
Dr. Margaret H. Lloyd, University of Connecticut

31st Annual Research & Policy Conference on Child, Adolescent and Young Adult Behavioral Health
March 7, 2018
Tampa, Florida
Presentation Overview

• Prevalence of Parental SUD in Foster Care
• Policy-Driven Rationale for Drug Testing in Child Welfare
• Literature Review
• Recovery-Oriented Approach to Drug Testing
• Evidence-Based Drug Testing
• Considerations for a Child Welfare-Involved Population
Prevalence and Trajectories through CWS

- The percentage of children removed due to parental drug use has increased nearly 8% since 2009 (Young et al., 2016)
- Children removed due to parental drug use less likely to reunify, more likely to re-enter care compared to children without drug removals (Brook et al., 2010; Brook & McDonald, 2009)
- Young children (ages 0-3) with parental drug removals least likely to achieve permanency vs. ages 0-3 without drug removals and ages 4+ (Lloyd et al., 2017)

Prevalence of Parental SUD
Rationale for Drug Testing in Child Welfare

- Untreated SUD can threaten a parent’s ability to safely care for their child (Wood et al., 2011)
- No reified threshold exists for “safe drug use” (Wood et al., 2011)
- Self-reported substance use is unreliable (Hunt, et al., 2015)
- Biological specimen testing is objective (Moeller et al., 2008)
- Drug testing is a common practice in mandated (i.e., substance abuse treatment, criminal justice) and voluntary (i.e. workplace) settings (Moeller et al., 2008)
Reasonable Efforts Clause

• The state is required to make reasonable efforts to avoid foster care placement and, if placement occurs, reunify the child with their biological parent before moving for termination of parental rights (ASFA; Pub. L. 105-89)

• Reasonable efforts include providing services to address issues that threaten child safety (ASFA; Pub. L. 105-89; Edwards, 2014)

• Given the prevalence of parental SUD among child welfare-involved families, establishing that reasonable efforts have been made, and have failed, frequently rests on two factors:
  – Completing substance abuse treatment; and
  – Establishing a pattern of abstinence using biological specimen drug tests
Drug Testing Is A Common Practice

- 79% of parents required to submit to drug testing, while only 75% had substance abuse as an issue (D’Andrade & Chambers, 2012)
  - 24% were ordered to testing once per week
  - 73% were ordered twice per week
  - 4% were ordered three times per week
Drug Testing Is An Effective Practice

- Newmark (1995) compared 169 parents tested for drug use in child welfare cases to 159 parents who were not tested.
  - Testing initially conducted on a weekly basis
  - Parents who participated in drug testing were more likely to experience shorter case processing times
  - Children in drug testing group more likely placed in kinship care
  - Parents received more referrals to available services
  - Parents were more cooperative with referrals to diagnostic services
  - However, groups were not randomly assigned
Drug screens were identified as one of six key factors affecting professionals’ decisions to reunify families with parental SUD (Karoll & Poertner, 2001), and the importance of drug screens did not differ between judges, caseworkers, and substance abuse professionals (Karoll & Poertner, 2003).

When probed regarding number of months of clean drug screens necessary for safe reunification, these professionals’ median response was 8 months and 12 consecutive clean drug screens (Karoll & Poertner, 2001).

Drug use (positive drug tests) and addiction were found to be the most common termination factors in 48 TPR cases (Vesneski, 2012).
Grounds for Terminating Parental Rights

24 states include environmental AOD use as grounds for TPR

4 states include prenatal AOD exposure as grounds for TPR

Texas:
Used a controlled substance in a manner that endangered the health or safety of the child and failed to complete a court-ordered substance abuse treatment program or after completion of a treatment program, continued to abuse a controlled substance.

(Child Welfare Information Gateway, 2016)
Smith (2003) found that treatment completion was the strongest predictor of reunification for parents with SUD, even if the parent reported continued substance use (self-report, not drug test).
Compliance Not Predictive of Re-Abuse

- Rittner & Dozier (2000) rated case records for SUD caretaker case plan compliance as “good”, “fair”, or “poor”.
  - “Good”, defined as $\geq 50\%$ of treatment + no positive drug tests
  - “Fair”, defined as $< 50\%$ of treatment; dropped out of treatment after a “Good” rating, or positive drug tests despite $>50\%$ of treatment attendance
  - “Poor”, defined as no treatment, positive drug tests plus no treatment, or additional substance-exposed newborn
- Over time, rates of non-compliance stayed consistent
  - At 6- to 12-month review, 40\% of moms “good”, 12\% “fair”, 48\% poor
  - At 13- to 18-month review, 39\% of moms “good”, 11\% “fair”, 49\% “poor”

