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Availability of Treatment for Opioid Use Disorder in Areas of High Foster Care Increases

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HIGHLIGHTS

Parental opioid use disorder (OUD) is a risk factor for the maltreatment of children and placement into foster care. Opioid agonist therapy (OAT) is an evidence-based treatment for OUD using medications such as methadone and buprenorphine. OAT can help parents enter recovery, reduce the risk of maltreatment, and potentially improve child welfare outcomes. Child welfare agencies are increasingly looking to connect parents with treatment. However, inadequate supply of OAT providers is a concern. This brief explores the availability of OAT in counties experiencing different increases in foster care entry rates. Highlights are:

- Counties with the highest increases in foster care entries from 2013 to 2018 had the least access to OAT.
- In particular, they were less likely to have an opioid treatment program that can dispense methadone, and they had lower average buprenorphine patient capacity than other counties.
- Decisions about increasing access to OAT should take into consideration the risk of child maltreatment and foster care placement resulting from parental OUD. Foster care caseload dynamics could be considered as indicators of need for greater treatment capacity.

Introduction

The impact of parental substance use on child welfare is well documented. Although not all areas experiencing high foster care caseloads or increases in caseloads are heavily affected by the opioid crisis, areas most affected by opioid use disorder (OUD) have seen heightened strains on foster care systems, court dockets, and related services (Radel et al. 2018a). One major barrier documented by ASPE (Radel et al. 2018b) is the limited availability of opioid agonist therapy (OAT) for treatment of OUD.

Although studies identify gaps in treatment availability in relation to risk of OUD and other factors (e.g., Andrilla et al. 2018; Ghertner 2019; Jones et al. 2015), little is known about how treatment availability relates to foster care. Qualitative work suggests that the availability of OAT providers for clients of child welfare systems is often limited (Radel et al. 2018b). An additional complicating factor is that buprenorphine providers have the option to be listed publicly in the federal government's Buprenorphine Practitioner Locator, and in 2018, 43 percent chose not to

be listed (Ali et al. 2019). This can impede the ability of child welfare caseworkers and administrators to identify and access treatment for clients in their community.

Using national data, this study quantifies the relationship between OAT provider availability in counties and recent changes in foster care entry rates. It also identifies geographic areas with the highest increases in foster care that also have limited availability of treatment. This study does not have causal findings, meaning that it does not determine whether changes in treatment availability affect foster care entries or vice versa.

Current standards of care for OUD consist of counseling and other psychosocial supports in combination with a medication approved by the Food and Drug Administration (FDA; Center for Substance Abuse Treatment 2018). Methadone and buprenorphine are FDA-approved opioid agonists that numerous studies find to be effective in treating OUD and reducing relapse, among other outcomes (Connery 2015).

Although barriers to incorporating OAT into child welfare case plans and prevention efforts continue to exist, caseworkers and courts are increasingly recognizing that OAT is a legitimate, evidence-based form of treatment and that they should actively promote client uptake of such treatment as directed by health care providers (National Judicial Opioid Task Force 2018). Moreover, as of June 2019, methadone maintenance therapy for substance use is an intervention included in the Administration for Children and Families' evidence-based clearinghouse of foster care prevention programs (Children's Bureau 2018), which means that it is reimbursable under Title IV-E funds until at least 2021.

What Is Opioid Agonist Therapy?

OAT, a form of medication-assisted treatment, is the use of opioid agonists to treat OUD. Opioid agonists are medications that bind to opioid receptors in the brain and provide pain relief or feelings of euphoria. As part of OAT, the medications work to prevent withdrawal symptoms and reduce cravings for opioids. These medications are indicated for use with counseling and other psychosocial supports. The FDA has approved two opioid agonist medications: methadone and buprenorphine.[1] Methadone is a full opioid agonist and can generally only be dispensed at opioid treatment programs (OTPs) certified by the Substance Abuse and Mental Health Services Administration (SAMHSA). Buprenorphine is a partial opioid agonist and can be prescribed by health care providers who have received a waiver from the Drug Enforcement Administration. Providers must meet certain requirements to qualify for a waiver, such as receiving training or having appropriate board certification.[2] Both methadone and buprenorphine have been found to decrease opioid use, opioid-related overdose deaths, criminal activity, and infectious disease transmission while increasing social functioning and retention in treatment, as well as improving birth outcomes for pregnant women with OUD (National Institute on Drug Abuse 2016). More information on methadone and buprenorphine for OUD can be found at https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat.

