

**The Integration of Services Training Series**

**MODULE 4. SUBSTANCE ABUSE**

**PARTICIPANT GUIDE**



## THE INTEGRATION OF SERVICES TRAINING SERIES

## BEFORE- AND AFTER-TRAINING SURVEY

*Before and After Training Survey – Module 4*

**Directions:** Rate your skill or knowledge level on a scale of 1-10 for each of the following statements. This is not a test. Don't overthink your rating. The training will be on these skills and knowledge. You are not expected to have a high level for all items before the training.

<b>Before Training:</b> Write a <b>B</b> in the numbered box that indicates your skill or knowledge level for each item. Use the scale to the right to guide your rating. Keep the survey in a safe place for use again after the training.  <b>After Training:</b> Write an <b>A</b> in the numbered box that indicates your skill or knowledge level for each item. You may change your “before” rating if you’d like.	<b>1-2</b>	<b>Novice</b>
	<b>3-6</b>	<b>Competent</b>
	<b>7-8</b>	<b>Proficient</b>
	<b>9-10</b>	<b>Expert</b>

Knowledge/Skill Items	Rating									
Describe why some people are more likely to abuse substances than others.	1	2	3	4	5	6	7	8	9	10
Describe the changes in the brain that lead to and result from addiction to substances.	1	2	3	4	5	6	7	8	9	10
Think of and use solution-focused questions to screen for substance misuse by a parent/caregiver.	1	2	3	4	5	6	7	8	9	10
Gather sufficient information from a variety of sources and make accurate substance abuse screening decisions.	1	2	3	4	5	6	7	8	9	10
Describe the main components of a substance abuse assessment.	1	2	3	4	5	6	7	8	9	10
Describe the six step change process used in substance abuse interventions and what the CPI/DCM can do to motivate a parent at each step.	1	2	3	4	5	6	7	8	9	10
Motivate the parent and collaborate with family team members (e.g., substance abuse counselor, informal supports, parent, etc.) during the assessment phase of the intervention.	1	2	3	4	5	6	7	8	9	10
Describe the main components of effective substance abuse treatments.	1	2	3	4	5	6	7	8	9	10
Determine a family's needs and the appropriate supports/providers to meet those needs during the treatment/intervention.	1	2	3	4	5	6	7	8	9	10
Motivate the parent and collaborate with family team members (e.g., substance abuse counselor, informal supports, parent, etc.) during the assessment phase of the intervention.	1	2	3	4	5	6	7	8	9	10
Define relapse and lapses and their implications in the recovery process.	1	2	3	4	5	6	7	8	9	10
With a substance abuse professional, develop a recovery plan for the parent.	1	2	3	4	5	6	7	8	9	10

Factors Influencing Potential for Substance Use		
Domain	Risk Factors	Protective Factors
Child Factors	<ul style="list-style-type: none"> <li>• Poor conflict management skills</li> <li>• Poor social skills</li> <li>• Impulsivity</li> <li>• Favorable attitudes toward substance use</li> <li>• Early initiation of oppositional behavior</li> <li>• Low school readiness</li> <li>• Language delays and learning disabilities</li> <li>• Attention Deficit Disorder</li> <li>• Difficult temperament, easily frustrated, difficulty in self-soothing</li> </ul>	<ul style="list-style-type: none"> <li>• Social competence (responsiveness, cultural flexibility, empathy, caring, communication skills, and a sense of humor)</li> <li>• Autonomy (sense of identity, self-efficacy, self-awareness, task-mastery, and adaptive distancing from negative messages and conditions)</li> <li>• Sense of purpose and belief in a bright future (goal direction, educational aspirations, optimism, faith, and spiritual connectedness)</li> <li>• Problem-solving (planning, teamwork, and critical and creative thinking)</li> </ul>
School and Peer Factors	<ul style="list-style-type: none"> <li>• Ineffective teacher responses</li> <li>• Use of substances among peers</li> <li>• Classroom aggression</li> <li>• Peer rejection</li> <li>• Academic failure beginning in late elementary school</li> <li>• Truancy</li> </ul>	<ul style="list-style-type: none"> <li>• Clear classroom management</li> <li>• Norm of positive behavior among peers</li> <li>• Positive social opportunities</li> <li>• Social bonding</li> <li>• Social skills competency</li> <li>• Academic achievement</li> <li>• Regular school attendance</li> </ul>
Parenting Factors	<ul style="list-style-type: none"> <li>• Harsh and ineffective parenting skills</li> <li>• Favorable parental attitudes towards substance use and own use</li> <li>• Poor monitoring</li> <li>• Poor parent and child attachment</li> <li>• Low cognitive stimulation</li> </ul>	<ul style="list-style-type: none"> <li>• Consistency in rule enforcement</li> <li>• Reinforcement of positive social involvement</li> <li>• Careful and appropriate parental monitoring</li> <li>• Strong parental bonding</li> </ul>
Contextual Factors	<ul style="list-style-type: none"> <li>• Marital discord</li> <li>• Family management problems (e.g., creating and following family rules and rituals)</li> <li>• Family conflict/abuse</li> <li>• Parent criminal activity</li> <li>• Parent substance abuse/history of substance use</li> <li>• Older children who are using substances</li> <li>• Life stressors</li> <li>• Parent mental illness</li> </ul>	<ul style="list-style-type: none"> <li>• Supportive family bonding</li> <li>• Reinforcement for positive social involvement</li> <li>• Positive family dynamics</li> <li>• No tobacco and other substance use/abuse in family</li> <li>• Extended family networks</li> </ul>
Community Factors	<ul style="list-style-type: none"> <li>• Low neighborhood attachment and community disorganization</li> <li>• Community norms (favorable towards drug use)</li> <li>• Transitional communities (e.g., frequent changes in neighborhood members resulting in low cohesion)</li> <li>• Availability of drugs</li> <li>• Extreme economic deprivation</li> <li>• Poverty</li> </ul>	<ul style="list-style-type: none"> <li>• Community connection and supports</li> <li>• Healthy beliefs and clear standards</li> <li>• Community-supported substance abuse prevention efforts and programs</li> <li>• Availability of constructive recreation</li> <li>• Careful and appropriate monitoring of youth's activities</li> </ul>

