National Center on Substance Abuse and Child Welfare

MEDICATION-ASSISTED TREATMENT

A PRIMER FOR JUDICIAL PROFESSIONALS SERVING PARENTS AND CHILDREN AFFECTED BY SUBSTANCE USE DISORDERS

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INTRODUCTION

Substance use disorder (SUD), which includes opioid use disorder (OUD), is a chronic relapsing brain disease caused by changes in neural pathways associated with the use of alcohol and/or drugs. SUD involves changes to the brain's reward circuitry affecting judgment, decision-making, learning, memory, and behavior control.[1] A licensed professional can make a clinical SUD diagnosis following a comprehensive assessment using the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

SUD treatment should meet a person's unique substance-related clinical and supportive needs. The SUD service continuum includes early identification, screening, and brief intervention; comprehensive standardized assessment; stabilization; appropriate, manualized, evidence-based treatment using medications if warranted; continuing care; and recovery support.

Many adults entering SUD treatment have children at risk of child abuse and neglect, developmental delays, and adolescent substance misuse.[2] Interactions between parents with SUDs and their children may have prolonged effects. A 2018 U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) survey found many caseworkers, courts, and other providers misunderstand how SUD treatment works, and lack guidelines on how to incorporate SUD services into child welfare practices.

Research shows parents who are screened and identified as having a SUD—and engage in treatment early—are more likely to retain custody or reunify with their children.[3] One key to reunifying children and families is engaging in collaborative practices that include early access to treatment, information sharing, and coordinated case planning among child welfare, court, SUD treatment, and other service professionals. The collaborative process helps patients access SUD treatment— including MAT—that meets the needs of parents and families.

10.1 million

A 2019 SAMHSA National Survey on Drug Use and Health found approximately **10.1 million** people aged 12 or older misused opioids in the past year and approximately **1.6 million** people aged 12 or older had an OUD.

21.6 million

An estimated **21.6 million** Americans over the age of 12 needed treatment for substance use in 2019.[4]

170 people die each day

Opioid overdose deaths increased fivefold over the last 15 years. Around **170 people die** from drug overdoses **each day**; 116 are opioid related.[5]

during pregnancy increased nearly 70%

The number of women who used opioids **during pregnancy increased nearly 70%** between 2015 and 2017.[6]

8.3 million children

Approximately **8.3 million children** live with at least one adult either dependent on alcohol or needing treatment for illicit drug abuse.[7]

out-of-home care 39% of the time

On average across the U.S., parental alcohol and/or substance use was listed as an identified condition of removal for children in out-of-home care 39% of the time in FY 2018.[8]

OVERVIEW OF MEDICATION-ASSISTED TREATMENT (MAT)

MAT is an evidence-based treatment for OUDs. MAT uses medications, in combination with counseling and other therapeutic techniques, to provide a "whole-patient" approach to the treatment of SUDs. [1,2,9] MAT is primarily used for addiction to opioids, such as heroin; prescription pain relievers containing opiates like morphine and codeine; and semi-synthetic opioids such as hydrocodone, oxycodone, Percocet, Vicodin, and fentanyl. SAMHSA, along with the National Institute on Drug Abuse (NIDA), the American Society of Addiction Medicine (ASAM), the Centers for Disease Control and Prevention (CDC), and the American Medical Association (AMA) all recommend MAT as a best practice for treating OUDs. The American College of Obstetricians and Gynecologists (ACOG) also recommends MAT as a best practice for treating pregnant women with OUDs.

Doctors have successfully prescribed buprenorphine (Suboxone and Subutex) for nearly two decades— and methadone for more than three decades—to treat OUDs.[4,5] More recently the Food and Drug Administration (FDA) approved oral naltrexone and extended-release injectable naltrexone (also known as Vivitrol) as highly effective medications.