Opioid agonist therapy (OAT) is an evidence-based treatment for OUD. OAT combines one of two FDA-approved OAT medications—methadone and buprenorphine—with psychosocial and other supportive services.

Buprenorphine capacity is the total patient limit of all providers with waivers to prescribe buprenorphine in a county divided by the county's adult population. Providers with waivers have a limit to the number of patients they can concurrently treat with this medication. Providers can be certified for limits of 30, 100, or 275 patients.

Opioid treatment programs (OTPs) are SAMHSA-certified facilities that can dispense methadone for OUD.

[1] Naltrexone is the third medication-assisted treatment approved by the FDA. Naltrexone is an opioid antagonist, blocking the opioid receptors rather than binding to them. It is not considered part of OAT.
[2] Providers who can receive a waiver include physicians, nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives.

Data and Methods

This study uses statistical and geospatial methods to identify the geographic relationships between county OAT treatment availability and foster care entry rates.

Foster care entry rates are drawn from the Adoption and Foster Care Analysis and Reporting System (AFCARS) of the Administration for Children and Families. Entry rates are calculated as the number of children entering foster care in a county during a fiscal year, per 100,000 children in that county. The study looks at the five-year percentage change in foster care entry rates between fiscal years 2013 and 2018, the most recently available data. Counties with fewer than 10 children entering care in 2018 were removed from the analysis. We look at children entering foster care for any reason and those for whom parental drug abuse was a circumstance for foster care entry. Counties are classified into four groups based on their change over that period (Table 1).

Table 1. Percentage Change in County Foster Care Entry Rate, Fiscal Years 2013 to 2018

Foster Care Change	Number of Counties
Decrease	820
No increase or increase between 0% and 33%	487
Increase between 34% and 66%	325
Increase over 66%	605
Total	2,237

Note: Excludes counties with fewer than 10 children entering foster care in fiscal year 2018.

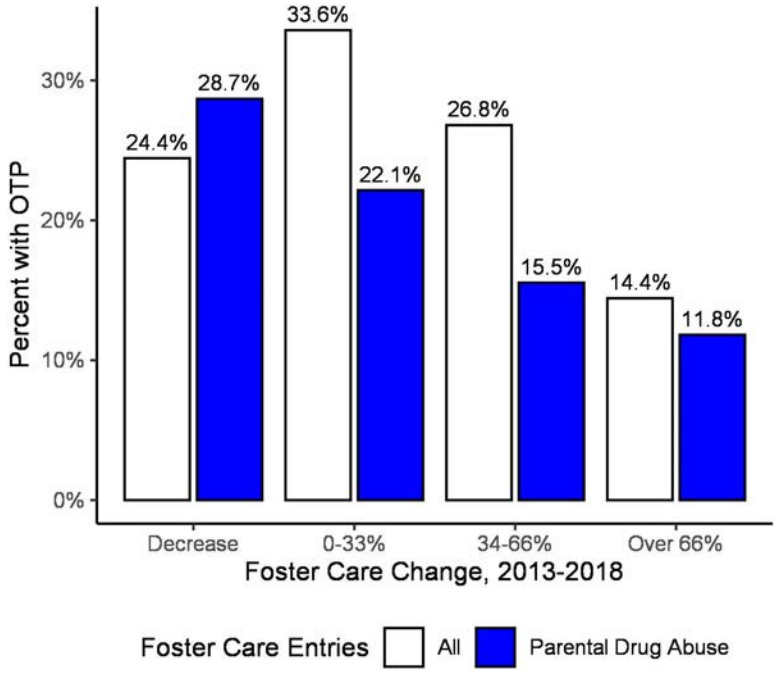
We use two measures of OAT availability: the presence of an OTP that can dispense methadone in a county and the total number of patients who can be treated with buprenorphine. Buprenorphine patient capacity is the sum of the patient limits for all waivered providers (including those not listed publicly) in a county, per 100 adults age 18 or over. Data on the capacity of OTPs are not available. We look at the presence of an OTP rather than the number of OTPs because 86 percent of counties have either zero or one OTP and few counties have higher numbers of OTPs. Data for buprenorphine patient capacity and OTPs come from administrative records at the Center for Substance Abuse Treatment within the Substance Abuse and Mental Health Services Administration.