Source: National Center on Substance Abuse and Child Welfare. (2007). *Curriculum two: Self tutorial. Understanding substance use disorders, treatment and family recovery: A guide for child welfare professionals*. Rockville, MD: SAMHSA.

## Substance Use Continuum: Use, Abuse, Dependence

### Stage 1: Experimental and Social Use (Recreational)

#### Frequency of Use

Occasional use, perhaps a few times monthly, usually on weekends with friends. The person may use alone, too.

#### Reasons for Use

- Curiosity
- Peer pressure
- Obtain social acceptance
- Break parental rules
- Thrill seeking
- Boredom
- Fun and pleasure
- Reduce shyness
- Feel in control

#### Effects

Person feels extremely good (euphoria) when using and returns to a normal state after use. A small amount may make the person intoxicated.

#### Signs Person Is Using

Limited at this stage, and includes:

- Little changes in overall behavior
- Lying about use or whereabouts
- Appearing moderately hung over
- Leaving around evidence of use, such as beer cans or marijuana joints

If the use continues, the person may begin to experience problems related to the use. The fun and pleasurable feelings that were first experienced are still desired, but after the effects of the drug stop the person may not return to the normal state. The person is now progressing to Stage 2.

### Stage 2: Abuse

#### Frequency of Use

The person is now using the drug several times per week and may begin using during the day. They also may be using alone, not just with friends.

#### Reasons for Use

- Try to feel better through the pleasure the drug or alcohol produces
- Try to handle stress and uncomfortable feelings, such as pain, guilt, anxiety, and sadness
- Try to overcome feelings of inadequacy
- Avoid feelings of depression that may happen when not using

#### Effects

- Euphoria still occurs when using the substance
- It may take more use of the drug or alcohol to feel the same effect
- Intoxication occurs more frequently
- May experience depression and discomfort when not using
- May begin to feel guilt, fear, or shame about use

- May have suicidal thoughts or attempts
- May try to stop or reduce the use, but unsuccessfully

#### Signs Person Is Using

More noticeable than for Stage 1, and may include:

- Decline in school or work performance and attendance
- Mood swings
- Changes in personality
- Lying and trying to trick others
- Change in friends, replacing former friends with others who use mind-altering substances
- Dropping other activities like sports, clubs, dance, etc.
- Changes in dress to look more like a member of the drug culture
- More conflict with parents and other family members
- Interest in how to get the drugs

If the substance abuse continues, the person may enter the stage of dependency/addiction. This happens when substance users experience physical or psychological distress when they stop using the substance. At this point the person may no longer feel the pleasurable feelings that they used to have when using the substance. Instead, they have to continue using to feel “normal” or to avoid the uncomfortable feelings they may have when not using. These uncomfortable feelings may include actual physical response that is called withdrawal. If this occurs, it means that the body is at the point where it needs the substance to function normally. At this point, the individual is dependent upon or addicted to the substance. This is Stage 3.

### **Stage 3: Dependency/Addiction**

#### Frequency of Use

Daily.

#### Reasons for Use

- Must use the drug or alcohol to avoid the negative feelings of pain or depression.
- Wants to avoid dealing with the reality of what is happening in their life.
- May no longer have daily control over use (for example, the person may sometimes be able to only have a few drinks during an evening out but, the next day, they drink to intoxication and do not remember what happened).
- Has an uncontrollable desire to use the mind-altering substance, and continue to use despite negative consequences.

It is at this point that the person may start to experience problems at work, get arrested for a DUI, or do things “under the influence” that people who are not addicted would not do. In addition, this is the point at which people may start to experience “blackouts” when later (usually the next day) they cannot remember doing certain things or interacting with others.

