The Daily Life Realities of a Parent with an Opioid Use Disorder (OUD)

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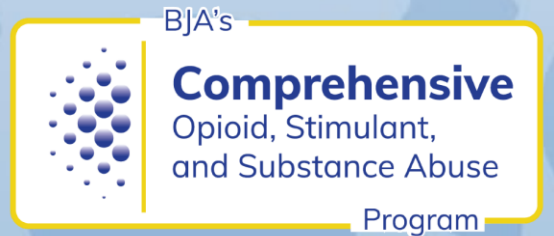
May 6, 2020



OVC-BJA National Stakeholder Partnership (NSP)

The content provided by this resource is made possible through participation in the Office for Victims of Crime (OVC) and Bureau of Justice Assistance (BJA) **National Stakeholder Partnership (NSP)**.

This **Partnership**, comprised of seven national organizations, leverages expertise on child and youth impacted and victimized by the nation's opioid and broader substance use crisis, with an emphasis on multidisciplinary collaborations, research, and promotion of training and education.

Members of the NSP dedicate time and resources to inform the planning, development, and implementation of OVC and BJA initiatives designed to respond to, treat, and support those impacted by the opioid epidemic, specifically young victims. In addition, members participate in informative, national conversations regarding children and youth impact and best-practice models that focus on innovative strategies and force-multiplying partnerships.

The overarching goals of this work are to *advance awareness and knowledge to help mitigate the traumatization of children and youth* and *to advance dissemination of innovative practices throughout the field*.

Upon completion, participants will be able to:

- Understand the many pathways associated with developing an opioid use disorder (OUD).
- Identify complexities associated with parental OUD and affects on children, youth, and families.
- Review common sense and practical solutions to help individuals and families affected by OUD get on a healthy road to recovery.

Source this Quote…

"Today feels like a great day to develop an addiction to drugs so bad that I will risk my health, my family, my job, my future, my freedom and possibly even my life."
Source?

DRUM ROLL…

NO ONE!!!

Pathways to opioid/other substance use are varied and complex!

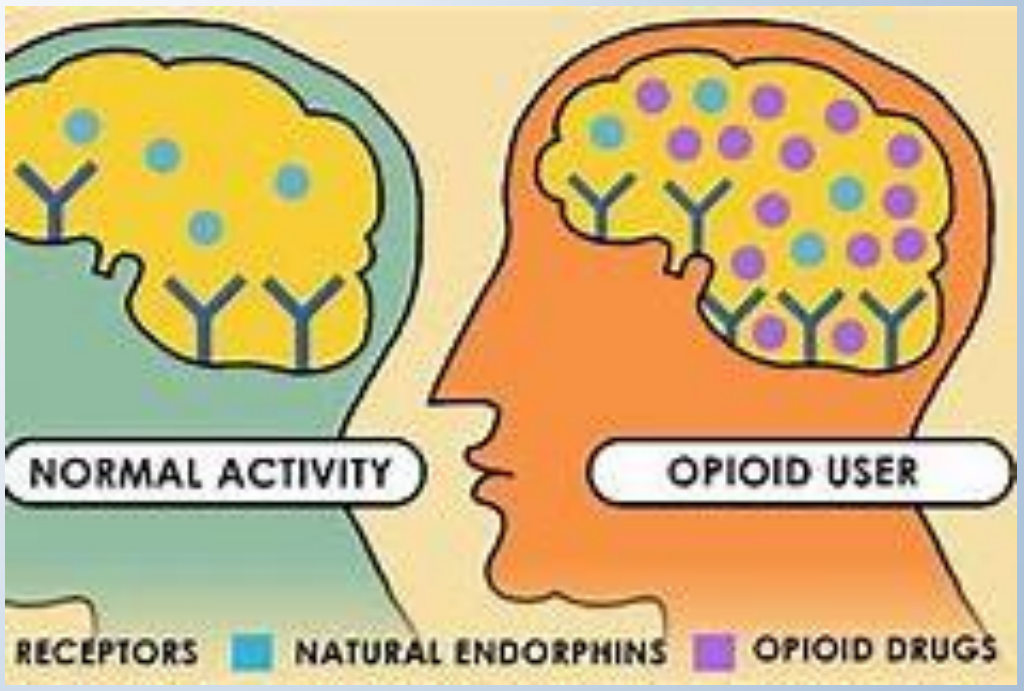
Many pathways to OUD and other SUDs…

Polling Question…

- Yes or No?
- Do you understand how opioid use affects the brain?

Naturally occurring opioids…[1]

- Dopamine is one of the chemicals in the brain that is essential for human survival.
- Dopamine is released when we enjoy good food, have sex, give birth, or see our baby. This way our brains are wired to ensure that we will repeat life-sustaining activities by associating those activities with pleasure or reward.



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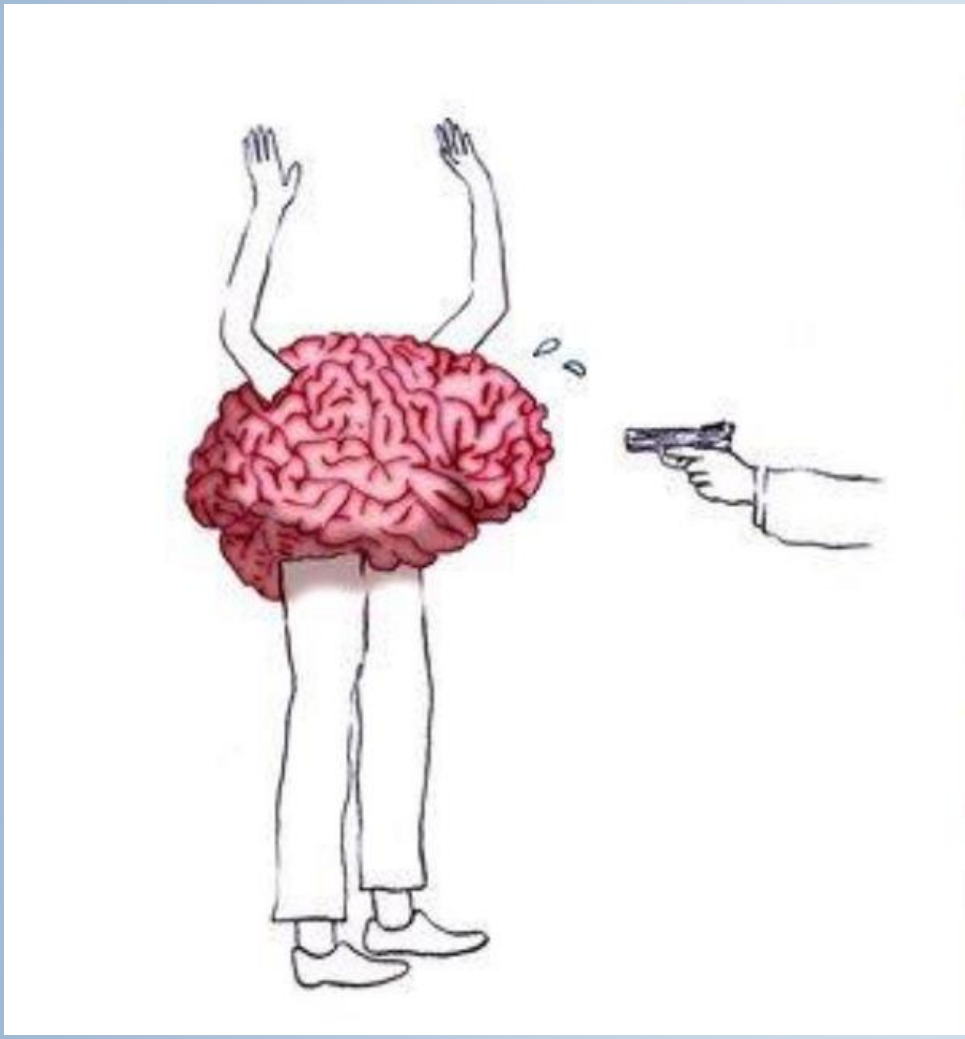
External (Exogenous) Opioids



- Exogenous opioids are those introduced from outside the body such as heroin, or pain meds.
- Because their chemical structure is similar to our naturally occurring opioids, they highjack the body's natural reward system flooding the brain with overwhelming amounts of dopamine.[2]

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Voluntary?