*Compliance with substance abuse treatment not associated with rates of re-abuse*
Untreated SUD is one factor that increases risk of harm to children. SUD are prevalent among families with children in foster care and are associated with repeat maltreatment. Drug testing is one of the most common child welfare responses to SUD. Drug test results may influence decision making, although treatment compliance/completion is a critical factor as well. Treatment compliance rates & substance abstinence are low, typically less than 50%, and treatment completion rates are even lower (~25% or less). Treatment compliance is not a good metric for reduced repeat maltreatment.
A Recovery-Oriented Approach

• The rationale for testing in treatment settings is not to “catch people doing something bad”, but to gauge whether the type and dosage of treatment is effective and make treatment adjustments.

• This recovery-oriented approach to drug testing has been adopted in family drug treatment courts (Young et al., 2013).
Evidence-Based Drug Testing: Drug Court Perspective

- SUD diagnosis is a requirement for drug court participation (Young et al., 2013)
- Behavior modification program outcomes improve when substance use detection is likely AND when participants receive incentives for abstinence and treatment adjustments for positive test results (Schuler et al., 2014; Hawken & Kleiman, 2009)
- Self-disclosure is an unreliable, and treatment adverse, approach to monitoring (Peters et al., 2015; Nirenberg et al., 2013)
Random Drug Testing

- Drug testing must be random (Carey et al., 2012)
- Participants should have equal likelihood of being tested every day (2 in 7 days; 28% chance of being tested on a given day)
- Odds of testing on weekends and holidays should be the same as every other day (Marlowe, 2012)
Testing Timelines

Client notified of drug test

Specimen provided within 2-3 hours (Cary 2011)

Notified of results within 48 hours (Carey et al., 2012)

Treatment adjustments made immediately (Carey et al., 2012)

Client notified of results

Treatment adjustment made

Negative drug tests for 90 days before case closure (Carey et al., 2012)

Frequent (2x week) random drug testing should occur throughout duration of case (Carey et al., 2012; Marlowe, 2011; 2012)
Type of Testing

- Testing should cover more than a standard five- or eight-range panel (Mee-Lee, 2013).
- Drug testing must be witnessed by trained and experienced staff person (Mee-Lee, 2013) and tested for validity using temperature, creatinine and specific gravity (Mee-Lee, 2013).
- Testing for cannabinoids: excretion is slower than other substances, but a positive cannabinoid test is unlikely to occur greater than 10 days after cessation of chronic usage (Cary, 2005).
<table>
<thead>
<tr>
<th>Specimen</th>
<th>Window of Detection</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine</td>
<td>Up to 2-4 days</td>
<td>• Most accurate results</td>
<td>• Specimen can be adulterated, substituted, or diluted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Least expensive</td>
<td>• Limited detection window</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Most flexibility for testing different drugs</td>
<td>• Collection can be invasive or embarrassing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Most likely to withstand legal challenge</td>
<td>• Specimen handling and shipping can be hazardous</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Specimen can be adulterated, substituted, or diluted</td>
<td></td>
</tr>
<tr>
<td>Oral Fluid</td>
<td>Up to 48 hours</td>
<td>• Collecting the oral fluid specimen can be observed</td>
<td>• Drugs and drug metabolites do not remain in saliva as long as in urine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Minimal risk of tampering</td>
<td>• Less efficient than other testing methods for detecting marijuana use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Noninvasive</td>
<td>• pH changes can alter specimen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Can be collected easily in virtually any environment</td>
<td>• Moderate to high cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Can be used to detect alcohol use</td>
<td></td>
</tr>
<tr>
<td>Sweat</td>
<td>FDC cleared for 7 days</td>
<td>• Relatively noninvasive</td>
<td>• Only a few laboratories offer sweat patch testing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sweat patch worn for 7 days</td>
<td>• Those with sensitive skin may react to the patch</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quick application and removal of sweat patch</td>
<td>• Possible time-dependent drug loss from the patch</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patch seal tampering minimized</td>
<td>• Possible external drug contamination from improper skin cleansing prior to application</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Longer window of drug detection than urine or blood</td>
<td>• For marijuana, current use by a native user may not be detected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Relatively resistant to specimen adulteration</td>
<td>• For marijuana, positive sweat results are possible in current abstinent, but previously chronic high dose users</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No specimen substitution possible</td>
<td>• Sweat production dependent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Only a few laboratories offer sweat patch testing</td>
<td>• Moderate to high cost</td>
</tr>
<tr>
<td>Hair</td>
<td>Up to 4-6 months</td>
<td>• Collecting the hair specimen can be observed</td>
<td>• Moderate to high cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Long detection window</td>
<td>• Cannot be used to detect alcohol use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Does not deteriorate</td>
<td>• Cannot be used to detect drug use 1-7 days prior to drug test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Can be used to measure chronic drug use</td>
<td>• Not effective for compliance monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Convenient shipping and storage; needs no refrigeration</td>
<td>• External contamination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Noninvasive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More difficult to adulterate than urine</td>
<td></td>
</tr>
<tr>
<td>Breath</td>
<td>Up to 12-24 hours</td>
<td>• Minimal cost</td>
<td>• Very limited detection window for alcohol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reliable detector of presence and amount of alcohol</td>
<td>• Can only be used to detect presence of alcohol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Noninvasive</td>
<td></td>
</tr>
<tr>
<td>Blood</td>
<td>Up to 12-24 hours</td>
<td>• Can be used to detect presence of drugs and alcohol</td>
<td>• Invasive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Test produces accurate results</td>
<td>• Moderate to high cost</td>
</tr>
<tr>
<td>Meconium</td>
<td>Up to 2-3 days after birth</td>
<td>• Can be used to detect long-term use</td>
<td>• Short detection window after infant’s birth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Can be used to detect presence of drugs and alcohol</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Easy to collect and highly reliable</td>
<td></td>
</tr>
</tbody>
</table>
Drug Testing Research from Family Drug Courts