#### Effects

- Without the drug or alcohol they feel pain or discomfort
- Usually do not feel the pleasurable effects of the substance, only feeling normal when using
- May have suicidal thoughts or try to commit suicide
- Often feel fear, shame, and sadness over their use
- May experience blackouts, memory loss, fear that someone is after them (paranoia), or other mental problems
- Frequent mood changes, experiencing feelings such as sadness, anger, irritation, or that they don’t care about anything at all (apathy)

Signs Person Is Using

These signs and their consequences, become much more noticeable and serious:

- Loss of weight and other health problems
- Poor appearance
- May lose their job or drop out of school
- May be absent from home much of the time
- May overdose
- Primary concern is getting and using the drug
- Are not very worried about being caught

**Note:** When the substance of choice is alcohol, the person abusing the substance can often manage the addiction for years. Often only their family members know something is wrong but not employers or friends. With alcohol addiction it can take years before the effects are obvious.

## Substance Use Continuum and CPI/DCM Implications

Alcohol and Drug Use Continuum	Implications for Child Welfare/ Examples of Risk to Children
Use of alcohol or drugs to socialize and feel effects; use may not appear abusive and may not lead to dependence. However the circumstances under which a parent uses can put children at risk of harm.	<ul style="list-style-type: none"> <li>• Use during pregnancy can harm the fetus.</li> <li>• Use of prescription pain medication per the instructions from a prescribing physician can sometimes have unintended or unexpected effects- a parent caring for children may find that he or she is more drowsy than expected and cannot respond to the needs of children in his or her care.</li> </ul>
<p><b>Abuse</b> of alcohol or drugs includes at least one of these factors in the last 12 months:</p> <ul style="list-style-type: none"> <li>• Recurrent substance use resulting in failure to fulfill obligations at work, home or school</li> <li>• Recurrent substance use in situations that are physically hazardous</li> <li>• Recurrent substance-related legal problems</li> <li>• Continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the substance</li> </ul> <p>The American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition, Text Revision (DSM-IV/DSM-IV-TR)</p>	<ul style="list-style-type: none"> <li>• Driving with children in the car while under the influence</li> <li>• Children may be left in unsafe care- with an inappropriate caretaker or unattended- while parent is partying</li> <li>• Parent may neglect or sporadically address the children's needs for regular meals, clothing, and cleanliness</li> <li>• Even when the parent is in the home, the parent's use may leave children unsupervised</li> <li>• Behavior toward children may be inconsistent, such as a pattern of violence then remorse</li> </ul>
<p>Dependence, also known as addiction, is a pattern of use that results in three or more of the following symptoms in a 12 month period.</p> <ul style="list-style-type: none"> <li>• Tolerance - needing more of the drug or alcohol to get "high"</li> <li>• Withdrawal – physical symptoms when alcohol or other drugs are not used, such as tremors, nausea, sweating, and shakiness</li> <li>• Substance is taken in larger amounts and over a longer period than intended</li> <li>• Persistent desire or unsuccessful efforts to cut down or control substance use</li> <li>• A great deal of time is spent in activities related to obtaining the substance, use of the substance or recovering from its effects</li> <li>• Important social, occupational, or recreational activities are given up or reduced because of substance use</li> <li>• Substance use is continued despite knowledge of persistent or recurrent physical or psychological problems caused or exacerbated by the substance</li> </ul>	<ul style="list-style-type: none"> <li>• Despite a clear danger to children, the parent may engage in addiction-related behaviors, such as leaving children unattended while seeking drugs</li> <li>• Funds are used to buy alcohol or other drugs, while other necessities, such as buying food, are neglected</li> <li>• A parent may not be able to think logically or make rational decisions regarding children's needs or care</li> <li>• A parent may not be able to prioritize children's needs over his or her own need for the substance</li> </ul>

Source: Breshears, E.M., Yeh, S., & Young, N.K. (2004). *Understanding substance abuse and facilitating recovery: A guide for child welfare workers*. Rockville, MD: Substance Abuse and Mental Health Services Administration.



## **RECORDS REVIEW: CONFIDENCE-BUILDING QUESTIONS**

A records review not only gives you information about the incident and family; it can be used to motivate you for the engagement with the family.

### ***Questions to ask:***

- What mental picture do you have of the family? (E.g., Is the maltreatment episodic or are there deep underlying factors? What stressors are obvious? To what degree is the family cohesive? Is the family integrated within an extended family or community organizations?)
- What filters does the case “fire” in you? What filters do the family members display?
- What emerges as the strongest issue about the case?
- What strengths are evident at this point?
- What would the family see as the most important issue? How would you find this out?
- Who would be the most influential person in this family, and how would you enlist this person’s assistance?
- Did a previous caseworker do something that was particularly helpful for the family? What could have been done differently?
- What do you still want to know about this family?
- How do you think previous encounters with the department may impact how this family will react to another encounter with the department?