- While the initial decision to use substances is often voluntary,* the brain changes that occur over time challenge a person's self control and ability to resist intense impulses urging them to continue using substances.[3]

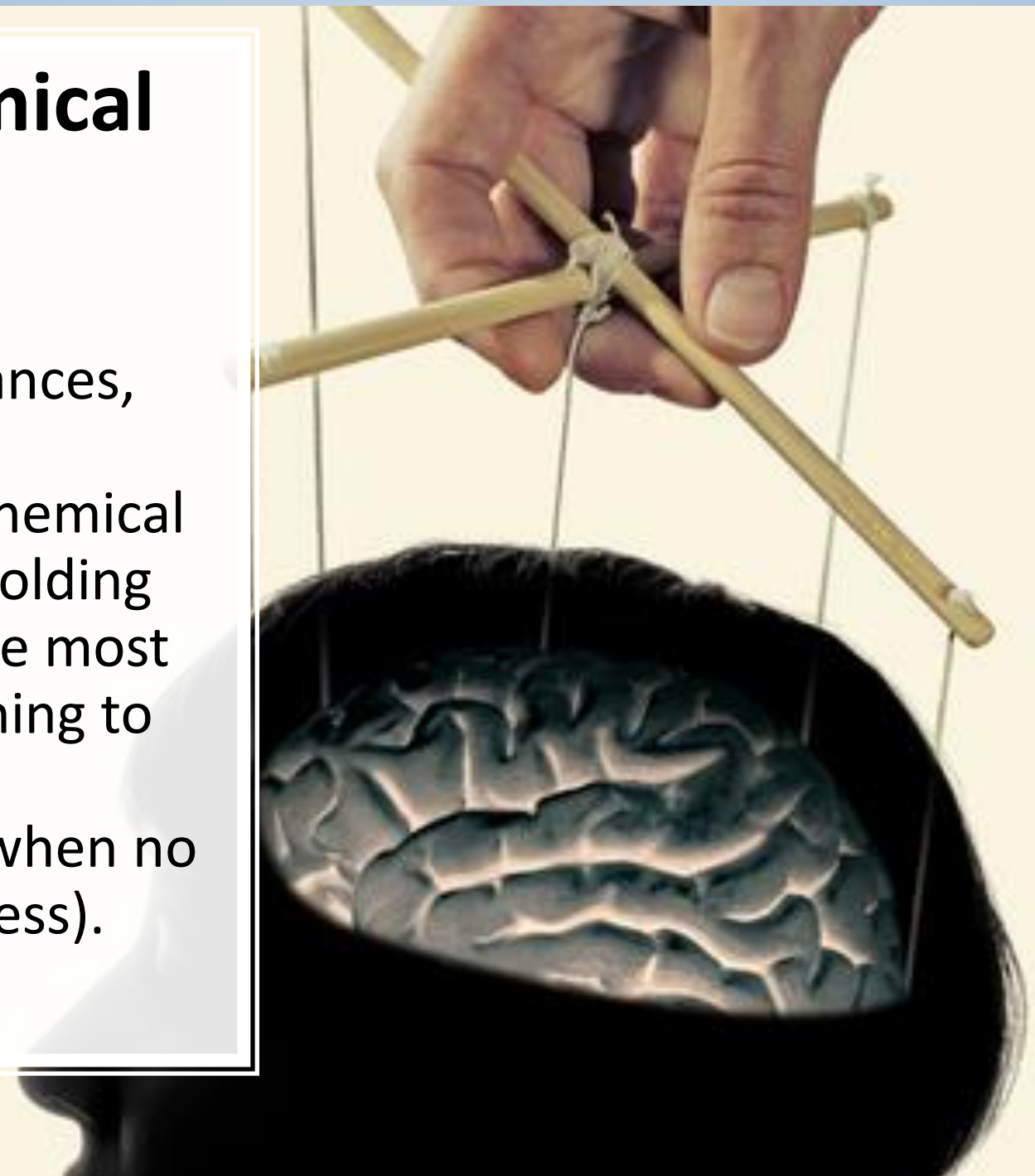
* Coercion is often a factor.

Scenario #1

Let's consider our first scenario…a young girl who is victimized by a perpetrator (e.g., mother's boyfriend or uncle). He may force substances on her to facilitate his control or she may voluntarily take them to "numb out" during and after the traumatic experiences.

Opioid Chemical Control

- Unlike other substances, opioid use creates opportunities for chemical control (e.g., withholding them when they are most needed or threatening to administer Narcan overdose reversal when no overdose is in process).



Vicious Cycle

Without effective and timely intervention the young girl too often grows up to be a woman in a violent relationship (IPV).

Substance use and DV findings

The National Center for DV and Trauma Substance Use Coercion Survey found:[4]

26.0% of DV victims reported using alcohol or other drugs as a way to reduce the pain of their partner's or ex-partner's abuse. 27.0% said that a partner or ex-partner had pressured or forced them to use alcohol or other drugs or made them use more than they wanted.

Ongoing trauma

Invariably the trauma continues as does the opioid or other drug use, one compounding the other in a vicious cycle. Failure to recognize and treat underlying trauma and the use of stigmatizing language (drug of “choice”) and approaches are significant barriers for affected individuals.

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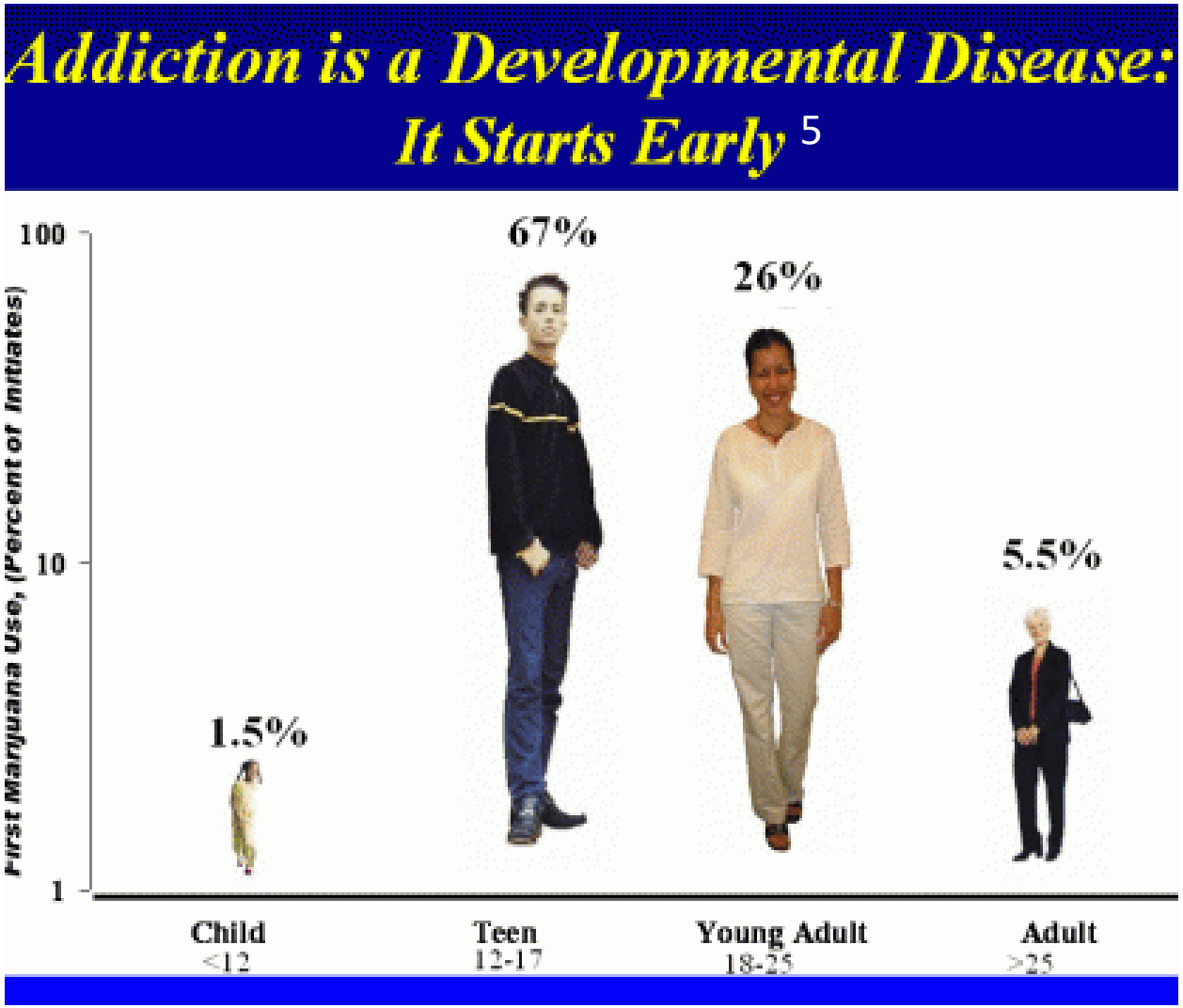
Scenario #2

- Look at the face of this young girl whose mom was just arrested for substance use. She is terrified. This trauma becomes a wound that is difficult to heal, especially when compounded by other experiences living in a home where she may not be exposed to opportunities for health and wellbeing. She may also have a genetic predisposition to substance use.