Tabulations and summary statistics were calculated for counties to identify the relationships between treatment availability and the change in foster care entry rates. Tests of statistical significance were not conducted because we used population data, not a sample.

Findings

Counties with larger increases in foster care are less likely to have an opioid treatment program. As shown in Figure 1, counties with the highest increases in foster care (more than 66 percent) had the lowest probability of having an OTP that dispenses methadone. For all foster care entries, 33.6 percent of counties with relatively small foster care increases had an OTP. In contrast, 14.4 percent of counties with the largest increases had an OTP. In the case of drug-related foster care entries, the story is similar. More than 20 percent of counties with small increases or no increase had an OTP. Fewer than 12 percent of counties with the largest increases had an OTP.

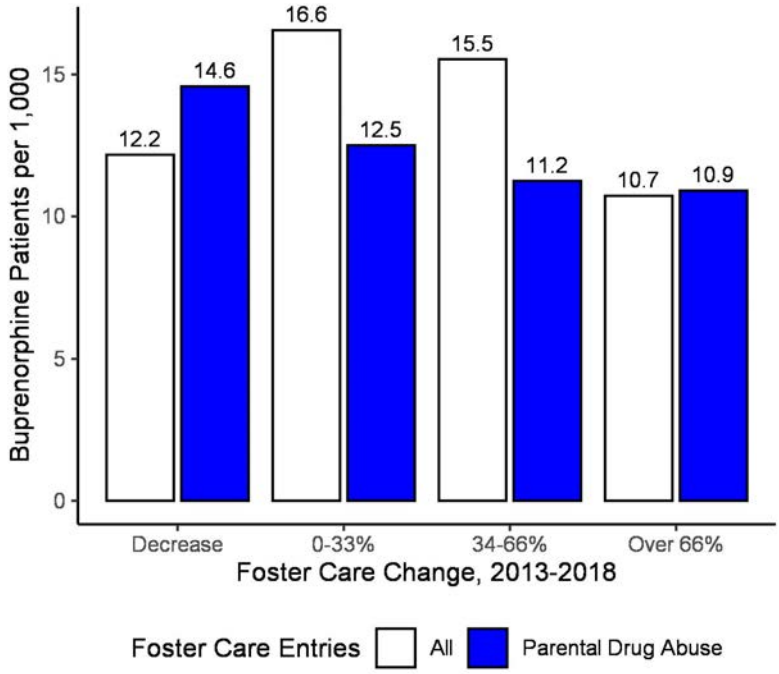
Figure 1. Availability of Opioid Treatment Programs in 2019 by County Change in Foster Care Entry Rate from 2013 to 2018



Note: N = 2,237 counties.

Counties with larger increases in foster care have lower buprenorphine capacity. As shown in Figure 2, counties with foster care increases of more than 66 percent between 2013 and 2018 had an average buprenorphine capacity of 10.7 patients per 1,000 adults in 2019. This is lower than the average capacity in counties experiencing smaller increases in foster care entries. Counties with low increases in foster care had the highest patient capacity. When looking at drug-related removals, counties with decreases on average had capacity to treat 14.6 patients per 1,000. In contrast, counties with foster care increases of at least 34 percent could treat less than 12 patients per 1,000 adults.

