Harm Reduction and Child Welfare
Advocating for Evidence-Based Practices

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Some Key Principles of Harm Reduction*

• Policies and practices should minimize the negative health, social and legal impacts associated with drug use and drug policies.

• Drug users should be “met where they are” without judgment and with compassion.

• People should be able to access services without having to overcome unnecessary barriers, including abstinence.

• Drug policies and programs should be informed by evidence.

• People who use drugs should be involved in the creation and evaluation of policies and programs that serve them.

*adapted from Harm Reduction International
“The principles of harm reduction require that we do no harm to those suffering from substance addiction, and that we focus on the harm caused by problematic substance use, rather than substance use per se.”

“Four Pillars Drug Strategy” (City of Vancouver, 2017)
Why harm reduction?

Realistic / pragmatic
Evidence-based / effective
Rooted in compassion / trauma-informed
What are some examples of harm reduction in action?

• Overdose prevention:
  • Safe consumption sites (sometimes called “safe injection sites”)
  • Widespread availability of naloxone (Narcan)
• Disease prevention:
  • Needle distribution/exchange
  • Distribution of “safe crack use kits” etc.
  • Distribution of biohazard/sharps containers
• Medically assisted treatment (“MAT”) (methadone, buprenorphine, naltrexone)
• Medically supported detox
• Non-coercive services (offered without threat of jail/child removal)
• Low-barrier, non-abstinence-based housing (“housing first”)
• Decriminalization
• Treatment on demand
• Safe supply
What does this have to do with child welfare?

Abstinence-only thinking is deeply entrenched in child welfare systems.  
A parent’s use of illegal or non-prescribed drugs is assumed to be *per se* harmful to their children.  
A parent who has a history of problematic substance use must abstain from all use of “mind-altering substances” (including marijuana or alcohol) and embrace abstinence in order to regain custody of their children.
What is neglect?

• Not just “undesirable parent behavior”*  
• Parent’s behavior results in serious harm or potential harm*

Substance use by a parent, in and of itself, does not meet this standard.


Policies and practices should minimize the negative health, social and legal impacts associated with drug use and drug policies.

Separation of parents and children is one of the harms caused by drug policy. Can that harm be minimized?

Reducing the harms associated with parental substance use requires reducing the harms associated with child welfare intervention.
What would a harm reduction approach to child welfare look like?

It would look a lot like what child welfare practice is supposed to look like now.
Does a parent’s substance use result in—or is it likely to result in—abuse or neglect?
Child Safety Framework:

Is the parent’s substance use a safety threat? Why?

What protective factors exist within and around this family?

A child can be safe from serious harm even when safety threats exist.
Reasonable Efforts

Current child welfare practice:
- No efforts (particularly with newborns)
- Drug testing
- Chemical dependency assessment and treatment

Harm reduction approach:
- Access to treatment (including medically assisted treatment)
- Access to resources
- Safety planning
Safety Planning with Substance Users

• Safety plans do not rely on the assumption that a parent will stop using. If you are going to use, how will you make sure your children are safe?
• What resources are available or can be made available to you to minimize harm?
• Recognize the expertise, knowledge, and good intentions of drug users. Recognize that a drug user is not incapable of making good choices.
We remove children to reduce the harm of parental drug use.

In doing so we cause harm.

A harm reduction approach allows for removal when the harm of removal is outweighed by the harm occurring or likely to occur as a result of the parent’s drug use and other tools (reasonable efforts) haven’t worked.
What does harm reduction look like at different stages of a child welfare case?

• CPS intervention

• Permanency planning

• Termination of parental rights
Harm Reduction Glossary and Terms

**Addiction:** The American Society of Addiction Medicine (ASAM) defines addiction as follows:

A primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission.

**Co-occurring disorders (COD) and Mentally ill and chemically affected/addicted/abusing (MICA):** COD is the term used to describe the diagnosis of substance abuse disorder and at least one other disorder in the areas of mental health, physical health or a cognitive disorder. MICA refers to a person who has both a substance use issue and a diagnosable significant mental illness. Research shows that individuals with CODs and MICA need special considerations in drug treatment and recovery. Research also shows that women who use drugs problematically have significantly higher rates of CODs (especially trauma-related) than non-female drug users and the general population.