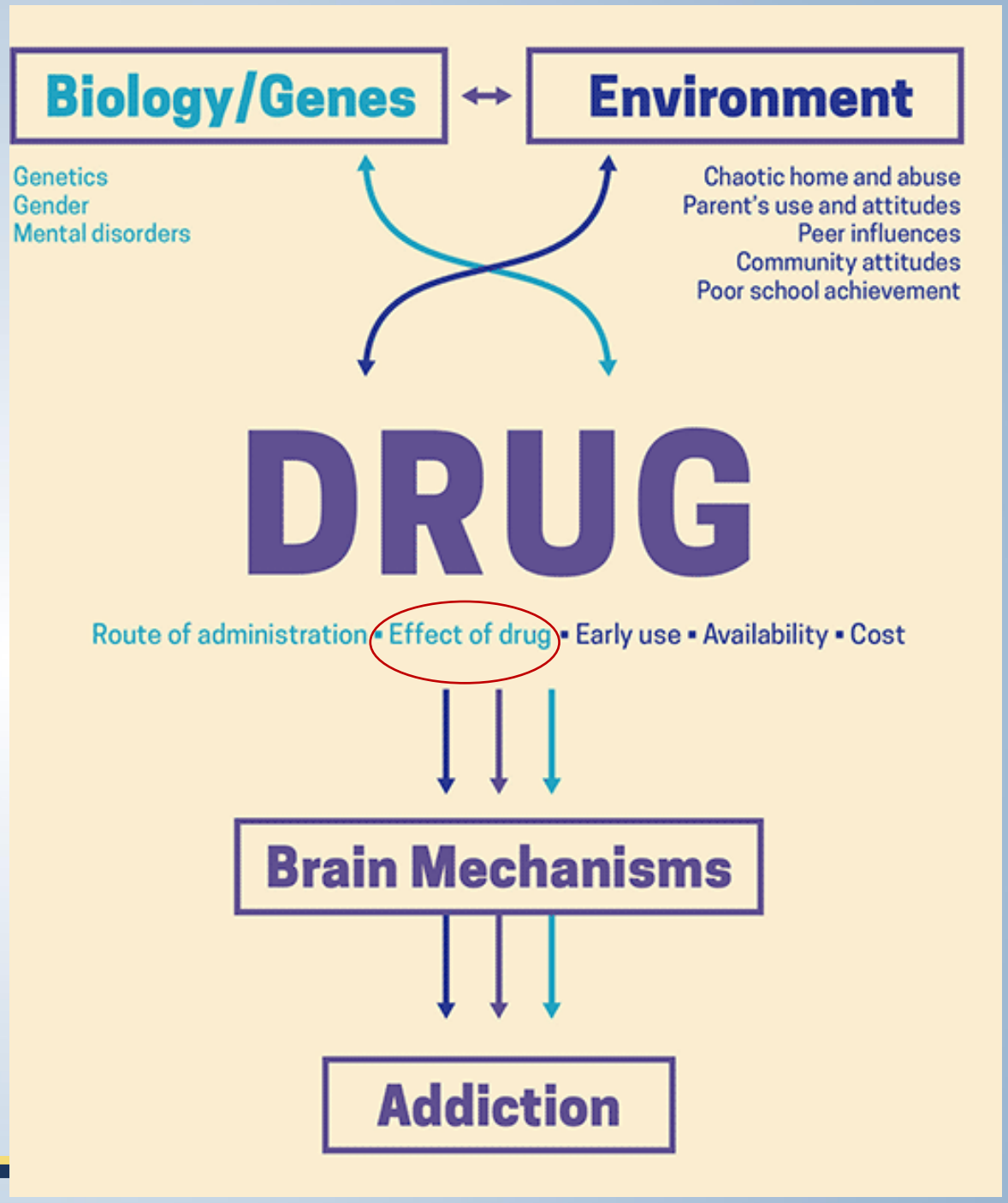


Scenario #2 cont.

This young girl, as all other young people, will be exposed to drugs is school if not already in the home. Sixty-seven percent (67%) of substance use starts among 12-17 year olds.

Complex Interplay[6]

However, if she is genetically pre-disposed, when she uses, even experimentally, her brain will experience this use differently and will be very reinforcing.



When she becomes a mother the vicious cycle continues. “Effective parenting is contingent upon experiencing the essence of such parenting. Parents cannot authentically give to their children what they have not personally experienced.”[7]

Scenario #2 cont.

- Like scenario #1 (and most others), the common denominator is trauma which invariably continues as does the opioid or other drug use, one compounding the other.

Polling Question…

- Yes or No?
- The most dangerous time for a child whose parent or caregiver has an OUD is when they use the opioid in front of the child?

Parental Opioid Use and Daily Life

- The examples provided in the balance of this presentation of opioid-affected daily life activities and conditions (e.g., withdrawal, preoccupation, diverted finances/resources, procurement, consumption, child exposure) are common to parents whose opioid use rises to the level of a diagnosable opioid use disorder (OUD) but who are not in treatment.
- While we will not cover it in its entirety today, we will also address how certain daily opioid life experiences can contribute to child safety risks (including toxic stress).

What we know…After an initial pleasurable "rush," people who use opioids may be very drowsy for several hours, with clouded mental functioning.
Repeated use often results in addiction – where seeking and using the drug becomes the primary purpose in life.

Examples of Activities Common to Parents/Caregivers with OUD

<u>Parental/caregiver opioid withdrawal:</u>

They wake up in the morning in pre-withdrawal/early withdrawal discomfort, experiencing flu-like symptoms and anxiety (“dope sick”).

Intimate partner power and control dynamics may be involved. That is, the survivor may be forced to rely on perpetrator for access to opioids or opioids are used by perpetrator as chemical tool for control.

Withdrawal (may begin 4-6 hrs. post last use)

- Excessive perspiration
- Shaking and muscle spasms
- Severe muscle and bone pain
- Vomiting, nausea, and diarrhea
- Irritability
- Insomnia
- Restlessness
- Dilated pupils
- Rapid heart rate/anxiety

Death is not likely from opioid withdrawal, but people may feel like they're dying.

The parent/caregiver is in withdrawal. Meanwhile, the child…

- May be left in a soiled diaper and in distress.
- May be having to take on responsibilities, including care for younger children, that may be beyond their developmental capacity (e.g., “parentified child”).
- May miss daycare or school.
- And remember…this is not the flu. This “sickness” won’t go away in a few days!