BENEFITS OF MAT

MAT has proven clinically effective in reducing both substance use and the need for inpatient detoxification services.[12-15] "Medications relieve the withdrawal systems and psychological cravings that cause chemical imbalances in the body and allow the person to focus on other aspects of their recovery."[15] MAT, as part of a comprehensive treatment program, has improved patient survival rates and increased retention in treatment, while decreasing illicit opiate use, criminal activities leading to rearrest and reincarceration, drug-related HIV risk behaviors, and pregnancy-related complications.[16-21] MAT helps with detoxification while preventing withdrawal symptoms and other related medical complications.[22] *Without* MAT, opioid relapse rates are high—between 65 and 80% just one month after discontinuing MAT—and over 90% after six months.[23-29]

Research shows medications used in MAT, when provided at the proper dose, have no adverse effects on a person's intelligence, mental capability, physical functioning, or employability.[30] MAT, along with a range of clinical and supportive services, can help people achieve stability while focusing on other aspects of their recovery, such as finding work, housing, or enhancing their parenting skills. One study found parents with OUDs who were involved in child welfare and received MAT had a significantly higher prevalence of retaining child custody than a comparison group not receiving MAT. With each additional month of MAT, parents in the study were 10% more likely to retain custody; the number of parents who retained custody increased to 120% after one year.[31]

RISKS OF MAT

Medications used in MAT, many of which are controlled substances, have the potential for misuse and overdose. This can occur when someone accidentally takes an extra dose; deliberately misuses a prescription opioid; or mixes opioids with other medications, alcohol, or over-the-counter products. When a person takes an opioid medication prescribed for someone else, particularly children and adolescents, they are especially vulnerable to accidental overdoses.

For those who have either a co-occurring anxiety-related mental health diagnosis, or misuse medications for the treatment of anxiety, combining medications used in MAT with anxiety-treatment prescriptions can prove **fatal**. Types of anxiety medications include derivatives of benzodiazepines like Xanax or Valium. **Addiction medications may have various side effects for each person. Information specific to side effects can be found on the U.S. Food and Drug Administration website's medication search engine. Each medication described by SAMHSA can be found on their page for Medications, Counseling, and Related Conditions.**

> **Medications relieve the withdrawal systems and psychological cravings that cause chemical imbalances in the body and allow the person to focus on other aspects of their recovery.**

BARRIERS TO TREATMENT WITH MAT

Certain attitudes, beliefs, and stereotypes could create barriers to accessing MAT that are not only potentially illegal, they may also seriously delay access to critical health and human service programs. Women who overdosed on opioids, in addition to facing greater barriers to MAT and overdose reversal medications were almost three times less likely to receive naloxone, the medication for overdose reversal, than men.[32] Women with OUDs (and their infants) face critical barriers to optimal care, including:

- Fear of reprisal from significant others and family members; fear of not being able to care for the children (or the loss of custody); and concerns about confidentiality.
- Legal obstacles such as efforts to protect the fetus or infant from opioid exposure. However, legal consequences in several states that sanction pregnant women with OUDs may drive these women away from available care—thereby potentially leading to worse outcomes for both the mother and child.

Systemic barriers include the cost of treatment, insurance requirements, waiting lists, lack of appropriate treatment, shortages of quality childcare, transportation, employment, safe and affordable housing, conflicting demands from other systems such as child welfare and Temporary Assistance for Needy Families (TANF) requirements, as well as legal consequences.

- Regulatory requirements stipulating individuals treated for an OUD with methadone must receive the medication under the supervision of a physician may limit access. Daily clinic visits for methadone can seriously affect transportation, scheduling, family and employment obligations, and participation in child welfare plans.

People with OUDs are highly stigmatized. Stigma permeates community institutions, affecting both the policies and attitudes of service professionals and criminal justice agencies. It discourages individuals from accessing early treatment and remaining in services. Stigma also affects programs' location and access. One of the first steps in building collaborative relationships with professionals who support individuals with OUDs (and their families) is identifying the perceptions and stigma of SUDs as well as the implications.

- Language considerations also play a role. Professionals working with individuals affected by a SUD can fight stigma in their everyday practice by using person-first language that suggests the person *has a problem that can be treated*. Table 2, adapted from the White House Office of National Drug Control Policy (2015), provides additional examples of language considerations.