### ***Records to Review***

#### CPI

- Prior reports – maltreatments on those reports and more detail reviewed on verified reports and their indicators
- Previous services – what was done and what was the degree of compliance
- Existing court orders
- Reporter and source information

#### Case Management

- Current assessment
- Current case plan and prior case plan (as applicable)
- Last six months of chronological notes
- Talk to people – prior case manager, teachers, counselors, etc.

## **Effects of Substance Abuse on Children's Behavior**

Children may have experienced postnatal family environments that exhibit a lack of resources to meet their needs or suffer from serious parental inconsistencies in relationships with or support of a child. Or, they may lack the steady presence of caregiving persons.

The following are examples of typical experiences of children whose primary caregiver abuses substances (Breshears, Yeh & Young, 2005):

- The home life may be chaotic and unpredictable.
- There may be inconsistent parenting and a lack of appropriate supervision.
- Substance-abusing adults may provide inconsistent emotional responses to children, or they may provide inconsistent care, especially to younger children.
- Parents may have abandoned children physically and emotionally.
- Parents may emphasize secrecy about home life.
- Parental behavior may make the child feel guilt, shame, or self-blame.

Because of their life experiences, children may have developed feelings, such as:

- Believing they have to be perfect
- Believing they have to become the parent to the parent
- Difficulty with trusting others
- Difficulty with maintaining a sense of attachment
- Difficulty with achieving self-esteem
- Difficulty with achieving self-autonomy
- Feelings of extreme shyness or aggressiveness

## UNCOPE Questions

- U** Have you continued to **use** alcohol or drugs longer than you intended?
- Or
- Have you spent more time drinking or using than you intended?
- N** Have you ever **neglected** some of your usual responsibilities because of alcohol or drug use?
- C** Have you ever wanted to stop using alcohol or drugs but couldn't? (**cut down**)
- O** Has your family, a friend, or anyone else ever told you they **objected** to your alcohol or drug use?
- P** Have you ever found yourself **preoccupied** with wanting to use alcohol or drugs?
- Or
- Have you frequently found yourself thinking about a drink or getting high?
- E** Have you ever used alcohol or drugs to relieve **emotional discomfort**, such as sadness, anger, or boredom?

**Scoring:** Two or more positive responses indicate possible abuse or dependence and need for further assessment.

## CRAFFT Questions

<b>C</b>	1. Have you ever ridden in a <b>Car</b> driven by someone (including yourself) who was high or had been using alcohol or drugs?
<b>R</b>	2. Do you ever use alcohol or drugs to <b>Relax</b> , feel better about yourself, or fit in?
<b>A</b>	3. Do you ever use alcohol or drugs while you are by yourself <b>Alone</b> ?
<b>F</b>	4. Do you ever <b>Forget</b> things you did while using alcohol or drugs?
<b>F</b>	5. Do your <b>Family</b> or <b>Friends</b> ever tell you that you should cut down on your drinking or drug use?
<b>T</b>	6. Have you ever gotten into <b>Trouble</b> while you were using alcohol or drugs?

Scoring: Two or more positive items indicated the need for further assessment.

The CRAFFT is intended specifically for adolescents. It draws upon adult screening instruments, covers alcohol and other drugs, and calls upon situations that are suited to adolescents.

From: Knight JR; Sherritt L; Shrier LA//Harris SK//Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Archives of Pediatrics & Adolescent Medicine* 156(6) 607-614, 2002.

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## **Parent and/or Child Substance Abuse: Open-ended, Solution-Focused Questions**

### Sample Questions;

- In your opinion, what role has drinking or drugs played in your family?
- In the past, have you felt that you should cut back on your drinking or drug use?  
What happened?
- What have other people in your family said about drinking or drug use, either yours or someone else's
- Have drugs or drinking cost you or your family in the past?
- Who in your family uses alcohol or drugs?
- Who in your extended family has gone into recovery for drug or alcohol use?
- When you were growing up, what was your community view about drugs and alcohol? How did your family view drugs and alcohol?
- What impact do you think drugs and alcohol in your family have had on the children?
- What do you think your children would say about the use of drugs and alcohol in the family?
- If you were to stop using drugs and/or alcohol, what would be the toughest times to resist using again?
- What do you think you would have to give up or lose in order to give up the drugs and/or alcohol?

### Things to look for:

- Inconsistent reports of use and impact
- Binge drinking that results in disruption in the family and reduces parent's ability to care for the child.

### Strengths to build on:

- Treatment was successful and parent or child maintains sobriety
- Attends AA, NA, or other support group
- Child or parent says that he is able to say no to peers
- Child admits using and has frank conversations with parents
- Child is able to express concerns about personal use
- Child or parent can describe what would lead them to relapse and is willing to plan for and make changes to stay sober or off drugs.