Examples of Activities Common to Parents/ Caregivers with OUD

Opioid preoccupation:

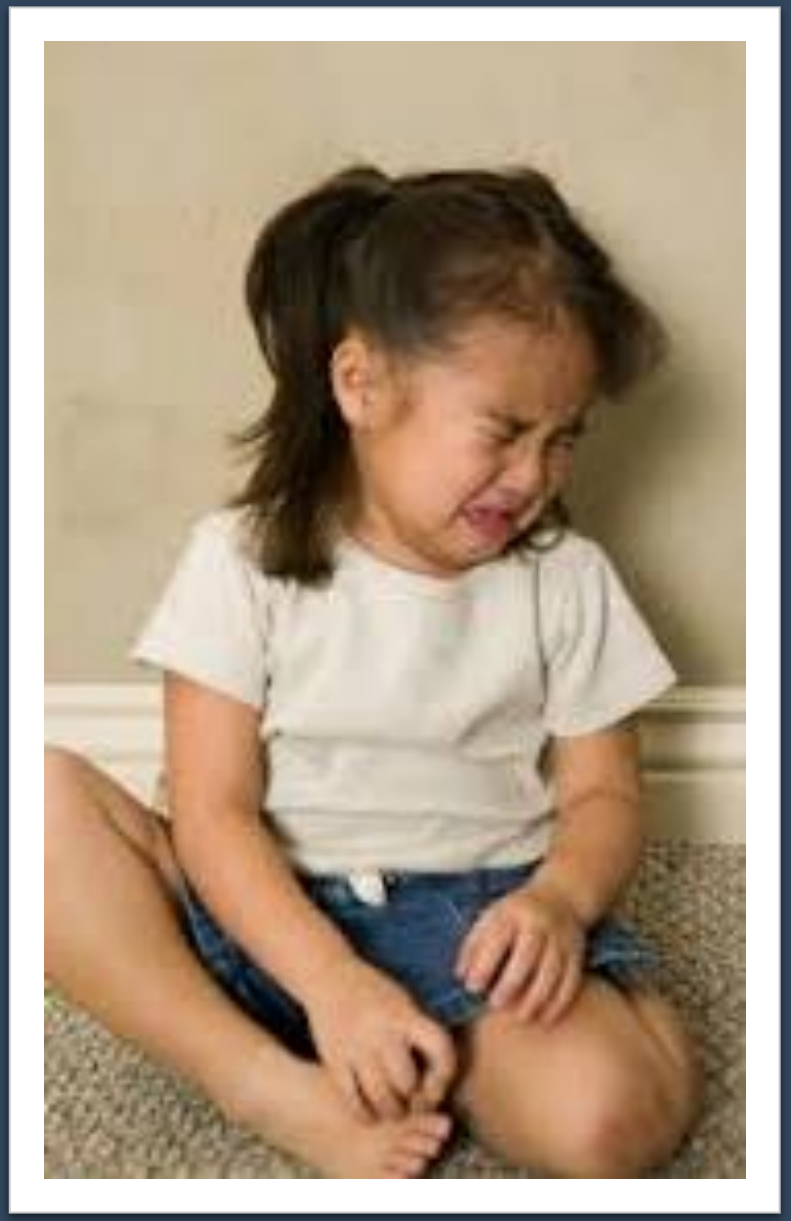
Preoccupation involves opioid seeking for next use. Considerable time must often be spent setting up daily connections to procure opioids (e.g., multiple calls to multiple dealers, wrangling over money owed).

Note: The strong physical dependence and compulsive use symptoms associated with regular opioid use render buying ahead and "stashing/rationing" nearly impossible (many parents will use ALL they have WHEN they have it). Therefore, many such individuals engage in daily transactions, increasing the potential harm to themselves and their children.

Opioid Preoccupation

“To my caseworker, I blame long hours at my job for my strange sleeping patterns and frequent absences, I have no job. I’m just always on the hunt for more heroin. My opioid addiction has taken me over.”

“My life is broken down into four- to five-hour increments to get high, to put off feeling sick.”



The parent/caregiver is obsessing about their next use. Meanwhile, the child…

- May have an untreated ear infection or other ailment that goes unnoticed to the caregiver
- May be left in front of a TV or computer to YouTube for the majority of their day while the caregiver works to obtain drugs
- May be at higher vulnerability to common dangers in the home (e.g., hot stoves, steep stairs, choking hazards, heavy dressers) because of caregiver's distraction
- If older, may personally contact known dealers in attempt to satisfy a caregiver's opioid needs

Opioid Preoccupation[8]

A parent with an OUD, who is mood altered, preoccupied with getting high or spending significant amounts of time recovering from the effects of substances, may miss the opportunities to foster healthy attachment with their child.

Opioid Preoccupation (cont.)

- Parents/caregivers with significant opioid-seeking preoccupation may have substantially less interaction with their child.
- Chronic neglect can lead to persistent activation of the stress response systems (toxic stress) in a young child that affects the architecture of their brain.

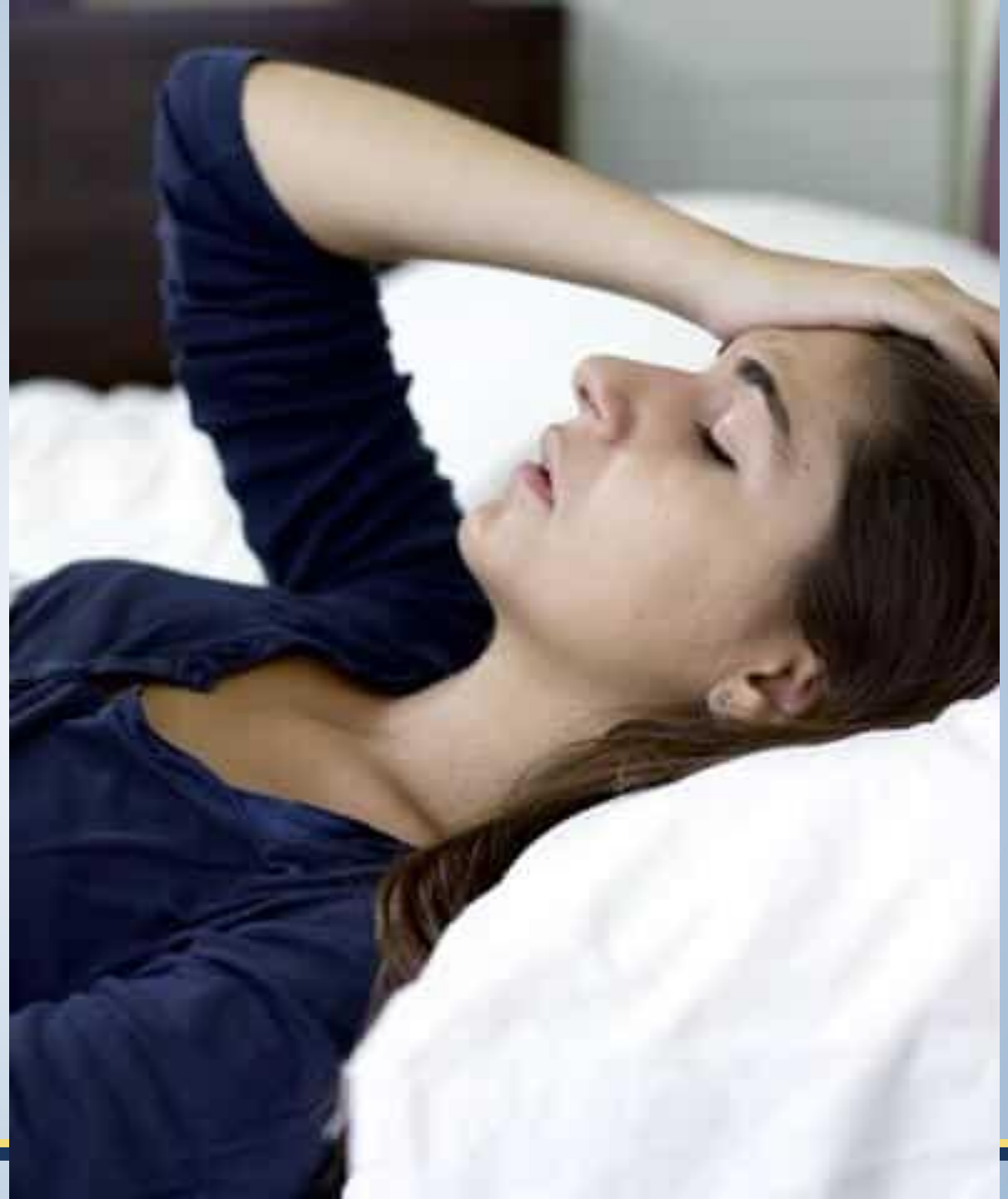
Opioid Preoccupation:

Potential fetal impact

If a pregnant woman uses opioids, her opioid-seeking behavior and fear of drug testing may result in avoidance of personal health care and prenatal care, contributing to malnutrition and adverse fetal development.

Diverted Finances

“I need heroin to feel normal. I don't love anymore. Now I'm sick. I can't afford the heroin that I need. How did $10 used to get me high? Now I need $100.”