- Frequent, random drug testing is a standard in family drug courts (Young et al., 2013)
- More frequent urinalyses associated with greater time in treatment and increased likelihood of completing treatment (Worcel et al, 2007)
- Relapse most likely to occur in the first three weeks of court involvement, and between weeks 15-19 (Haack et al, 2004)
Other Considerations for Child Welfare

• Drug tests and the 4th amendment:
  – Results not shared with law enforcement without parental consent to testing;
  – The interests of the state/child must outweigh the privacy expectations of the parent;
  – “Probable cause” must exist, i.e., the parent has a substance use disorder that threatens child safety (Coleman, 2005)

• Drug use status should not impact visitations (Leathers, 2002)
  – Use of supervised visitation at mother’s home if safety is a concern

• Child welfare professionals need education on addictions (Young et al., 2013)

• Parental substance use does not in itself constitute a threat to child safety (CSAT, 2010)
Objections to Drug Testing in Child Welfare

- One-time testing provides little information (CSAT, 2002; Wood et al., 2011)
- A positive drug test result **does not** indicate a substance use disorder, a threat to child safety, or parent or family dysfunction (CSAT, 2002; Wood et al., 2011)
- Drug test results must be considered in concert with other factors:
  - repeated frequent, random drug tests
  - substance use disorder assessment
  - comprehensive assessment of parent and family strengths and needs
- Positive drug tests should be confirmed by a second testing technique (Wood et al., 2011; Mee-Lee, 2013; Cary, 2011)
Summary of Drug Testing Best Practices

Famularo et al (1988) outlined four questions related to drug testing in child welfare that remain salient:

1. Will the program aid in detection of substance abuse?
2. Will testing motivate the parent to engage in substance abuse treatment?
3. Will testing aid in the treatment process?
4. Will testing increase the chances of a favorable outcome for the child?
Practice & Research Agenda for Drug Testing in Child Welfare

- Approximately 370 family drug treatment courts exist across the country (Young et al., 2013)
- For several reasons, FDTCs are only serving 7-10% of families with parental SUD (Young et al., 2013)
- Best practices on drug testing should not be reserved for parents with cases in FDTCs
- Several unanswered research questions remain:
  - Relationship between positive drug tests at specific times in case process and case outcomes (reunification, re-entry)
  - Compliance versus abstinence and likelihood of maltreatment re-reports
QUESTIONS & DISCUSSION

margaret.lloyd@uconn.edu
References

References


• Leathers, S. J. (2002). Parental visiting and family reunification: Could inclusive practice make a difference?
References


References


• Vesneski, W. M. (2012). *Judging parents: Courts, child welfare, and criteria for terminating parental rights*