TABLE 2: LANGUAGE CONSIDERATIONS

Instead of:	Try:
Addict/Drug abuser	Person with a substance use disorder
Clean	Abstinent
Dirty/Dirty screen	Actively using/testing positive for substance use
Drug habit	Compulsive or regular substance use
Former/Reformed addict/Alcoholic	Person in recovery/long-term recovery
Recreational, casual or experimental users	People who use drugs for non-medical reasons
Addicted baby	Infant affected by prenatal substance exposure
Drug of choice	Drug of use
Opioid replacement	Medication-assisted treatment or medication for opioid use disorder
Visitation	Family or parenting time
Foster child	Child in care or out of home placement
Placed with a family	Joined a family
Behavioral health	Substance use and/or mental disorders

As professionals it is important to incorporate evidence-based treatment for OUDs across systems and ensure those services are available to all populations. For more information about the role of medications in treating opioid use disorders, please visit SAMHSA's handbook *Decisions in Recovery: Treatment for Opioid Use Disorder Medications for Opioid Addiction*.

NEED FOR COLLABORATION

Judges, court personnel, attorneys, child protective services, treatment professionals, and other community partners collaborate on coordinating services. Collaboration helps ensure children have safe, nurturing, and permanent homes; family members receive the needed supports and services; and parents achieve stable recovery within mandatory time frames.[33] The result of this intense collaboration is a multisystem focus on family recovery, including early intervention, increased access to treatment, and engagement in services.

MULTIDISCIPLINARY FOLLOW UP

This step should include health care, developmental interventions, as well as social and emotional support. Infants born to women who used opioids during pregnancy should be monitored for neonatal abstinence syndrome (NAS) by a multidisciplinary team of providers—including early intervention, home visiting programs, pediatric care specialists, and pediatricians.

SPECIAL POPULATIONS AND CONSIDERATIONS

USE OF MAT DURING PREGNANCY

Substance use while pregnant, especially opioid use, has escalated dramatically in recent years, mirroring the epidemic observed in the general public. Pregnancy provides an important opportunity to identify and treat women with SUDs. Pregnant women who undergo early universal screening and referral to treatment and supportive services show improved maternal and infant outcomes.[34] The types of agencies and professionals providing treatment and other services to pregnant women with OUDs can vary widely from one community to another. Every professional involved needs to understand a pregnant woman's distinct needs, and those of her family members, before implementing the most appropriate and comprehensive plan of care.

"Pregnant women who are physically dependent on opioids should receive MAT from a physician rather than withdrawal management or abstinence, since those approaches may pose a risk to the pregnant woman and the fetus."[35] According to the American College of Obstetricians and Gynecologists (ACOG), the current standard of care for pregnant women with OUDs is referral for MAT with methadone and/or buprenorphine since "abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor, fetal distress, or fetal demise."[36]

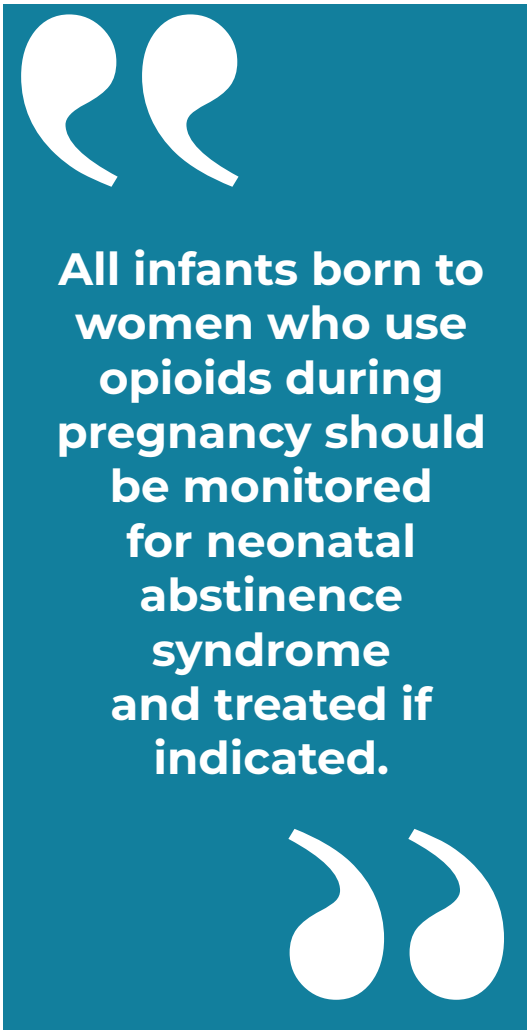
There is **no** known risk of increased birth defects specific to the use of buprenorphine or methadone.[34] For pregnant women diagnosed with an OUD, there is a chance that their infant may experience withdrawal symptoms after birth. Like any medication given during pregnancy, MAT has both risks and benefits to the mother and fetus. Therefore, MAT needs careful consideration and coordination from all treatment and medical professionals involved.