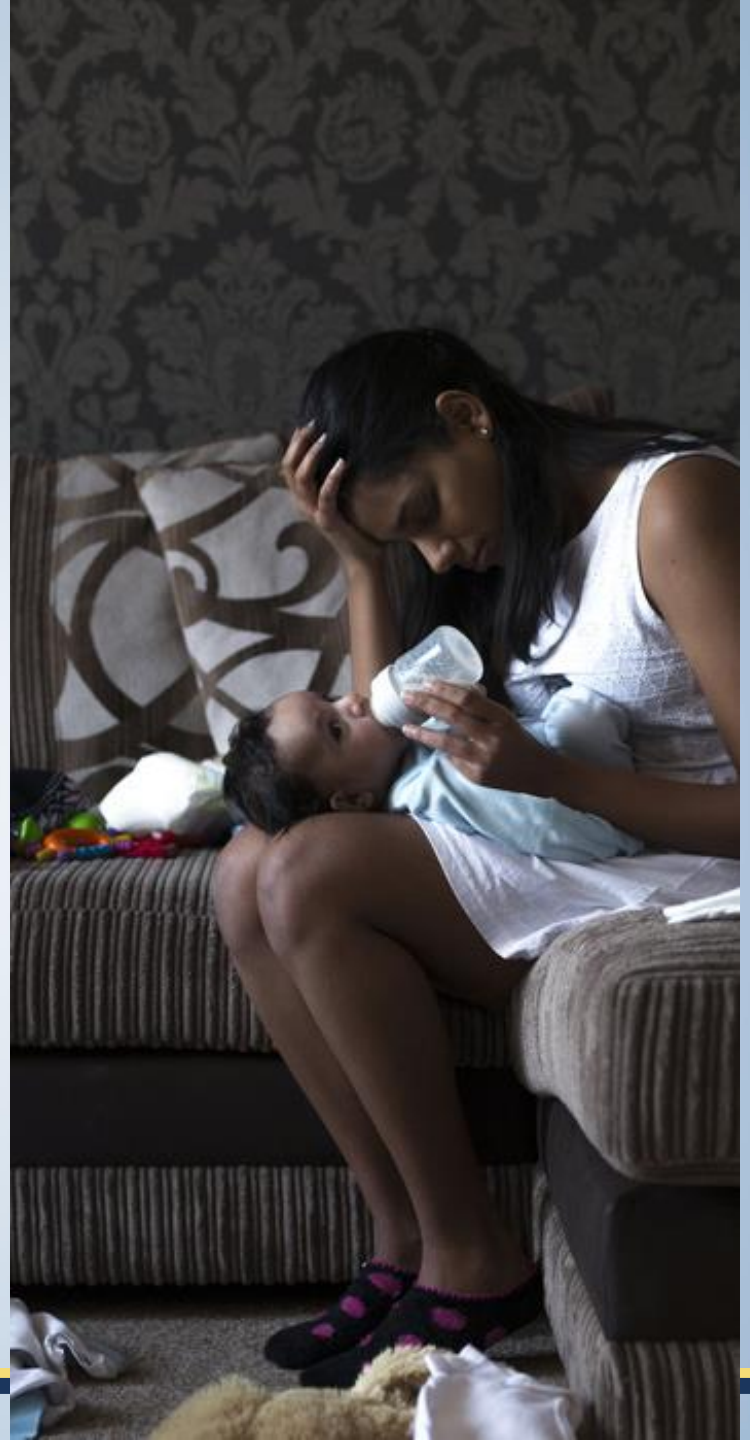
Examples of Activities Common to Parents/Caregivers with OUD

Diverted finances/resources:

Available money or resources are prioritized to support opioid use. Users will also steal, pawn, sell things, trade sex, and become a dealer themselves to obtain drugs. Parents who use opioids multiple times daily may be unable to maintain employment, resulting in “sofa surfing” from loss of stable housing.

The caregiver diverts finances. Meanwhile, the child…

- May have inadequate food, poor nutrition, lack of medical treatment or safe housing.
- May be exposed to a chaotic lifestyle (e.g., frequent moves, being temporarily placed with various family members, and/or in and out of different daycare centers- no baseline).



The parent/caregiver diverts finances Meanwhile, the child…

May experience loss of family and other supportive relationships as opioid use and associated behaviors (e.g., theft from family members) causes estrangement from once supportive individuals and can lead to chronic anxiety and hypervigilance or contribute to developmental and cognitive delays in children.

May be exploited for financial or sexual purposes.

Examples of Activities Common to Parents/Caregivers with OUD

Opioid procurement:

Obtaining opioids involves considerable time, commitment, and risk.

- Procurement is rarely timely (can involve significant delays).
- Procurement may occur in neighborhoods that are unsafe.
- Persons dealing drugs may be unsafe individuals.
- Fentanyl can be knowingly or unknowingly included in the opioid substance.

Opioid Procurement

“I grab my keys and head to my car, throw my kid in the back seat and off I go to the neighborhood I usually cop in. The drive always feels longer than it is when your withdrawals are kicking in again. I call my dealer and he says it’s going to be 10 minutes which I know isn’t true, I’m looking at around at least 45 minutes to an hour. I check my phone waiting for him to call, I’m starting to get dope sick again.”

The parent/caregiver is procuring opioids. Meanwhile, the child…

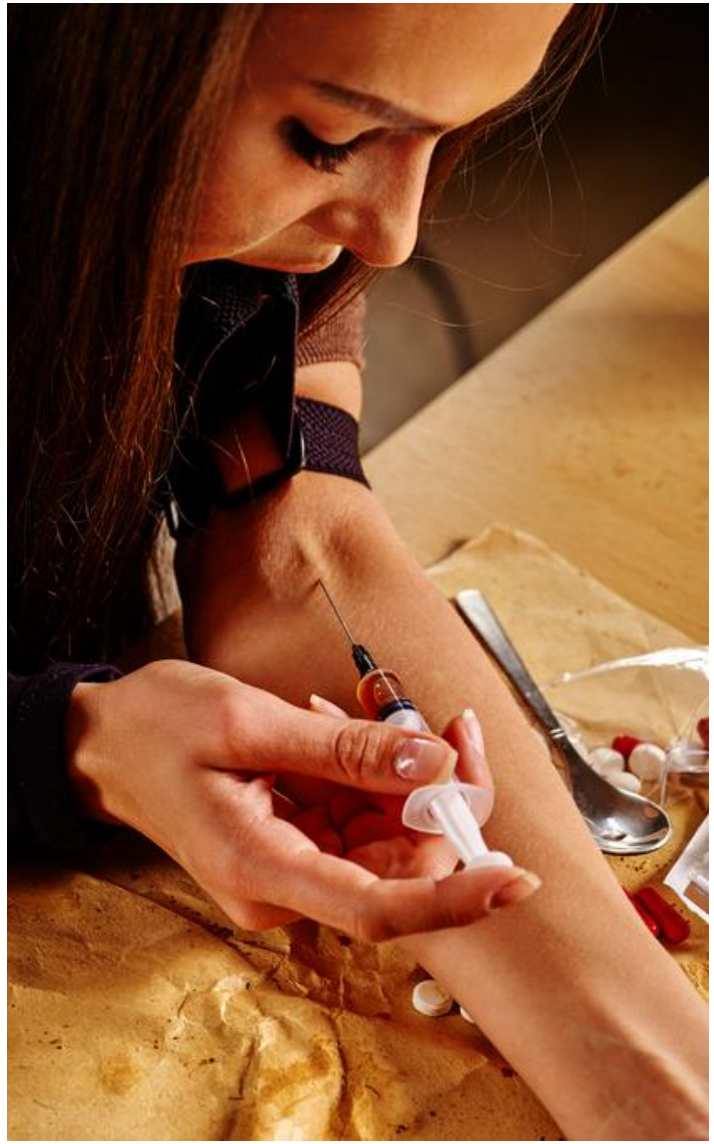
- May be left with unknown and/or unsafe caregivers.
- May be left home alone or strapped in a car seat for hours or days at a time and potentially exposed to unsafe people while caregiver is procuring.
- May witness the caregiver's frantic attempts to procure or steal opioids.
- May be at risk for car-related injuries/fatalities if caregiver uses right after procurement and has accident due to intoxicated state or leaves child in car exposed to extreme temperatures.
- If older, may be asked to drive the caregiver to obtain opioids in unsafe locations.

Examples of Activities Common to Parents/Caregivers with OUD

- **<u>Opioid consumption:</u>**
- Depending on the type, strength, and amount of opioids consumed, the duration of the parent's "high" can vary considerably in length of time and the severity or the extent of associated behaviors (e.g., nodding out, disorientation).
- Overdose risk may be present.
- Risks may be high for contracting infectious diseases (e.g., HIV, hepatitis) through infected injection equipment and or/unprotected sex with an infected person.

