUBSTANCE USE DISORDERS

A. Statewide Overview of Substance Use

Substance use by parents in DFPS cases is very common. Current trends show that methamphetamine continues to be the primary drug threat ranked by Dallas, El Paso, and Houston law enforcement and treatment providers. Indicators of drug use (poison control calls, treatment admissions, deaths, and toxicology reports on substances seized and identified) all show methamphetamine and cocaine as the largest problems in Texas with no FDA-approved Medication Assisted Treatment (MAT) available. The Texas Prescription Monitoring Program (PMP) and overdose prevention programs have led to decreases in the number of other opiate, synthetic narcotic, and benzodiazepine drugs prescribed.[193]

Death rates associated with heroin have increased steadily since 1999 with the highest number of deaths occurring in the 24-34 age group. There has been a decrease in heroin-related poison center calls, yet a rising number of toxicology reports, deaths, and seizures are being identified; however, Texas has not suffered the epidemic of overdoses seen in the northeast United States.[194]

1. Useful Definitions from the HHSC

- Substance Use: use of a substance.
- Substance Misuse: using a substance not consistent with medical or legal guidelines (i.e. using two pills rather than one as prescribed to assist with sleep).
- Risky Use: refers to using a substance in ways that threaten the health and safety of the user or others (i.e. drunk driving).
- Substance Use Disorder (SUD): a medical condition in which the use of a substance leads to a clinically significant impairment or distress in a person's life. Substance use disorders range can range widely in severity (Mild, Moderate, Severe) with severe substance use disorders typically including clinical criteria of tolerance and withdrawal.
- Recovery: per the HHSC, is not only the elimination of substance use but a personal journey of increased hope and personal identity.

B. Substance Use Among Women

Substance use disorders in women tend to be multifaceted and highly correlated with comorbid mental health conditions such as depression and anxiety. Additionally, substance use disorders are strongly correlated to childhood personal violence and trauma. Women who inject drugs have significantly higher mortality rates, increased likelihood of injection-related problems, faster progression from first drug use to a disorder, higher rates of communicable diseases, higher levels of risky injecting and/or sexual risk behaviors, greater overlap between sexual and injecting social networks, and more commonly report interpersonal violence than the general population.

According to a 2009 Substance Abuse and Mental Health Services Administration (SAMHSA) publication, pregnant women may be reluctant to seek prenatal care due to fear of losing custody of the infant or other children. Most mothers who are in substance use disorder treatment feel a strong connection with their children and want to be good mothers. Most of these mothers want to maintain or regain custody of their children and become "caring and competent parents." Women who believe they have not cared for their children adequately or who believe that they are perceived as having neglected their children carry enormous guilt. Therefore, for many women, maintaining caring relationships with their children is sufficient motivation to keep them in treatment. Unfortunately, they often have inadequate role models in their own lives or lack the information, skills, or economic resources that could make motherhood less difficult.[195]

In its 2018 biennial report, the Texas Maternal Mortality and Morbidity Task Force found that drug overdose (typically opioids) was the leading cause of maternal mortality for women typically occurring after 60 days postpartum.[196]

C. Pregnant Women and Relapse Prevention and Safety Plans

1. Pregnant Women and Substance Use

Since 1994, SAMHSA has designated pregnant women as a federal priority population in substance use disorder treatment services. Additionally, SAMHSA requires states to spend five percent of the states' overall budget on specialized female program for pregnant and parenting women. Pregnant women using opioids should not discontinue opioid use due to the risk of maternal relapse, overdose, withdrawals, and fetal demise. The American College of Obstetricians and Gynecologists (ACOG) and Substance Abuse and Mental Health Services Administration (SAMHSA) recommend Medication Assisted Treatment (MAT) for best practice in managing an Opioid Use Disorder in pregnancy. Tapering of MAT dosing during pregnancy is associated with more frequent relapse into addiction. Every health region in Texas has an Outreach, Screening, Assessment and Referral (OSAR) Center which can assist any Texas resident with finding appropriate treatment and community resources. To find your local resource and for more assistance please visit the DFPS OSAR webpage.[197]

2. Relapse Prevention

Parents in DFPS cases who have difficulty with substance use can relapse. However, with the right support and appropriate level of intervention, it is possible to achieve successful reunification with a parent who has addressed their substance use. At this time, there are no standardized resources statewide. DFPS uses state funded and community resources that use individualized treatment approaches to meet the needs of parents and families. DFPS policy states the following regarding relapse prevention planning:

Developing a Safety Plan in Case a Client Relapses

- Relapse is the return to the pattern of use, as well as the process during which indicators appear before the client's resumption of substance use.
- In the relapse safety plan, the parents has verbalized steps he or she plans to take to ensure the safety of the children when triggers or relapse becomes an issue; for example, the client might state in the relapse safety plan that:

- he or she will place the children with DFPS-approved family members or friends when experiencing a relapse; and
- the children will remain with the family members or friends until the parent returns to abstinence and/or is once again engaged in treatment or aftercare services.