- NAS represents the pattern of effects linked to withdrawal for newborns with prenatal exposure to certain substances, including opioids.[37] Many factors influence NAS symptoms, including the type of opioid involved, the point in gestation when the mother used the opioid, genetic factors, and exposure to multiple substances including tobacco.[38]

- NAS is a treatable condition. According to ACOG, "All infants born to women who use opioids during pregnancy should be monitored for neonatal abstinence syndrome and treated if indicated. There are no known risks of increased birth defects with pharmacotherapy medications."[34]

PARENTS INVOLVED IN CHILD WELFARE

Family-centered practice focuses on working with the family unit to strengthen protective factors, reduce risks and ensure the best possible outcomes for children in a variety of settings across child welfare and other service systems. It is designed to meet the needs of each member in the family as well as support the whole family's functioning, not only the person diagnosed with the SUD. While the length of the services, type of setting (e.g., residential, outpatient), and size of the programs may vary, the common objectives across all family-centered treatment approaches are that parents receive full support in their parenting roles, and children receive necessary services and supports to remain with their parent(s) during the treatment and recovery process. Family-centered treatment focuses on parental recovery and includes specific services to recovery from family trauma—along with social, emotional, and developmental challenges.[39]



Both traditional treatment and family-centered treatment include strategies regarding to reduce effects of SUDs, teach coping mechanisms to achieve sobriety, and help clients develop continuing care plans. However, only family-centered treatment carries out these fundamental practices for the individual within the context of the family and relationships. Family-centered treatment ensures development of treatment plans not only for the identified client, but also for other individuals in the family, and the family as a whole. Family-centered treatment goes beyond a parent's SUD to examine relationship dynamics and seeks to prevent intergenerational transmission of SUDs.

- **Reasonable efforts:** Laws in all states require that child welfare agencies make "reasonable efforts" to help families mitigate the conditions that brought the child and family into the system and federal law requires "active efforts" are made for native children and families. Provisions to the Adoption and Safe Families Act of 1997 (ASFA), clarified reasonable efforts as an emphasis on children's health and safety. They also require states seeking federal foster care matching funds to "make 'reasonable efforts' to prevent removal of the child from the home and return those who have been removed as soon as possible."[40]

- **Barriers to treatment:** Issues include competing requirements and timetables involving substance use treatment, child welfare, and the courts.

    - The SUD treatment timetable considers treatment and recovery for a parent with a SUD. Some parents may have treatment and recovery timetables incompatible with child welfare and reform deadlines.

    - The child welfare/court timetable relates to ASFA time limits:

        - ASFA reduced the time allowed to resolve child maltreatment cases from 18 to 12 months.

        - ASFA requires a "termination of parental rights" proceeding to free a child for adoption once that child has been waiting in foster care for at least 15 of the most recent 22 months, unless it is not in the best interest of the child.[39] The 12-month timetable may move too quickly to give parents enough time to complete treatment or demonstrate sufficient stability to care for their children. Individual states have allowed termination at six months for infants with parents showing no progress, while also allowing an extension to 18 months if parents are demonstrating substantial progress.