Opioid Consumption

“My dealer gives me what I need, now I need to find a good bathroom; I can’t wait to get home to use. I find one of my favorites; single stalls give you more privacy and time. I park out front and walk straight to the back where the bathrooms are. I’m obsessed with the ritual of shooting up, the water, the mixing the pop of my vein when the needle goes in. I release the belt and the heroin floods my brain. Wandering back out to my car I get some looks from customers like they know, but I really don’t care.”



The caregiver is misusing opioids. Meanwhile, the child…

- May not be able to wake the caregiver or may witness the caregiver's overdose (even a fatal one).
- May go without basic care like diaper changes, baths, or appropriate meals for hours or days.
- May not have a safe sleep environment (e.g., co-sleeping, loose blankets in the crib, unrelated men in the home, etc.).
- If older, may misuse opioids themselves with or without a caregiver's permission.

OTHER "CONSUMPTION " FACTORS

- Parents/caregivers who use opioids multiple times daily often lack hunger cues/appetite, contributing to inconsistent meal schedules for their child.
- A parent/caregiver high on opioids may have reduced parental capacity to respond to a child's other cues and needs.
- If older children observe/become aware of parental opioid use, it may normalize such use and contribute to their access and/or other environmental reinforcement contributing to their use.
- Parent/caregiver may have difficulty regulating emotions, contributing to physical or emotional abuse of children/other family members.

Child Exposure to Opioids/Paraphernalia

Parents/caregivers may expose children to opioids/paraphernalia causing:

- Poisoning from accidental ingestion (e.g., pain meds look like candy to children).
- Harm to child from straight edge razors used to “cut” heroin or pain meds for snorting or injecting.
- Exposure of child to infectious diseases (e.g., HIV, hepatitis) from contaminated syringe and needles.

Child exposure examples (cont.)

- Children are much more susceptible to (and affected by) secondhand smoke (opioids can be smoked) at much lower dosages than adults (e.g., may experience a “contact high,” asthma, respiratory problems).
- Belts/laces/plastic tubing used to “tie off” for heroin injection could pose a strangulation hazard.

WWYW? (Mention in Chat Box)

- Broke (financially and personally)
- Tired
- Traumatized/Scared
- Homeless/Or at risk of becoming
- Unemployed/Underemployed
- No transportation
- Parent/Caregiver
- Clouded mental functioning
- Multiple/often conflicting required appts.

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DEAD END
DEAD END
DESTINATION RECOVERY
CAUTION
INEFFECTIVE
CAUTION
SHORT DURATION
CAUTION
EXCLUSIONARY CRITERIA
CAUTION
INFRASTRUCTURE BARRIERS
DEAD END
CAUTION
WAITING LISTS
DEAD END
TOLL ROAD
TOLL ROAD
CAUTION
LOW INTENSITY
CAUTION
FINANCIAL BARRIERS
CAUTION
MISALIGNED POLICIES

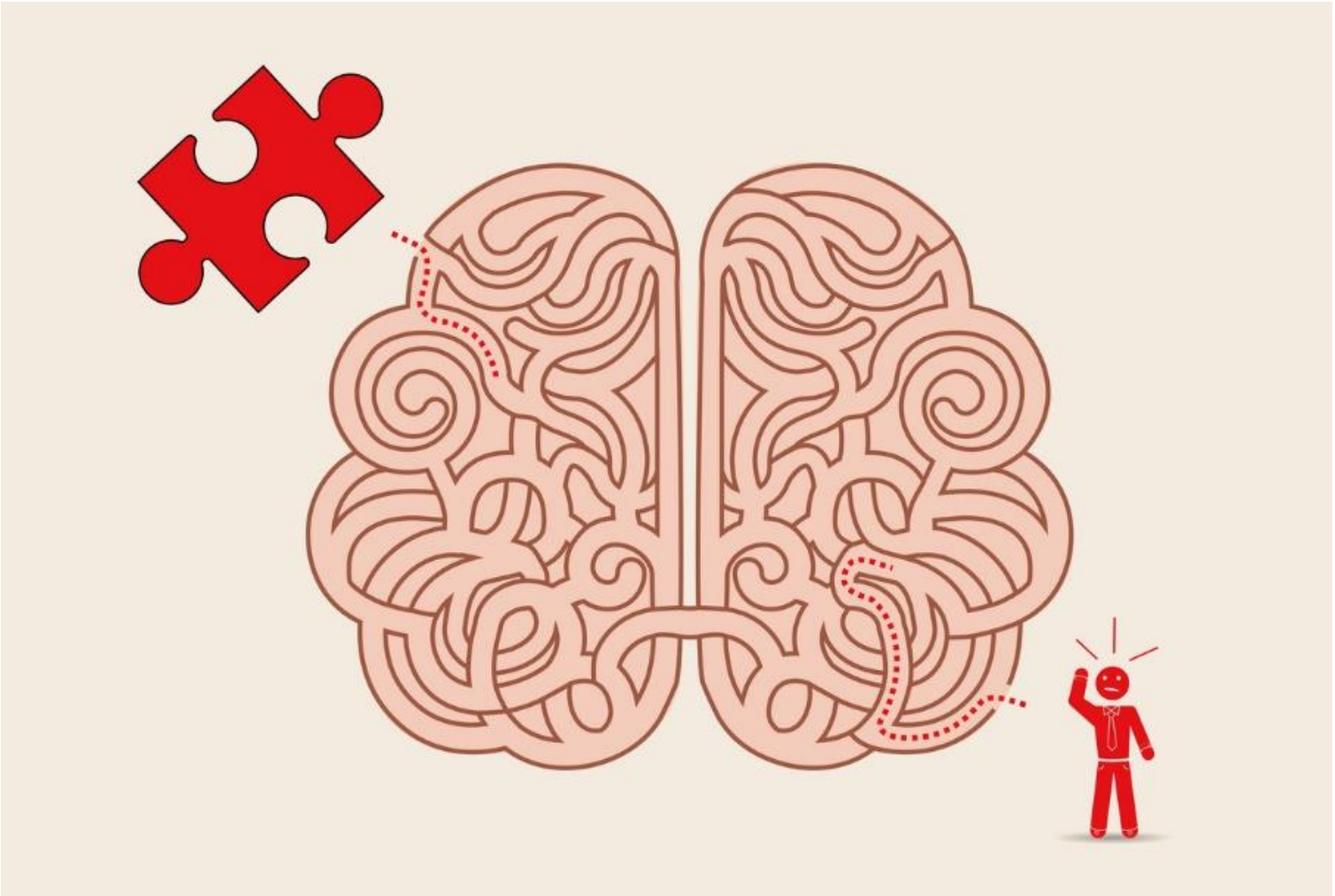

HOMELESS
CJ HISTORY
DV SURVIVOR
TRAUMA VICTIM
SINGLE PARENT/
PREGNANT
LOW JOB SKILLS
4 X DAY OPIOID USER
NO TRANSPORTATION
3RD GENERATION
SUBSTANCE USER
Don’t worry!
We can squeeze you
in every Wednesday
from 3:00-4:00
starting in 2 weeks

Polling Question…

- Yes or No?
- Have you experienced one or both of the treatment access barriers covered in the last two slides?

System failure

“We are routinely placing individuals with high problem severity, complexity, and chronicity in treatment modalities whose low intensity and short duration offer little realistic hope for successful post-treatment recovery maintenance. For those with the most severe problems and the least recovery capital, this expectation is not a chance, but a set-up for failure—a systems failure masked as personal failure.” (Bill White, 2013)



Brain rebalancing takes time.[9]

The changes in the brain caused by opioid dependence will not correct themselves right away, even though opioid use has stopped.

Treatment important…but alone not enough.

- Parental drug treatment is important and life saving. Alone, however, it won't typically address the harms to young children.
- Most parents will need an evidence-based parenting program.
- When an evidence-based parenting program is not enough, intervention may be needed to heal the infant-or child-parent relationship (Skill-Based Parenting Interventions and Attachment-Based Parenting Interventions).

Evidence-Based Parenting Support

Child-Parent Psychotherapy (CPP)[10]

CPP is a therapeutic intervention that helps young children heal and catch up developmentally within the context of their relationship with their parent AND helps the parent increase their capacity to nurture and care for their child. The CPP bonding opportunities could increase a parent's motivation to strengthen parenting skills too.