Figure 2. Average Buprenorphine Patient Capacity in 2019 by County Change in Foster Care Entry Rate from 2013 to 2018



Note: N = 2,237 counties.

High foster care increases show similar geographic patterns as low OAT availability. Figure 3 shows the geographic distribution of counties by foster care change and presence of an OTP. A number of counties experiencing the greatest increases in foster care lack OTPs; examples include counties in Indiana, Ohio, West Virginia, and Kentucky. Nearly three-quarters of the counties lacking an OTP that also had large increases in foster care are in nonmetropolitan areas. Some counties with the highest increases also lack OTPs in neighboring counties, as can be seen in Wisconsin and Mississippi, for example. These results confirm previous ASPE findings (Radel et al. 2018a) that parents must often travel great distances to an OTP. This is particularly true in rural communities, where the average drive time to an OTP is longer than in nonrural counties (Joudrey, Edelman, and Wang 2019).

Figure 4 shows the geographic distribution of counties by foster care change and those with the highest buprenorphine capacity (in the top third). The map highlights that many counties with the greatest increase in foster care have lower buprenorphine capacity, similar to the patterns in Figure 3. Once again, these counties are more likely to be in nonmetropolitan areas.

Discussion

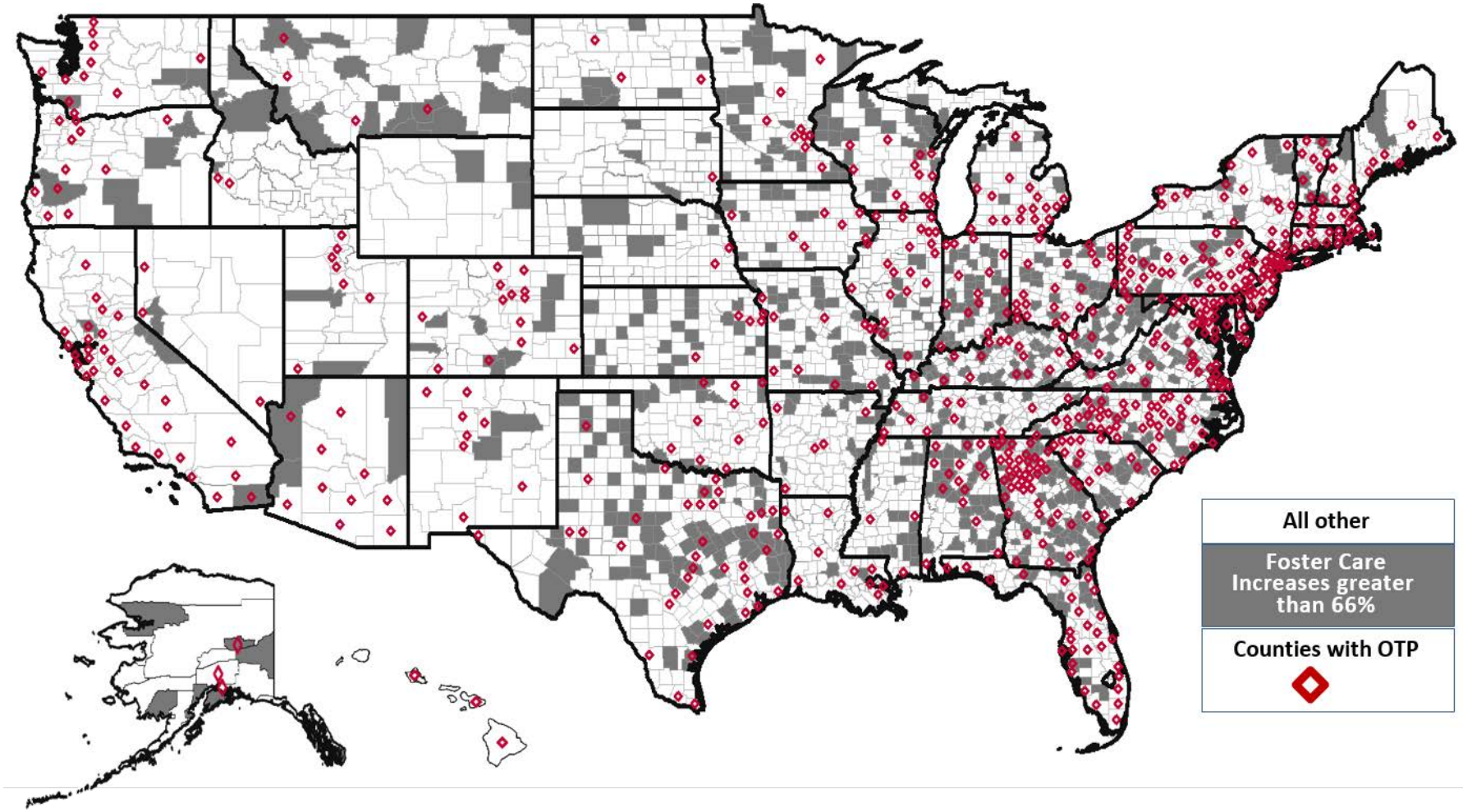
Child welfare systems nationwide continue to face negative consequences of the opioid crisis, including high caseloads, foster care shortages, caseworker burnout, and lower reunification rates (Radel et al. 2018a). In response to the crisis, child welfare agencies increasingly recognize the potential role of OAT for clients with OUD and seek to collaborate with treatment providers. Despite increased funding at all levels of government and advocacy efforts by the broader public health community, populations at risk of OUD still face numerous barriers to accessing OAT.