CO-OCCURRING DISORDERS

People with mental illness are more likely to experience a SUD according to SAMHSA's National Survey on Drug Use and Health. "The co-existence of both a mental illness and a substance use disorder, known as a co-occurring disorder, is common among people in medication- assisted treatment."[40] Co-occurring disorders (CODs) refer to co-occurring SUDs and mental disorders.[41] Individuals with CODs have one or more mental disorders as well as one or more SUDs as identified in the DSM-5. "Some of the most common mental disorders seen in MAT patients include anxiety and mood disorders, schizophrenia, bipolar disorder, major depressive disorder, post-traumatic stress disorder (PTSD), and attention deficit hyperactivity disorder (ADHD)."[42]

"One hallmark of CODs is the highly interactive nature of mental health and substance use disorders and how each disorder affects the symptoms, course, and treatment of the others. The American Psychiatric Association (APA) describes a number of ways in which two sets of disorders are interdependent and interactive:

- One disorder may predispose a person to another type of disorder.
- A third type of disorder (e.g., chronic health conditions such as HIV/AIDS) may affect or elicit the onset of mental or substance use disorders.
- Symptoms of each disorder may be augmented, as these often overlap between mental and substance use disorders (e.g., anxiety, depression [APA, 2013]).
- Other disorders, such as borderline personality disorder (BPD) as classified by the DSM-5, may predispose individuals to more severe mental disorders such as major depressive disorder and SUDs.
- Alcohol and other drugs may induce, or more frequently mimic, a mental disorder."[43,44,45]

Physicians may use additional medications alongside counseling to treat or manage COD symptoms. According to SAMHSA's ***Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occurring Mental and Substance Use Disorders***, the selection of interventions should move from lower- to higher-risk strategies depending on clinical response. Certain medications effective for one condition may have a crossover benefit for the other.

CODs strongly correspond to socioeconomic and health factors that challenge recovery such as unemployment, homelessness, incarceration/criminal justice involvement, and suicide.[43] Treatment should be comprehensive to meet the dynamic needs clients that frequently co-occur, while considering immediate and long-term needs to help people enter into and navigate systems of care, remove barriers to recovery, stay engaged in the recovery process, and life full lives in their community of choice.

KEY TAKEAWAYS

- The use of MAT, type of medication, dosage, frequency, and duration of treatment are ***individualized medical decisions*** made at the sole discretion of the licensed medical professional providing services.
- It is important for everyone to know that ***federal disability rights protections*** apply to some people with OUDs and SUDs. **NCSACW**, together with the Department of Health and Human Services, Office for Civil Rights (OCR), created a **video and webinar series** to provide information to child welfare and court professionals on federal disability rights laws, and protections for qualified individuals with a disability in the child welfare system.
- Individuals are more likely to comply with treatment and have better outcomes when judges give them opportunities to voice their perspectives while showing respect and support. When FTC participants were asked to identify the most important elements of the court, they ranked participant/judge rapport among the top six.[34]
- It is important to know the individual policies for using MAT with treatment providers, programs, and supportive services within each community. This includes, but is not limited to, sober living homes, AA/NA groups, and both inpatient and outpatient treatment programs.
- Judicial oversight includes an understanding of state and federal case law regarding the use of MAT. Among the factors that play a role: adhering to the special considerations listed in this document, monitoring the team's and court's reliance on these considerations, locating qualified providers that use evidenced-based practices and a family-centered approach, ensuring that team members have training in the use of MAT, settling differences of opinion about the use of MAT with factual information, and using person-first language.

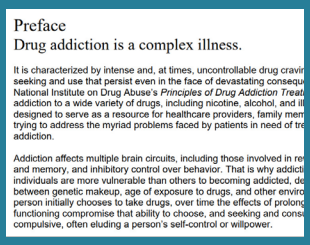
RESOURCES

- **NCSACW** is a national resource center providing information; expert consultation; and free training and technical assistance (TTA) tools for child welfare, **dependency court**, and substance use treatment professionals to improve the safety, permanency, well-being, and recovery outcomes for children, parents, and families.