**Detox:** A process or period of time in which one abstains from or rids the body of substances, usually alcohol or opiates. Medical detoxification serves to manage the acute physical symptoms of withdrawal associated with stopping drug use in a medically supervised setting. The harm reduction community recognizes that not all users choose to detox in a medical setting and that some users may choose to DIY (Do It On Your own) or (DIWH- Do It With Help). All detox methods can be part of a “planned detox.” Planned detox by any method can require a few days off work, a place for kids to stay for a few days and/or help from friends and family. If doing it DIY/DIWH, this can include staying with someone who does not use drugs.

**Drug Policies:** Laws, systems, practices and assumptions that govern how we treat people who use drugs. Refers to the sum total of policies and laws affecting supply and/or demand of illicit drugs, and may include issues such as education, treatment, and law enforcement. Historically, these policies have never been race neutral and have had disproportionately harmful impacts on communities of color.

**Drug Treatment Courts (DTC)/Family Treatment Courts (FTC):** Special court programs in some jurisdictions designed to respond to the unique needs of people who use drugs and have court involvement related their drug use. These court programs may be mandated or optional. In family courts, the intention of specialized treatment courts is to help respondents with abuse or
neglect allegations that include drug use to keep their children in their care or reunify. Many strive to quickly link parents with appropriate drug treatment programs, monitor compliance with treatment, respond to progress and/or problems through graduated sanctions/rewards, establish cooperation and communication among agencies involved in the process, and assure information is up-to-date and comprehensive. They involve judges, prosecutors, defense attorneys, treatment providers, and court staff in a collaborative effort to address defendants’ substance use disorders.

Many treatment courts have rigid standards, so client driven defense teams need to ensure that parents know exactly what the requirements of the treatment court are and what the repercussions of non-compliance might be. An admission that the child is neglected or dependent as a result of the parent’s substance use is generally required. These specialty court models may be very helpful for some clients who use drugs, but not for others.

**Harm reduction:** A set of practical strategies, ideas and interventions that seek to reduce negative consequences and harms of drug use, incorporating a spectrum of strategies from safer use, to managed use, to abstinence. At its core, harm reduction is a user-directed approach based on acknowledging the dignity and humanity of people who use drugs and bringing them into a community of care in order to minimize negative consequences and promote optimal health and social inclusion. Harm reduction principles acknowledge that historic and current drug policies are often ineffective and highly racialized. For families impacted by substance use, harm reduction seeks to increase opportunities for families to remain together while parents address problematic drug use and recognizes that drug use and adequate parenting can and do coexist. (Adapted from the Harm Reduction Coalition, Drug Policy Alliance.)

**Medication- Assisted Treatment (MAT):** A highly effective treatment of opioid use disorder with medication (most commonly methadone and suboxone®, sometimes also naltrexone (Vivitrol®)) used in combination with counseling and behavior therapies. The use of medication in opioid treatment can safely be used long term. There is a greater need for access to MAT across the board, including during and after pregnancy and in jails and prisons. Although supported by research and the medical and treatment communities, not all courts/jurisdictions recognize the benefits of MAT or its legality.

**Methadone:** An FDA approved medication used to treat opioid use disorder and pain. Available in liquid form (usually for opioid use) and pill form (usually for pain).

**Motivational Interviewing:** Motivational interviewing is an evidence based counseling approach developed by clinical psychologists William R. Miller and Stephen Rollnick. Developed for use with problematic substance users, it has now been shown to work with a variety of people in different settings. It is a collaborative, goal-oriented style of communication with particular attention to the “language of change.” It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring a person’s own reasons for change within
an atmosphere of acceptance and compassion. May be an effective tool in working with system involved parents and especially system involved parents with problematic drug use.

**Naloxone/ Narcon®:** A low cost, FDA approved medication whose only function is to reverse the effects of opioids and opioid overdoses. Comes in nasal spray and injection forms. Non-addictive, no risk of misuse, not a controlled substance in NYS and other places (can be carried and administered by non-medical professionals). Requires brief training in proper use.

**Neonatal Abstinence Syndrome (NAS):** The collection of withdrawal symptoms that newborns present with at birth following prenatal exposure to narcotics. In particular, babies born to women who are dependent on opioids may experience related symptoms at birth and require administration of morphine and/or other medical treatment to address those symptoms. Babies born to women who use opioids as prescribed can also experience NAS. Particularly when it comes to other drugs, such as methamphetamine or cocaine, many of the “symptoms” that may be cited by CPS are common or shared with other non-narcotic related conditions at birth such as prematurity or poor maternal health. See the now infamous study by Dr. Ira Chasnoff published in 1985 in the *New England Journal of Medicine*, that gave rise to the “crack-baby” panic.