The Effects of Substances Abuse on Behavior and Parenting		
Substance	General Effects	Parenting Effects
<b>ALCOHOL</b>		
<b>Alcohol</b>	<ul style="list-style-type: none"> <li>• Lowers inhibitions, often leading to inappropriate or risky behaviors</li> <li>• Impairs judgment</li> <li>• Diminishes motor coordination</li> </ul>	<ul style="list-style-type: none"> <li>• A parent may forget or neglect to attend to parenting responsibilities.</li> <li>• A parent may stay out all night and leave children alone due to intoxication.</li> <li>• A parent may have rages and depressive episodes, creating an unstable environment for children.</li> </ul>
<b>ILLEGAL DRUGS</b>		
<b>Cocaine</b>	<ul style="list-style-type: none"> <li>• In addition to an influx of energy, cocaine also heightens the senses. Colors appear brighter, smells seem stronger, and noises sound louder.</li> <li>• After prolonged use, cocaine also increases irritability and aggression in the user.</li> <li>• Cocaine can result in psychotic distortions of thought such that the user imagines and acts on projections to others of his or her own aggression.</li> </ul>	<ul style="list-style-type: none"> <li>• A child's crying, which may be only a mild annoyance to a nonusing parent, is magnified in its intensity to the parent on cocaine.</li> <li>• A parent may become angry or impatient with a child for any reason because of thought distortion and misperception of the child's intent.</li> </ul>
<b>Crack/Crack Cocaine</b>	<ul style="list-style-type: none"> <li>• In the smokeable form known as crack, cocaine cycles rapidly through the body so that a physical and psychological "high" vanishes quickly, within 5 to 15 minutes, leaving in its wake anxiety, depression, and paranoia, as well as an intense craving for a return to the euphoric state.</li> <li>• Crack heightens feelings of power and control over one's life, feelings that may be sorely lacking in those belonging to oppressed social groups.</li> </ul>	<ul style="list-style-type: none"> <li>• A parent addicted to crack can leave an infant or toddler alone for hours or sometimes days at a time to pursue the drug.</li> <li>• CPS workers frequently investigate maltreatment reports in homes barren of furniture and appliances that have been sold to purchase crack and other drugs.</li> <li>• The absence of food in the refrigerator or cupboards is evidence of parental inability to attend to a child's most basic needs.</li> <li>• Some parents will do whatever it takes to pursue their habit, even if it means sacrificing the health and well-being of loved ones.</li> <li>• Crack can contribute to a significant increase in sexual abuse of young children in two ways: <ul style="list-style-type: none"> <li>○ The heightened physical sensations induced by crack can lead users to seek out sexual encounters. A child who is available and unprotected by a functioning adult, as when children accompany parents to so-</li> </ul> </li> </ul>

The Effects of Substances Abuse on Behavior and Parenting		
Substance	General Effects	Parenting Effects
		<p>called crack houses, is an easy target for sexual abuse by an individual high on crack.</p> <ul style="list-style-type: none"> <li>○ Very young children, even babies, can be prostituted by their crack-addicted parents desperate to obtain the drug.</li> </ul>
<b>Heroin</b>	<ul style="list-style-type: none"> <li>• Highly addictive drug leading to serious, even fatal health conditions.</li> <li>• Injecting, snorting, or smoking heroin causes initial euphoria, followed by an alternatively wakeful and drowsy state.</li> <li>• Tolerance to the drug develops with regular use, meaning that the abuser must use more heroin to produce the same effect. Physical dependence and addiction develop, and withdrawal can occur as soon as a few hours after the last use.</li> </ul>	<ul style="list-style-type: none"> <li>• A parent may forget or neglect to attend to parenting responsibilities.</li> <li>• Parents may leave children alone while seeking, obtaining, or using the drug.</li> <li>• Parents may “nod out” while under the influence of heroin and be unable to supervise or protect their children.</li> <li>• Parents may expose their children to heroin dealers, other users, and hence unsafe and dangerous situations.</li> </ul>
<b>Methamphetamine</b>	<ul style="list-style-type: none"> <li>• Releases high levels of dopamine, which stimulates brain cells, enhancing mood and body movement.</li> <li>• Smoking or injecting methamphetamine causes a euphoria that is notable for its intensity and length. Snorting or ingesting methamphetamine produces a milder and less intense euphoria.</li> <li>• Following the initial euphoria, the user “crashes” into an irritable, anxious, paranoid, aggressive, or empty feeling. The user may continue to use methamphetamine to regain the euphoric state.</li> <li>• Severe withdrawal symptoms may include psychotic episodes and extreme violence.</li> <li>• Methamphetamine use can quickly lead to addiction and is linked to long-term brain damage, and cardiovascular and other major health problems.</li> </ul>	<ul style="list-style-type: none"> <li>• Methamphetamine is an increasing problem among parents in the child welfare system.</li> <li>• Parents may not supervise children or provide for their basic nutritional, hygienic, or medical needs.</li> <li>• Violence, aggression, and paranoia may lead to serious consequences for children of meth abusers.</li> <li>• Additional risks to children can be quite extreme if the drug is being “cooked” in their residence. These risks include fire and explosions as well as unintentional absorption of the drug from the home environment.</li> </ul>