- Any court orders supersede any actions stipulated by the client involving a voluntary caregiver in the relapse safety plan.
- Please also see the Guide to Addiction Recovery & Relapse.[198]

D. DFPS Response to Substance Use Disorders

The Child Abuse Prevention and Treatment Act (CAPTA, P.L. 93-247) was originally enacted in 1974 and was amended by the Comprehensive Addiction and Recovery Act (CARA, P.L. 114-198) in 2016. Under these federal laws, states are required to have plans of safe care for infants born and identified as being affected by substance use or withdrawal symptoms of both legal and illegal substances. The plans of safe care are required to "ensure the safety and well-being of such infant following [the infant's] release from the care of health care providers to be achieved through addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver. 42 U.S.C.S. § 5106a(b)(1)-(2).

To avoid confusion, DFPS does not utilize the unique federal term "plan of safe care" as set forth in CARA, as there are a number of DFPS tools and policies that reference "plans." Statewide Intake protocols, safety and risk assessment tools, and the service planning process used in different stages of service, the state meets the requirements under the CARA plans of safe care. Examples of types of plans that do not include removal include: use of Parental Child Safety Placements (PCSP) to assure safety as the parent initiates or becomes engaged in services, use of residential substance use disorder treatment programs that allow a mother (or father in a few programs) to live in a treatment setting with the child, when appropriate, use of Medication-Assisted Treatment in combination with behavioral therapies, and the guidance of specialized drug courts in some areas. While access to treatment can be challenging, families referred by DFPS are considered a state priority population for state-funded substance use disorder treatment services.

Doctors and nurses are required by mandatory reporting laws to report suspected child abuse and neglect, and definitions of child abuse in Texas law include the use of controlled substances by an adult in a manner or to the extent that the use results in physical, mental, or emotional injury to a child. Tex. Fam. Code § 261.101(b) and Tex. Fam. Code § 261.001(1)(I).

DFPS Statewide Intake advances any reports of substance-exposed infants to the field for an investigation. During the investigation, multiple steps occur including: a child assessment, parental assessment, holistic family assessment, safety planning and the development of initial services. In some cases, the parent has sufficient support, is protective and/or engaged in treatment services, thereby eliminating the need for further DFPS involvement beyond investigation. Other parents may be assisted in development of a plan and access to services during the investigation stage of services, or a Family Based Safety Services stage may be opened to provide ongoing services without removal. Where safety cannot be assured, DFPS will seek removal of the infant.

It is important to note that an infant born substance-exposed does not result in an automatic removal of that child, nor even an automatic disposition of child abuse or neglect. Each family's specific circumstance is assessed. DFPS is working closely with Health and Human Services agency partners who provide substance use disorder treatment services to strengthen the State's response to children and parents with a substance use disorder.

1. Behavioral Health Division at DFPS

In Fiscal Year 2019, the Behavioral Health Services Division with CPS was formed. This division is fully staffed and includes a Behavioral Health Services Division Administrator who manages Substance Use Disorder, CANS assessment, Trauma-Informed Care, and Mental Health subject matter experts. A Medical Services Division remains, covering medical and dental issues for Child Protective Services with Nurse Consultants and Well-Being Specialists. The Behavioral Health Services Division Administrator, and Trauma Informed Care Program Specialist are based at the State Office in Austin. One CANS Program Specialist is housed in San Antonio and a second CANS Program Specialist in in Houston. The division includes three Substance Use Program Specialists housed in San Antonio, Dallas, and Houston. These positions complement a two additional Substance Use Program Specialists and two Mental Health Program Specialists who are based in Austin and report to Child Protective Investigations. These staff work together to provide support, resources, and technical assistance to direct delivery staff in their work with families experiencing Substance Use Disorders through every stage of service.

E. Resources

Substance Abuse and Mental Health Services Administration (SAMHSA)[199]

Texas Health and Human Services Mental Health and Substance Use[200]

National Institute on Drug Abuse[201]

Children and Family Futures[202]

National Center on Substance Abuse and Child Welfare (NCSACW)[203]

NCSACW Information on Family Treatment Drug Court[204]