SUBSTANCE USE DISORDERS

A. Statewide Overview of Substance Use

Substance use by parents in DFPS cases is very common. In 2019, 66% of children removed from their homes and placed in out-of-home care had parental alcohol or other drug abuse as an identified condition for removal[120].

Special Issue: *The term "abuse" is highly associated with negative judgments and punishments. The preferred terms are substance "use" when referencing illicit drugs and "misuse" for prescription medications used other than prescribed.* [121]

Methamphetamine continues to be perceived as the primary drug threat by the three DEA Field Divisions covering Texas. Cocaine indicators continue to decrease. However, heroin and fentanyl indicators have been increasing, as fentanyl is specifically used to "cut" heroin. The number of seizures of fentanyl items identified by law enforcement has risen from 23 in 2006 to 841 in 2020.[122]

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, even while 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.[123]

1. **Useful Definitions from the Health and Human Services Commission (HHSC)**

   - Substance Use: use of a substance.
   - Substance Misuse: using a substance in a way that is not consistent with medical or legal guidelines (e.g., 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 (e.g., drunk driving).
   - Substance Use Disorder (SUD): a condition marked by a cluster of cognitive, behavioral, and physiological symptoms in which the use of a substance leads to clinically significant impairment or distress in a person's life. Substance use disorders range can range widely in severity (mild, moderate, or severe), with severe substance use disorders typically including clinical criteria of tolerance and withdrawal.
   - Recovery: a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness and managing setbacks. Because setbacks are a natural part of substance use,[124] resilience becomes a key component of recovery.[125]

B. Substance Use Among Women

Substance use in women tends to be multifaceted and can be related to family or partner use or co-morbid mental health conditions such as depression, anxiety, and eating disorders. Additionally, substance use disorders in women are strongly correlated with childhood personal violence and histories of trauma. Consequences of substance use for women include physical complications, the risk of losing custody of children under their care, and exposure to partner violence. Women develop physiological complications from substance use, especially alcohol use, in a shorter time and at lower rates of consumption than men. Additionally, reproductive consequences for pregnant women may include fetal alcohol spectrum disorders, long-term cognitive deficits, low birth weight, or miscarriage.[126]

A gender-responsive approach to the treatment process and recovery for women includes the importance of relationships and family, the prevalence and history of trauma and violence, common patterns of co-occurring disorders, and, when applicable, particular recognition of caregiver responsibilities.[127]

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.[128]

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. In Texas, a pregnant woman who is financially eligible and clinically appropriate must be admitted to HHSC-funded treatment services within 48 hours of the woman's request for service. Additionally, SAMHSA requires states to spend five percent of the states' overall budget on specialized female programs for pregnant and parenting women.

Neonatal abstinence syndrome (NAS) is a treatable condition that newborns may experience as a result of prenatal exposure to certain substances, most often opioids. Neonatal Opioid Withdrawal Syndrome (NOWS) is a related term that refers to the symptoms that infants may experience as a result of exposure to opioids specifically.[129] Pregnant women using opioids should not discontinue opioid use due to the risk of maternal return to use, 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) as a best practice in managing an opioid use disorder in pregnancy.[130] Tapering of MAT dosing during pregnancy is also associated with more frequent return to use. Prior to birth, engaging pregnant women with opioid and other substance use disorders in substance use treatment and other services

as a component of prenatal care can also mitigate or prevent negative birth outcomes associated with NAS and NOWS.[131]

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 local resources and additional assistance, please visit the HHSC OSAR webpage.[132] Individuals can also locate substance use services in their area by visiting the substance use service locator map.[133]

Special Issue: *"Return to use" is the recommended term to avoid shame and stigma associated with the term "relapse," however "relapse" and "relapse prevention" are still commonly used terms.*

2. Relapse Prevention

Parents in DFPS cases who have difficulty with substance use may relapse or return to use. However, with the right support and appropriate level of intervention, it is possible to achieve successful reunification with a parent who has addressed or is addressing 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 in relevant part regarding relapse prevention planning:

- Relapse is a return to a pattern of substance use after a period of non-use.
- In the relapse safety plan, the client, along with a trusted support system, plans to ensure the safety of the child or children, in case relapse becomes an issue.
- Court orders supersede any actions that the client requests in the relapse safety plan.
- A relapse safety plan can be developed at any stage of service.

Please see *Developing a Safety Plan in Case a Client Relapses* (CPS Policy Handbook § 1982.2) for more information.

D. DFPS Response to Substance Use Disorders

The Child Abuse Prevention and Treatment Act (CAPTA, P.L. 93-247) was originally enacted in 1974, was last reauthorized in 2010, and amended most recently in 2019; additionally, certain provisions were amended by the Comprehensive Addiction and Recovery Act (CARA) of 2016 and the Victims of Child Abuse Act Reauthorization Act of 2018 (P.L. 115-424).[134]

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, collectively mean that 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 intervention and treatment services. In Texas, a client who is not pregnant and is referred to an HHSC-funded substance use intervention or treatment service by DFPS must be admitted to services within 72 hours or 3 business days, depending on the program or services.

Doctors and nurses are required by mandatory reporting laws to report suspected child abuse and neglect if they have reasonable cause to believe the child has been abused as defined by statute. Tex. Fam. Code § 261.101(b). Definitions of child abuse in Texas law include the current 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 § 261.001(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 and 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 (FBSS) stage may be opened to provide ongoing services without removal. Where safety cannot be assured, DFPS will seek removal of the infant.

***Special Issue**: The birth of a substance-exposed infant 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 works closely with Health and Human Services agency partners who provide substance use intervention or treatment services to strengthen the State's response to parents who engage in substance use or misuse.*

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1. Behavioral Health Division at DFPS

In Fiscal Year 2019, DFPS formed the Behavioral Health Services Division within CPS. The division now includes a Behavioral Health Services Division Administrator, a Trauma-Informed Care Manager, six new regional Trauma-Informed Care Program Specialists, a Behavioral Health Services Program Specialist Lead, three Substance Use Program Specialists, two CANS Program Specialists, and a Mental Health Program Specialist. The Medical Services Division covers medical and dental issues for CPS with Nurse Consultants and Well-Being Specialists. The Behavioral Health Services Division

Administrator and the Trauma Informed Care Program Manager are based at the State Office in Austin. The Behavioral Health Services Program Specialist is located in Houston, one CANS Program Specialist operates in San Antonio, and a second CANS Program Specialist is in Houston. The Trauma Informed Care Program Specialist positions are based in San Antonio, Dallas, Houston, Corpus, Midland, and Paris. The division includes three Substance Use Program Specialists located in San Antonio, Dallas, and Houston. These positions complement 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

Children and Family Futures[135]

American Addiction Centers' Information on Addiction Signs, Symptoms, Effects, and Treatment[136] and Addiction Cravings: Symptoms, Treatment and Relapse Prevention[137]

National Institute on Drug Abuse[138]

National Center on Substance Abuse and Child Welfare (NCSACW)[139]

National Council of Juvenile and Family Court Judges (NCJFCJ)[140]

NCSACW Information on Family Treatment Drug Court[141]

Substance Abuse and Mental Health Services Administration (SAMHSA)[142]

Texas Health and Human Services Mental Health and Substance Use[143]