<b>The Effects of Substances Abuse on Behavior and Parenting</b>		
<b>Substance</b>	<b>General Effects</b>	<b>Parenting Effects</b>
<b>Marijuana</b>	<ul style="list-style-type: none"> <li>It slows down the nervous system function, producing a drowsy or calming effect</li> </ul>	<ul style="list-style-type: none"> <li>A parent may forget or neglect to attend to parenting responsibilities.</li> <li>Parents may leave children alone while seeking, obtaining, or using the drug.</li> <li>Parents may fall asleep while under the influence of marijuana and be unable to supervise or protect their children.</li> </ul>
<b>PRESCRIPTION DRUGS AND PAIN MEDICATIONS</b>		
<b>Opioids (usually prescription pain medications)</b>	<ul style="list-style-type: none"> <li>They block the transmission of pain messages to the brain and produce euphoria followed by drowsiness.</li> <li>Chronic use can result in tolerance, dependence, and withdrawal.</li> <li>Methadone, buprenorphine, and naltrexone are synthetic opioids used to treat heroin addiction.</li> </ul>	<ul style="list-style-type: none"> <li>A parent may forget or neglect to attend to parenting responsibilities.</li> <li>Parents may leave children alone while seeking, obtaining, or using the drug.</li> <li>Parents may “nod out” while under the influence of opioids and be unable to supervise or protect their children.</li> <li>Parents may expose their children to dealers, other uses, and hence unsafe and dangerous situations.</li> </ul>
<b>Stimulants, including amphetamines and methylphenidate (prescription drugs)</b>	<ul style="list-style-type: none"> <li>They are stimulants to the central nervous system, which increase alertness, attention, and energy.</li> <li>A stimulant user may feel energetic with very little sleep.</li> </ul>	<ul style="list-style-type: none"> <li>Because their own sleep-wake cycles are so distorted by the drug, parents on amphetamines may be unable to attend to a child’s need for structure and pattern.</li> <li>The parent may become impatient or irritated with the child, who is unable to adapt to the parent’s level of energy.</li> <li>When a parent is not hungry, due to appetite-suppressive effects of stimulants, and therefore is not preparing meals for herself, she may also fail to consider a child’s hunger and therefore ensure that he is fed on a regular basis.</li> </ul>
<b>Central nervous system depressants</b>	<ul style="list-style-type: none"> <li>They slow down the nervous system function, producing a drowsy or calming effect.</li> <li>Stopping high dosage/prolonged usage of these drugs may lead to withdrawal symptoms, including seizures.</li> </ul>	<ul style="list-style-type: none"> <li>A parent may forget or neglect to attend to parenting responsibilities.</li> <li>Parents may leave children alone while seeking, obtaining, or using the drug.</li> <li>Parents may fall asleep while under the influence of depressants and be unable to supervise or protect their children.</li> </ul>
<b>Adapted from Dore, 1998; Gold, 1992; National Institute on Drug Abuse (NIDA), 2001; NIDA, 2003</b>		



## **A Beginning List: In-Home Indicators of Potential Substance Abuse**

Child welfare professionals should check for the following indicators as part of onsite investigations (Young & Gardner, 2002):

- A report of substance use was included in the child protective services call or report
- Paraphernalia is found in the home (syringe kit, pipes, charred spoon, foils, large number of liquor or beer bottles, etc.)
- The home or the parent may smell of alcohol, marijuana, or drugs
- A child reports use by parent(s) or other adults in the home
- A parent exhibits physical behavior of being under the influence of alcohol or drugs (slurred speech, inability to mentally focus, physical balance affected, extremely lethargic or hyperactive, etc.)
- A parent shows signs of addiction (needle tracks, skin abscesses, burns on inside of lips, etc.)
- A parent admits to substance use
- A parent shows or reports experiencing physical effects of addiction or being under the influence, including withdrawal (nausea, euphoria, slowed thinking, hallucinations, or other symptoms)

As with all cases of child abuse and neglect, workers must observe persons who frequent the home. The behaviors of parents' friends or associates can be an indication of behaviors practiced or of potential dangers to the child.

Young NK and Gardner SL. *Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services with Child Welfare*. Rockville, MD: Center for Substance Abuse Treatment, 2002.

## Matching Treatment to Person

Matching substance-abusing parents to treatment involves matching the severity of the substance use to intensity of service. Among the issues to consider are:

- **Acute intoxication and/or withdrawal potential** – What risk does the parent’s level of intoxication or withdrawal present?
- **Biomedical conditions and complications** – Does the parent have illnesses or chronic conditions that affect treatment?
- **Emotional/behavioral conditions and complications** – Does the parent have psychological or other problems that need specific mental health services?
- **Treatment acceptance/resistance** – Does the parent object to treatment or disagree with the substance abuse diagnosis? If the parent agrees to treatment, is the compliance to avoid a negative consequence, or is the parent internally motivated to address their alcohol or drug problems?
- **Relapse/continued use potential** – How aware is the parent of relapse triggers and what skills does he or she have to cope with cravings or life stresses and the impulse to use?
- **Recovery environment** – Does the parent have family relationships and friendships that support treatment and recovery? Conversely, are there family members, significant others, relationships, or living situations that may sabotage or threaten treatment engagement and success?