We find that counties facing the greatest increases in foster care entry generally have lower OAT availability. These results are consistent for all children entering foster care and for children for whom parental drug abuse is a circumstance of removal. An important limitation of this study is that we do not have data on treatment provided to parents whose children are at risk of foster care placement, nor do we have national data on children placed in foster care because their parents or caregivers had OUD.

Despite these limitations, these findings suggest the presence of a substantial treatment gap related to foster care caseloads. Child welfare agencies facing increases in foster care may have difficulty in locating OAT for parents with OUD. Generally, decisions about increasing access to treatment could take into account the risk that parental OUD poses for children's safety and well-being. More specifically, foster care caseload dynamics could be considered as indicators of need for additional treatment availability. SAMHSA already considers foster care rates as one factor in determining funding allocation for substance use treatment block grants. Other funding sources—including Title IV-E foster care prevention funds—could also be used to increase treatment availability.

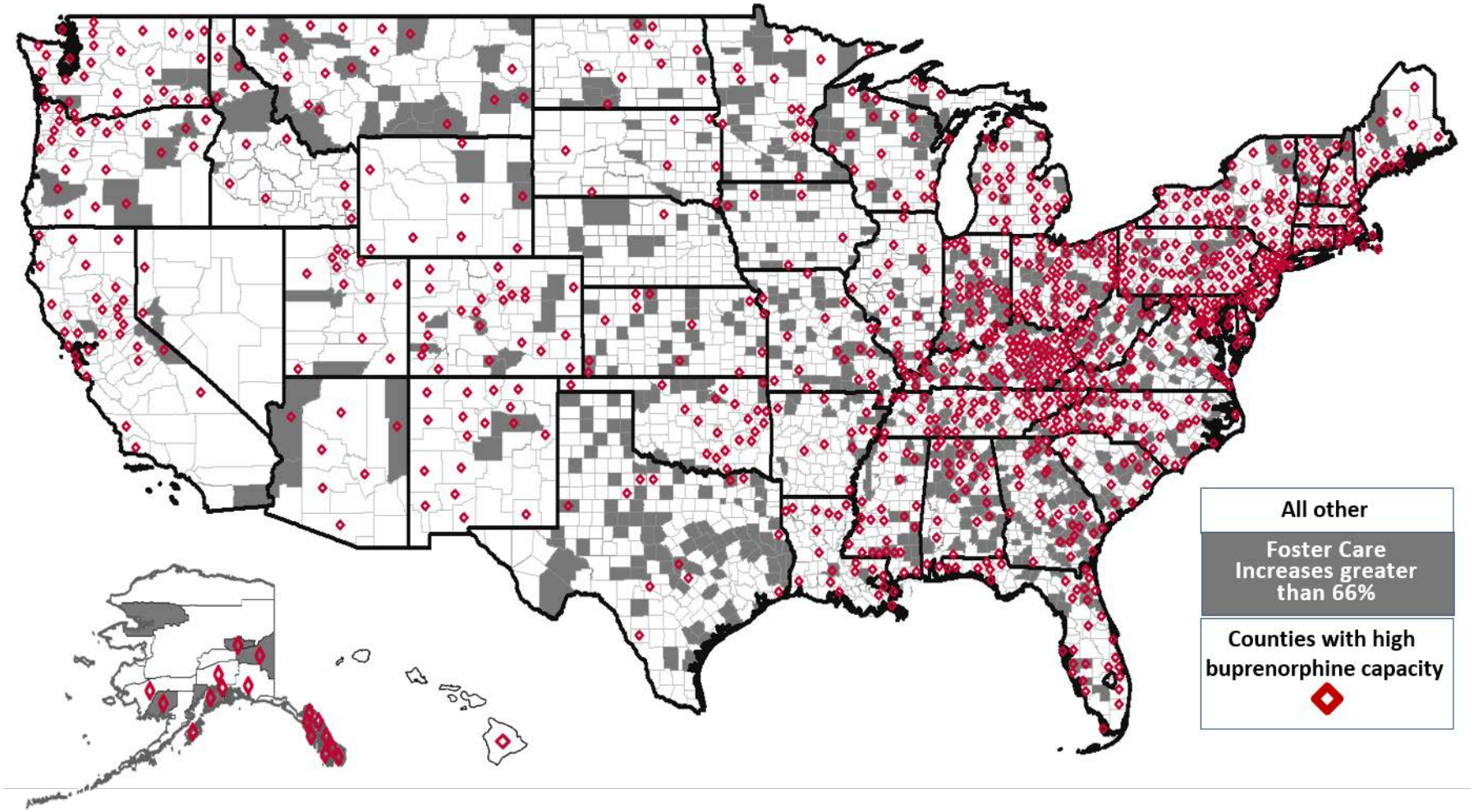
The results lend analytical support to the dismay that many child welfare caseworkers and administrators express about the lack of availability of OAT in their communities. Demand for OAT among parents with children in child welfare systems may increase further, driven not only by the continued prevalence of OUD but also by increased awareness among child welfare stakeholders of the effectiveness of treatment. As caseworkers, courts, law enforcement, and public health systems increase their knowledge and acceptance of OAT, they will increasingly seek treatment providers for their clients. OAT provider availability needs to keep pace to adequately address the consequences of the opioid crisis for children and families.

Figure 3. Counties with an Opioid Treatment Program in 2019 and Counties with Foster Care Increases of More than 66 Percent from 2013 to 2018



Note: Counties with suppressed foster care data available are included in the "All other" category.
Source: Foster care data: AFCARS; opioid treatment program data: Center for Substance Abuse Treatment, SAMHSA.

Figure 4. Counties with High Buprenorphine Capacity in 2019 and Counties with Foster Care Increases of More than 66 Percent from 2013 to 2018



Note: "High buprenorphine capacity" is defined as being in the top third of all counties. Counties with suppressed foster care data available are included in the "All other" category.
Source: Foster care data: AFCARS; buprenorphine provider data: Center for Substance Abuse Treatment, SAMHSA

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