Thriving in the face of adversity

The key to thriving in the face of adversity is often the presence of at least one stable and committed relationship with a supportive parent, caregiver, or other adult.[11] For this reason, child health and well-being is intrinsically linked to caregiver health and well-being.

Non-judgmental/non-stigmatizing approaches

- These are key to any successful helping relationship. Shame is a significant barrier.
- This is when it helps to remember the difficult pathways these individuals have taken to get to where they are, and the associated trauma.

Trauma-Informed Family Service Plan

- Service providers can be guided by a written, trauma-informed plan that employs evidence-based services.

Assure Every Child's Relationships and Environments Are:[12]

- **Safe** – the extent to which a child is free from fear and secure from physical or emotional harm
- **Stable** – the degree of predictability and consistency in a child's relationships such as familiar routines, people and places
- **Nurturing** – the extent to which parents and children have access to individuals who are able to sensitively and consistently respond to needs

Early Steps and Home Visitation Programs[13]

- Arranging early intervention services like occupational therapy can help young children catch up on their developmental milestones.

- The Early Steps provider comes to the home and works together with the parents, helping to show them activities that will help the child's growth.

Early Childhood Programs[13]

- Early Head Start program—an early childhood school setting can provide stable relationships, supports, structure, and nurturance.[14]
- They meet regularly to check in, anticipate difficult times, and ensure supports are in place to help parents adjust to be healthy and stable too.

Ripple Effects

An individual's opioid or other substance use disorder (OUD/SUD) sends ripples through families and communities.

Ignoring these ripples can cause long-lasting consequences.

Thank You!

- As human service providers, you have the opportunity to be the pebble in the pond that creates the ripple for positive change.
- Thank you for all that you are doing for the children and parents entrusted to your care to help them make their future better than their past!


TIP 63

MEDICATIONS FOR OPIOID USE DISORDER

Executive Summary

For Healthcare and Addiction Professionals, Policymakers, Patients, and Families

The Executive Summary of this **Treatment Improvement Protocol** provides an overview on the use of the three Food and Drug Administration-approved medications used to treat opioid use disorder—methadone, naltrexone, and buprenorphine—and the other strategies and services needed to support recovery.

TIP Navigation

Executive Summary
For healthcare and addiction professionals, policymakers, patients, and families

Part 1: Introduction to Medications for Opioid Use Disorder Treatment
For healthcare and addiction professionals, policymakers, patients, and families

Part 2: Addressing Opioid Use Disorder in General Medical Settings
For healthcare professionals

Part 3: Pharmacotherapy for Opioid Use Disorder
For healthcare professionals

Part 4: Partnering Addiction Treatment Counselors With Clients and Healthcare Professionals
For healthcare and addiction professionals

Part 5: Resources Related to Medications for Opioid Use Disorder
For healthcare and addiction professionals, policymakers, patients, and families

SAMHSA
Substance Abuse and Mental Health Services Administration


Medications for Opioid Use Disorder

For Healthcare and Addiction Professionals, Policymakers, Patients, and Families

UPDATED 2020

TREATMENT IMPROVEMENT PROTOCOL

TIP 63

SAMHSA
Substance Abuse and Mental Health Services Administration

SAMHSA

- Helpful SAMHSA MAT resources (links provided in notes page and references)

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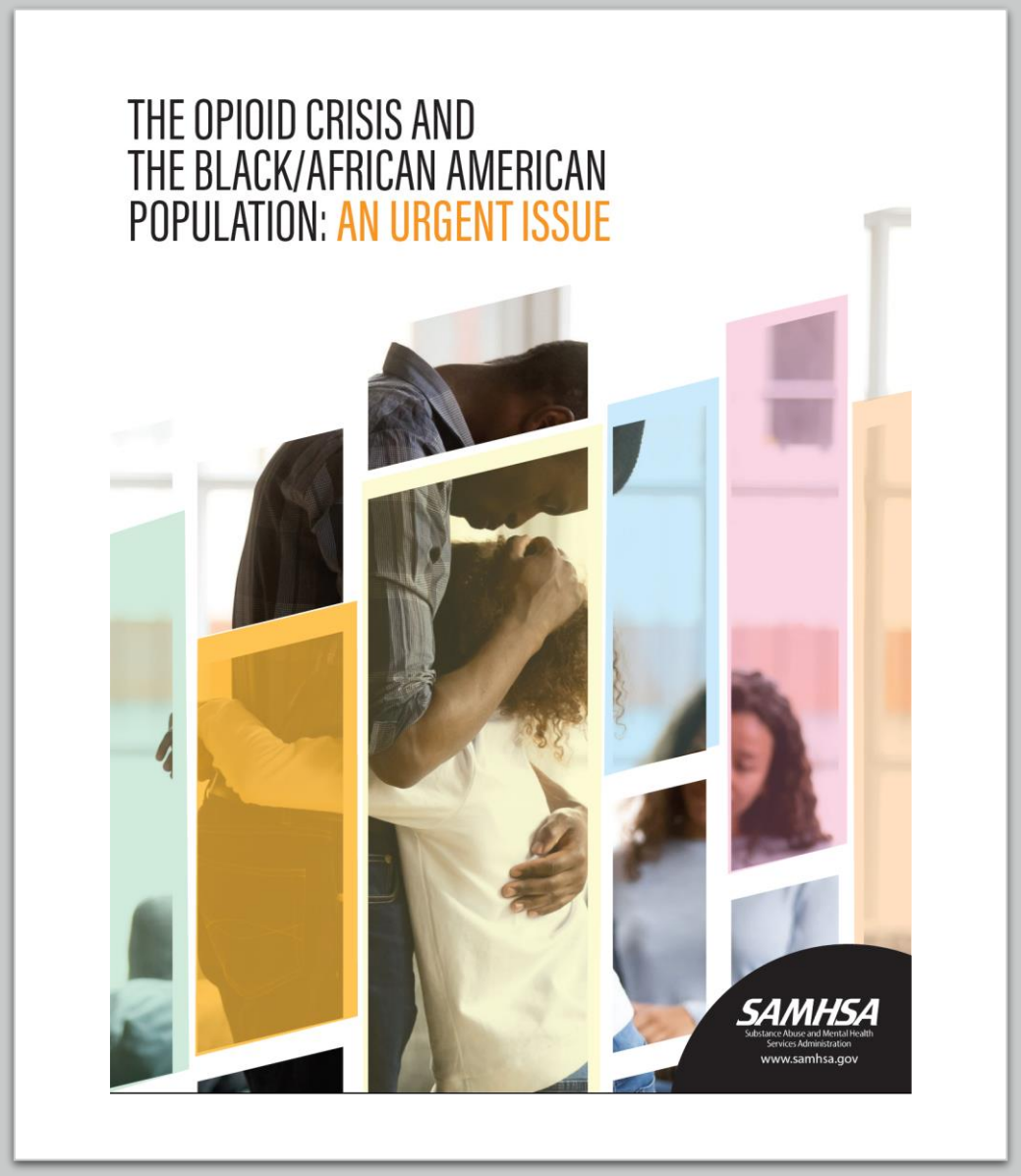
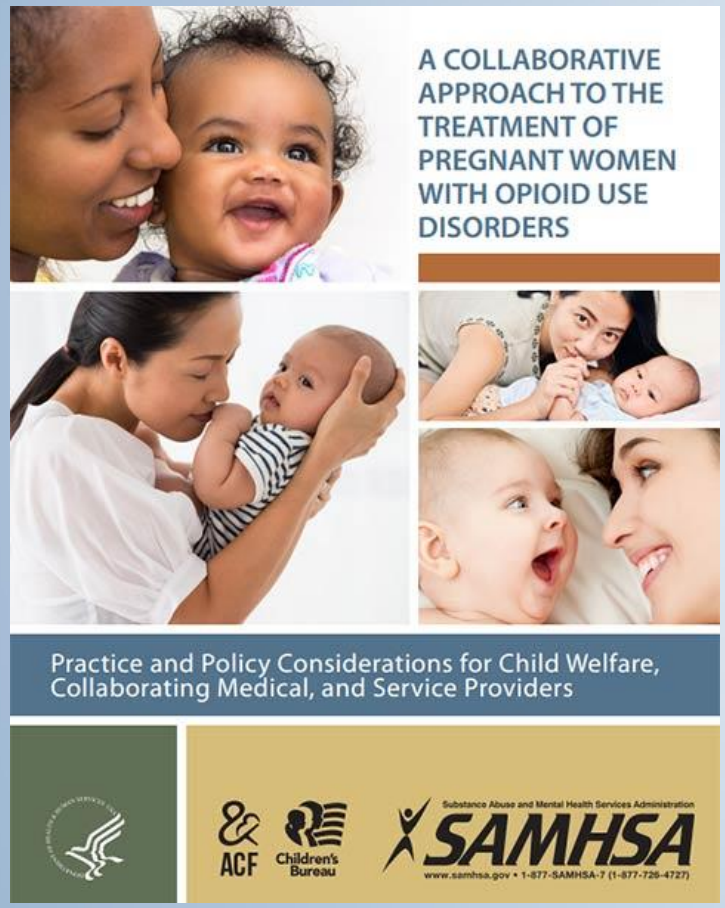
SAMHSA OUD Resource