## Stages of Change and Motivation Tasks

Parent's Stages of Change		Motivational Tasks for CPI/DCM
Pre-contemplation	No perception of having a problem or need to change	Increase parent's perception of the risks and problems with their current behavior; raise parent's doubts about behavior.
Contemplation	Initial recognition that behavior may be a problem and ambivalence about change	Foster and evoke reasons to change and the risks of not changing; tip the balance toward change.
Decision to change	Makes a conscious decision to change. Some motivation for change identified	Help parent identify best actions to take for change; support motivations for change.
Action	Takes steps to change	Help parent implement strategy and take steps.
Maintenance	Actively works on sustaining change strategies and maintaining long-term change	Help parent to identify triggers and use strategies to prevent relapse.
Lapse or relapse	Slips (lapses) from change strategy or returns to previous problem behavior patterns (relapse)	Help parent re-engage in the contemplation, decision, and action stages.

Adapted from:

Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals. Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Rockville, MD, 2004.

## Principles of Effective Treatment

1. Addiction is a complex but treatable disease that affects brain function and behavior. Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences.
2. No single treatment is appropriate for everyone. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
3. Treatment needs to be readily available. Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.
4. Effective treatment attends to multiple needs of the individual, not just his or her drug abuse. To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.
5. Remaining in treatment for an adequate period of time is critical. The appropriate duration for an individual depends on the type and degree of his or her problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.
6. Counseling—individual and/or group—and other behavioral therapies are the most commonly used forms of drug abuse treatment. Behavioral therapies vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies. For example, methadone and buprenorphine are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opioid-addicted individuals and some patients with alcohol dependence. Other medications for alcohol dependence include acamprosate, disulfiram, and topiramate. For persons addicted to nicotine, a nicotine replacement product (such as patches, gum, or lozenges) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioral treatment program.
8. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs. A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a

continuing care approach provides the best results, with the treatment intensity varying according to a person's changing needs.

9. Many drug-addicted individuals also have other mental disorders. Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.
10. Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse. Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and, for some, can pave the way for effective long-term addiction treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification. Motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement.
11. Treatment does not need to be voluntary to be effective. Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.
12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur. Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.
13. Treatment programs should assess patients for the presence of HIV/ AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases. Typically, drug abuse treatment addresses some of the drug-related behaviors that put people at risk of infectious diseases. Targeted counseling specifically focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Counseling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical treatments. Patients may be reluctant to accept screening for HIV (and other infectious diseases); therefore, it is incumbent upon treatment providers to encourage and support HIV screening and inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug abusing populations.

Source: National Institute on Drug Abuse. (2009, April). *Principles of drug addiction treatment: A research-based guide* (2<sup>nd</sup> ed.). NIH Publication No. 09-4180. Washington, DC: National Institute of Health.

## **Rationale and safe management of drug-mediated treatments**

### ***Isn't using treatment medications simply replacing one drug with another?***

- No—as used in maintenance treatment, buprenorphine and methadone are not heroin/opioid substitutes.
- They are prescribed or administered under monitored, controlled conditions and are safe and effective for treating opioid addiction when used as directed.
- They are administered orally or sublingually (i.e., under the tongue) in specified doses, and their pharmacological effects differ from those of heroin and other abused opioids.
- Heroin, for example, is often injected, snorted, or smoked, causing an almost immediate “rush,” or brief period of euphoria, that wears off quickly and ends in a “crash.” The individual then experiences an intense craving to use again so as to stop the crash and reinstate the euphoria.
- In contrast, methadone and buprenorphine have gradual onsets of action and produce stable levels of the drug in the brain; as a result, people maintained on these medications do not experience a rush, while they also markedly reduce their desire to use opioids.
- If an individual treated with these medications tries to take an opioid such as heroin, the euphoric effects are usually dampened or suppressed.
- Individuals undergoing maintenance treatment do not experience the physiological or behavioral abnormalities from rapid fluctuations in drug levels associated with opioid use.
- Maintenance treatments, properly prescribed, save lives.
- The medications used for drug-mediated treatments for opioid addictions (methadone and Buprenorphine) are highly regulated by Federal and State laws. They may only be prescribed and dispensed by qualified physicians who have been specially trained to work in addictions.
- Methadone may only be dispensed by Federally-approved Opioid Treatment Programs (e.g., methadone clinics). Physicians who prescribe and dispense Buprenorphine may work in Opioid Treatment Programs or may see patients in their private practices.

### Activity 3-2: Collaboration Practice Activity Worksheet

**Directions:** Use the practice case (Sonia Everett family) information to work as a team to identify the family needs, formal or informal supports that can help meet those needs, a general collaboration strategy among the team members to support the family during the intervention/treatment, and actions you anticipate team members may take to motivate the family to continue/complete their intervention/services.

The key questions are: What does Sonia and her children need? How can we best meet those needs with formal services and informal supports? How do we avoid overwhelming the family with services/schedules? How do we provide for the on-going safety of the children should Sonia lapse or relapse with her substances use?