- NCSACW, together with the **Office for Civil Rights (OCR)**, created a training series, *Exploring Civil Rights Protections for Individuals in Recovery from an Opioid Use Disorder*, to provide information to child welfare and court professionals about federal disability rights protections that apply to some parents with an opioid or other substance use disorder and involved in child welfare.

- SAMHSA is the agency within HHS that leads public health efforts to advance the health of the nation whose mission is to reduce the impact of substance use and mental illness nationally. Visit the **SAMHSA** website for more information on treatment services for SUDs, **rights for individuals on MAT, federal guidelines for opioid treatment programs**, and SAMHSA's treatment locator, which provides referrals to local treatment facilities, support groups, and community-based organizations (filtered by need). For more information visit SAMHSA's **"Find Treatment"** page, or call 800-662-4357 (HELP), a free and confidential helpline open 24/7.

- SAMHSA's 2021 update of *Treatment Improvement Protocol (TIP) 63: Medications for Opioid Use Disorder* reviews the use of the three FDA-approved medications used to treat OUD and the other strategies and services needed to support recovery for people with OUD.



Preface
Drug addiction is a complex illness.

It is characterized by intense and, at times, uncontrollable drug cravir
seeking and use that persist even in the face of devastating consequ
National Institute on Drug Abuse's *Principles of Drug Addiction Treat*
addiction to a wide variety of drugs, including nicotine, alcohol, and il
designed to serve as a resource for healthcare providers, family mem
trying to address the myriad problems faced by patients in need of tre
addiction.

Addiction affects multiple brain circuits, including those involved in re
and memory, and inhibitory control over behavior. That is why addicti
individuals are more vulnerable than others to becoming addicted, de
between genetic makeup, age of exposure to drugs, and other enviro
person initially chooses to take drugs, over time the effects of prolong
functioning compromise that ability to choose, and seeking and consu
compulsive, often eluding a person's self-control or willpower.

- The **National Institute on Drug Abuse (NIDA)** is the lead federal agency supporting scientific research on drug use and its consequences. NIDA's *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)* offers guidance and key components of effective treatment programs.

- The **Child Welfare Information Gateway** (CWIG) provides child welfare and adoption professionals, as well as the general public, access to information, resources, and tools covering topics on child welfare, child abuse and neglect, out-of-home care, adoption, and more.

REFERENCES

1. National Institute on Drug Abuse. (2020, July 10). *Drugs and the brain*. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain
2. Lander, L., Howsare, J., & Byrne, M. (2013). The impact of substance use disorders on families and children: From theory to practice. *Social Work in Public Health*, *28*(3-4), 194-205.
3. Hall, M. T., Wilfong, J., Huebner, R. A., Posze, L., & Willauer, T. (2016). Medication-assisted treatment improves child permanency outcomes for opioid-using families in the child welfare system. *Journal of Substance Abuse Treatment*, *71*, 63-67. https://doi.org/10.1016/j.jsat.2016.09.006
4. Substance Abuse and Mental Health Services Administration. (2019). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* (HHS Publication No. PEP 19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
5. Centers for Disease Control and Prevention. (2020, March 19). *Understanding the epidemic*.
6. Wiles, J. R., Isemann, B., Mizuno, T., Tabangin, M. E., Ward, L. P., Akinbi, H., & Vinks, A. A. (2015). Pharmacokinetics of oral methadone in the treatment of neonatal abstinence syndrome: A pilot study. *The Journal of Pediatrics*, *167*(6). https://doi.org/10.1016/j.jpeds.2015.08.032
7. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009, April 16). *Children living with substance dependence or substance-abusing parents: 2002-2007*. The NSDUH report. https://eric.ed.gov/?id=ED525064
8. The AFCARS report. (2000-2018). [Washington, D.C.]: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.
9. Substance Abuse and Mental Health Services Administration. (n.d.). *Medication-assisted treatment (MAT)*. https://www.samhsa.gov/medication-assisted-treatment
10. Drug Enforcement Administration, Diversion Control Division, Drug & Chemical Evaluation Section. (2019, December). *Buprenorphine*. https://www.deadiversion.usdoj.gov/drug_chem_info/buprenorphine.pdf
11. Drug Enforcement Administration, Diversion Control Division, Drug & Chemical Evaluation Section. (2019, December). *Buprenorphine*. https://www.deadiversion.usdoj.gov/drug_chem_info/buprenorphine.pdf
12. National Institute on Drug Abuse. (2020, June 4). *Effective treatments for opioid addiction*. https://archives.nida.nih.gov/publications/effective-treatments-opioid-addiction
13. Koehl, J. L., Zimmerman, D. E., & Bridgeman, P. J. (2019). Medications for management of opioid use disorder. *American Journal of Health-System Pharmacy*, *76*(15), 1097-1103. https://doi.org/10.1093/ajhp/zxz105
14. Bart, G. (2012). Maintenance medication for opiate addiction: The foundation of recovery. *Journal of Addictive Diseases*, *31*(3), 207-225. https://doi.org/10.1080/10550887.2012.694598