**Opioids:** Class of drugs including Heroin, tramadol (Ultram®, Ryzolt®), Methadone, Oxycodone (Oxycotin®, Percocet®), Hydrocodone (Vicadin®, Lortab®), Oxymorphone (Opana®), Fentanyl (Opana®), Morphine.

**Physical Dependence:** Opiate use, whether prescribed or unprescribed, can result in physical dependence, meaning that they will experience physical symptoms of withdrawal (“dope sickness”) unless they use regularly. Other, legal drugs like caffeine, nicotine, and some anti-depressants also cause physical dependence. Physical dependence is distinguished from addiction (see above).

**Suboxone® (Buprenorphine/naloxone):** An FDA approved medication that includes buprenorphine and naloxone used to treat opioid use disorder. Available as an oral tablet or sublingual film.

**Supervised Consumptions Spaces (also called safer consumption spaces/supervised injection sites):** Facilities where drug users can use drugs under medical supervision and access various services like sterile injection equipment, medical supervision, health services, access to drug treatment and information.

**Vivitrol®/ Naltrexone:** An FDA approved medication used to manage opioid and alcohol dependence. Naltrexone is an opiate antagonist, meaning it prevents a user from experiencing the typical effects of opiates. A drug user must first be “detoxed” from opiates before taking naltrexone, or the user will experience severe withdrawal symptoms. Available via oral tablet and
long-acting injection. May be less frequently covered by Medicaid than buprenorphine or methadone.

*A note on language and language choices in the Harm Reduction context and beyond:
Person-centered language: Generally our language should focus on the whole person, not the behavior. For example, instead of referring to someone as an “addict,” a preferred term is a person who uses drugs problematically or a person with substance abuse disorder. Instead of referring to someone as a “drug abuser,” saying a person who uses drugs (problematically or not) goes a long way toward “acknowledging that drug use is a nearly universal cultural behavior with a wide range of characteristics and impacts, depending on the individual user” (Drug Policy Alliance). Not all drug use is drug abuse, nor are all drug users experiencing addiction.

***Many of these definitions were adapted from materials created by the Drug Policy Alliance www.drugpolicy.org and the Harm Reduction Coalition www.harmreduction.org.

Ideas for Further Reading/Education:

Crackdown Podcast: https://crackdownpod.com/
Harm Reduction Journal: www.harmreductionjournal.com
National Advocates for Pregnant Women: www.advocatesforpregnantwomen.org
Vancouver Area Network of Drug Users: www.vandu.org
Harm Reduction International: https://www.hri.global/
North Carolina Harm Reduction Coalition: http://www.nchrc.org/


Hampton, Ryan, American Fix: Inside the Opioid Addiction Crisis—And How to End It

Hart, Carl, High Price: A Neuroscientist’s Journey of Discovery That Challenges Everything You Know About Drugs and Society

Lupick, Travis, Fighting for Space: How a Group of Drug Users Transformed One City’s Struggle with Addiction

Maté, Gabor, In the Realm of Hungry Ghosts: Close Encounters with Addiction

Szalavitz, Maia, Unbroken Brain: A Revolutionary New Way of Understanding Addiction
Child welfare practitioners use varied but complementary frameworks for assessing child safety and working with families. A shared understanding of definitions and common ground can help strengthen consistency in services for families.

### PROTECTIVE CAPACITIES FRAMEWORK

**Protective capacities** are caregiver characteristics directly related to child safety. A caregiver with these characteristics ensures the safety of his or her child and responds to threats in ways that keep the child safe from harm. Building protective capacities contributes to a reduction in risk.

#### PROTECTIVE FACTORS FRAMEWORK

**Protective factors** are conditions or attributes of individuals, families, communities, or the larger society that reduce risk and promote healthy development and well-being of children and families, today and in the future.

### THE COMMON GROUND

Both frameworks are strength-based approaches to assess, intervene, and serve families. By promoting both protective capacities (at the individual level) and protective factors (at the individual, family, and community levels), we can best ensure child safety and promote child and family well-being.