- Substance Abuse and Mental Health Services Administration (2018). *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054



https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001?referer=from_search_result

Pregnant Women with OUD/Collaborative Resource



- https://ncsacw.samhsa.gov/topics/supporting-families-affected-opioids.aspx

To combat OUD misperceptions…

- https://www.chcf.org/wp-content/uploads/2019/06/MATOpioidOvercomingObjections.pdf

JULY 2019

CHCF Issue Brief

MAT for Opioid Use Disorder:
Overcoming Objections

Californians struggling with substance use, including opioid use disorder (OUD), should be screened for these illnesses wherever they seek help; those with OUD can be treated immediately and referred for ongoing care. California is building a "no wrong door" health care system, ensuring that medications for addiction treatment are widely available in emergency departments and hospitals, primary care and mental health clinics, jails and prisons, residential treatment programs, and other care settings.

The need is urgent, since fentanyl (an extremely potent street drug) is increasingly responsible for overdose deaths for users of opioids and stimulants; fentanyl overdose deaths have more than quadrupled in California between 2014 and 2017.

Medication-assisted treatment (MAT) uses FDA-approved medicines such as buprenorphine (Suboxone), methadone, and naltrexone (Vivitrol), often supplemented by behavioral treatment and social supports. Harm-reduction services are employed to keep patients safe until they are ready to seek treatment — services such as dispensing naloxone, an opioid antidote that prevents death from overdose, and providing clean syringes to prevent HIV and hepatitis C. A medication-first approach allows patients to first be stabilized on medication, and then be brought into the right level of care to fit their needs — thereby decreasing the risk of overdose and relapse.

Despite data showing the success of MAT in treating drug addiction, objections are still common. Following are some frequent objections and evidence-based responses.

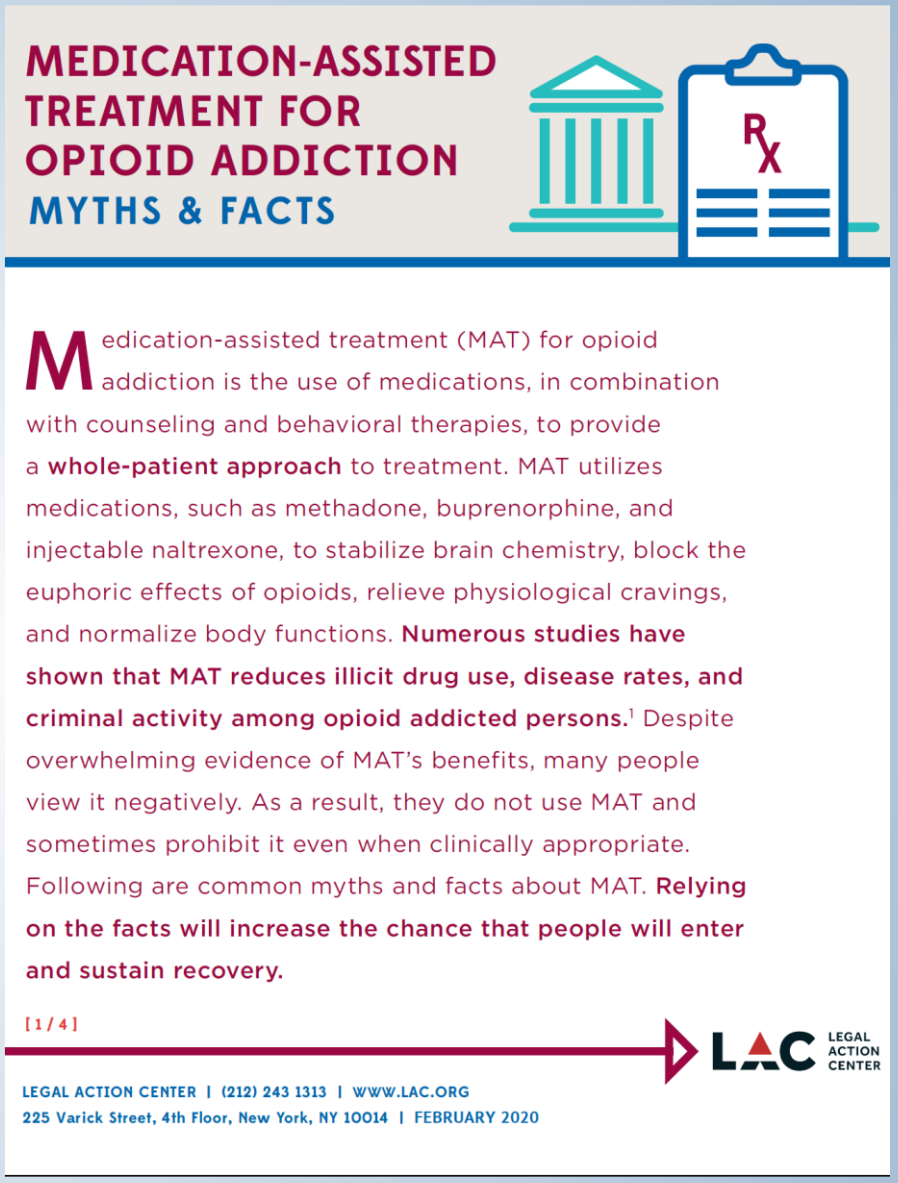
Why treat a drug addiction with a drug?

- Buprenorphine and methadone are proven to cut overdose death rates in half while decreasing illicit drug use and HIV[1] and hepatitis C[2] transmission, and improving patient retention in treatment.[3]
- Injectable extended-release naltrexone is shown to reduce illicit drug use and to increase retention in treatment in three- to six-month trials.[4]
- Twelve-step and other abstinence-based approaches may be helpful for many substance use disorders, but they only succeed in 10% to 15% of people with opioid addiction when used alone, compared to a 50% to 80% rate for MAT.[5]
- Patients on MAT have lower health care costs compared to those on drug-free treatment.[6]
- Prison system data show that MAT reduces deaths. Without treatment, the risk of opioid overdose death for people shortly after leaving prison is 129 times that of the general population.[7]
- After Rhode Island implemented the use of all three medications for opioid addiction in its jail and prison system, overdose death rates after release dropped by 61%.[8]

About the Author
Donna Strugar-Fritsch, MPA, BSN, is a principal at Health Management Associates. She has more than 30 years of health care policy, program development, and clinical nursing experience.

Myth and Facts

- https://www.lac.org/assets/files/Myth-Fact-for-MAT.pdf



MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION

MYTHS & FACTS

Medication-assisted treatment (MAT) for opioid addiction is the use of medications, in combination with counseling and behavioral therapies, to provide a **whole-patient approach** to treatment. MAT utilizes medications, such as methadone, buprenorphine, and injectable naltrexone, to stabilize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions. **Numerous studies have shown that MAT reduces illicit drug use, disease rates, and criminal activity among opioid addicted persons.**[1] Despite overwhelming evidence of MAT's benefits, many people view it negatively. As a result, they do not use MAT and sometimes prohibit it even when clinically appropriate. Following are common myths and facts about MAT. **Relying on the facts will increase the chance that people will enter and sustain recovery.**

[1 / 4]

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Questions and Answers (If time allows)

Thank You

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This project is supported by Grant No. 2017-AR-BX-K003 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance and the Office for Victims of Crime are components of the U.S. Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART). Points of view or opinions are those of the authors, contributors, or presenters and do not necessarily represent the official position or policies of the U.S. Department of Justice.

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