REFERENCES

15. Substance Abuse and Mental Health Services Administration. (n.d.). *Medication-assisted treatment (MAT)*. https://www.samhsa.gov/medication-assisted-treatment

16. Fullerton, C. A., Kim, M., Parks Thomas, C., Lyman, R., Montejano, L. B., Dougherty, R. H., Daniels, A. S., Shoma Ghose, S., & Delphin-Rittmon, M. (2013). Medication-assisted treatment with methadone: Assessing the evidence. *Psychiatric Services*. https://doi.org/10.1176/appi.ps.201300235

17. The American College of Obstetricians and Gynecologists. (2012). Committee opinion no. 524: Opioid abuse, dependence, and addiction in pregnancy. *Obstetrics & Gynecology*, *119*(5), 1070-1076.

18. Dolan, K. A., Shearer, J., White, B., Zhou, J., Kaldor, J., & Wodak, A. D. (2005). Four-year follow-up of imprisoned male heroin users and methadone treatment: Mortality, reincarceration and hepatitis C infection. *Addiction*, *100*(6), 820–828.

19. Gordon, M. S., Kinlock, T.W., Schwartz, R.P., & O'Grady, K.E. (2008). A randomized clinical trial of methadone maintenance for prisoners: Findings at 6 months post-release. *Addiction*, *103*(8), 1333–1342.

20. Havnes, I., Bukten, A., Gossop, M., Waal, H., Stangeland, P., & Clausen, T. (2012). Reductions in convictions for violent crime during opioid maintenance treatment: A longitudinal national cohort study. *Drug and Alcohol Dependence*, *124*(3), 307–310.

21. Kinlock, T. W., Gordon, M.S., Schwartz, R.P., & O'Grady, K.E. (2008). A study of methadone maintenance for male prisoners: Three-month post release outcomes. *Criminal Justice & Behavior*, *35*(1), 34–47.

22. Doweiko, H. (2011). *Concepts of Chemical Dependency*. Stamford, CT: Nelson Education.

23. Bailey, G. L., Herman, D. S., & Stein, M. D. (2013). Perceived relapse risk and desire for medication-assisted treatment among persons seeking inpatient opiate detoxification. *Journal of Substance Abuse Treatment*, *45*(3), 302-305. https://doi.org/10.1016/j.jsat.2013.04.002

24. Broers, B., Giner, F., Dumont, P., Mino, A. (2000). Inpatient opiate detoxification in Geneva: Follow-up at 1 and 6 months. *Drug Alcohol Dependence*, *58*(1-2), 85-92. https://doi.org/10.1016/S0376-8716(99)00063-0

25. Chutuape, M. A., Jasinski, D. R., Fingerhood, M. I., Stitzer, M. L. (2009). One-, three-, and six-month outcomes after brief inpatient opioid detoxification. *The American Journal of Drug and Alcohol Abuse*, *27*(1), 19-44. https://doi.org/10.1081/ADA-100103117

26. Gossop, M., Green, L., Phillips, G., Bradley, B. (1989). Lapse, relapse and survival among opiate addicts after treatment: A prospective follow-up study. *The British Journal of Psychiatry*, *154*(3), 348-353. https://doi.org/10.1192/bjp.154.3.348

27. Mark, T. L., Dilonardo, J. D., Chalk, M., & Coffey, R. M. (2002). Trends in inpatient detoxification services, 1992-1997. *Journal of Substance Abuse Treatment*, *23*(4), 253-260. https://doi.org/10.1016/S0740-5472(02)00271-4

28. Silsby, H. & Forest, S. T. (2009). Short-term, ambulatory detoxification of opiate addicts using methadone. *International Journal of the Addictions*, *9*(1), 167-170. https://doi.org/10.3109/10826087409046779

29. Smyth, B. P., Barry, J., Keenan, E., & Ducray, K. (2010). Lapse and relapse following inpatient treatment of opiate dependence. *Irish Medical Journal*, *103*(6), 176-179.

30. Substance Abuse and Mental Health Services Administration. (n.d.). *MAT medications, counseling, and related conditions*. https://www.samhsa.gov/substance-use/treatment/options/medications

31. Hall, M. T., Wilfong, J., Huebner, R. A., Posze, L., & Willauer, T. (2016). Medication-assisted treatment improves child permanency outcomes for opioid-using families in the child welfare system. *Journal of Substance Abuse Treatment*, *71*, 63-67. https://doi.org/10.1016/j.jsat.2016.09.006

32. Sumner, S. A., Mercado-Crespo, M. C., Spelke, M. B., Paulozzi, L., Sugerman, D. E., Hillis, S. D., & Stanley, C. (2015). Use of naloxone by emergency medical services during opioid drug overdose resuscitation efforts. *Prehospital Emergency Care*, *20*(2), 220-225. https://doi.org/10.3109/10903127.2015.1076096

33. Center for Children and Family Futures and National Association of Drug Court Professionals. (2019). Family Treatment Court Best Practice Standards. Prepared for the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Office of Justice Programs (OJP), U.S. Department of Justice (DOJ).

34. The American College of Obstetricians and Gynecologists. (2017, August). *Opioid use and opioid use disorder in pregnancy*. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

35. Substance Abuse and Mental Health Services Administration. *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. HHS Publication No. (SMA) 16-4978*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. Available at: http://store.samhsa.gov/

36. The American College of Obstetricians and Gynecologists. (2012). Committee opinion no. 524: Opioid abuse, dependence, and addiction in pregnancy. *Obstetrics & Gynecology*, *119*(5), 1070-1076.

37. Hudak, M. L., & Tan, R. C. (2012). Neonatal drug withdrawal. *Pediatrics*, *129*(2), 540-560. https://doi.org/10.1542/peds.2011-3212

38. Wachman, E. M., Hayes, M. J., Brown, M. S., Paul, J., Harvey-Wilkes, K., Terrin, N., Huggins, G. S., Aranda, J. V., & Davis, J. M. (2013). Association of OPRM1 and COMT single-nucleotide polymorphisms with hospital length of stay and treatment of neonatal abstinence syndrome. *Journal of the American Medical Association*, *309*(17), 1821-1927. https://doi.org/10.1001/jama.2013.3411

39. National Center on Substance Abuse and Child Welfare. (2021). *Implementing a family-centered approach module 1: Overview of a family-centered approach and its effectiveness*.

40. Children's Bureau. (2019). *Major federal legislation concerned with child welfare protection, child welfare, and adoption*. [Fact sheet].

41. Substance Abuse and Mental Health Services Administration. *Substance Use Disorder Treatment for People with Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series, No. 42. SAMHSA Publication No. PEP20-02-01-004*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

42. Substance Abuse and Mental Health Services Administration. (n.d.). *Co-occurring disorders and other health conditions*. https://www.samhsa.gov/substance-use/treatment/co-occurring-disorders

43. Substance Abuse and Mental Health Services Administration. *Screening and Assessment of Co-occurring Disorders in the Justice System*. HHS Publication No. PEP19-SCREEN-CODJS. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

44. American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). American Psychiatric Publishing.

45. American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.

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