Need	Who can help the family meet that need?	Motivational actions to support the family (and by whom)

General collaboration approach the team will use to support positive change for the Everetts:

## Common Needs of Families in Substance Abuse Treatment

### Needs of Children in Homes Where Parents Have Substance Abuse Disorders

- Children need the opportunity to identify and express feelings with a safe and trusted adult.
- Children need information about substance abuse and the disease of addiction so that they know they are not to blame.
- Children need to be screened for developmental delays, medical conditions, mental health problems, substance abuse problems, and appropriate follow-up needs to be provided.
- Children may need to participate in counseling or support groups.
- Children need consistent, ongoing support systems and caregivers who will keep them safe and help them recover over the long period of time.
- Where appropriate to the permanency plan, children need an effective visitation program between parents and children. The visitation program should enhance the children's understanding of what is occurring in their lives, and give them an opportunity to safely and positively maintain a relationship with their parents.

### Relapse/Safety Planning

Relapse planning includes: “What can a parent do differently?” For example, if emotions around holidays spent with family members result in high stress and a desire to use, what can be done differently to minimize stress? Or, what can the parent do to minimize the emotional impact of alcohol and drug use on the child? For example, one mother arranged for her daughter to participate in a weekly support group of teens with addicted parents, as the mother struggled (sometimes unsuccessfully) to maintain sobriety.

Part of effecting long-term change includes working with parents to identify the specific factors that preceded their substance use— What were the emotional, cognitive, environmental, situational, and behavioral precedents to the relapse? Parents who learn triggers can become empowered to plan proactively for the safety of their children and to seek healthy ways to neutralize or mitigate the trigger. One element in the process of recovery is to develop a relapse prevention plan and strategies.

The plan could include the following:

- Persons who will regularly check on the well-being of children, such as family members or neighbors.
- Identified safe havens where parents can send children if they feel they are going to start using substances or relapse into inappropriate behavior around and toward children.
- Persons agreed upon ahead of time, that the child can contact if the parents abandon the children or are unable to provide a safe environment.
- Monitoring of trigger behaviors that would bring safety plans into play.



## Service Needs of Parents in Treatment

### *Parenting Role*

The parenting role of women with substance use disorders is a complex matter that cannot be separated from their treatment. Many of these women have not learned to be good parents, may not know about normal child development, and may have unrealistic expectations of their children (Kassebaum, 1999).

Others may have been positive parents. However, their positive parenting abilities may have been compromised because of the loss of balance and wellness caused by the addiction and as the substance abuse cycle intensified.

### *Service Needs*

Addiction treatment should be individualized. However, there are services that most parents in the child welfare system will need at various points in the treatment process. Child welfare professionals can work with treatment providers to ensure that the following critical services are provided for parents in treatment:

- Access to physical necessities, such as food, housing, and transportation
- Medical care
- Substance abuse prevention counseling
- Parenting and child development training
- Support in sustaining frequent, consistent, and safe visitation with children
- Training in childcare techniques (e.g., bathing, holding, packing a diaper bag, giving medication)
- Social services and social support
- Psychological assessment and mental health care
- Family planning services
- Child care
- Family therapy and health education
- Life skills training in such areas as financial management, assertiveness training, stress management, coping skills, home management, anger management, conflict resolution, and communication skills
- Training in language and literacy
- Planned, continuing care after program completion

Kassebaum. *Substance abuse treatment for women offenders: A guide to promising practices*. Technical Assistance Publication Series Number 23. Rockville, MD: Center for Substance Abuse Treatment, 1999.

## Joint Case Review Questions

- Is the child safe? Have the protective factors, strengths, or the safety factors changed, warranting a change or elimination of the safety plan or the development of a safety plan?
- What changes, if any, have occurred with respect to the conditions and behaviors contributing to the risk of maltreatment?
- What outcomes have been accomplished, and how does the caseworker know that they have been accomplished?
- What progress has been made toward achieving case goals?
- Have the services been effective in helping parent achieve outcomes and goals and, if not, what adjustments need to be made to improve outcomes?
- What is the current level of risk in the family?
- Have the risk factors been reduced sufficiently so that parents or caregivers can protect their children and meet their developmental needs so that the case can be closed?

## How to Talk to Children About Their Parents' Addiction

Talk to a child about his or her parent's substance abuse. Help the foster parent or kinship care provider talk to the children in his or her care about the parent's substance use or dependence.

Use the following four talking points to help guide these discussions:

**Addiction is a disease.** Your parent is not a bad person. She has a disease. The alcohol or other drugs cause your parent to lose control. When they drink or use drugs, parents can behave in ways that do not keep you safe or cared for.

**You are not the reason your parent drinks or uses drugs.** You did not cause this disease. You cannot stop your parent's drinking or drug use.

**There are a lot of children like you.** In fact, there are millions of children whose parents are addicted to drugs or alcohol. Some are in your school. You are not alone.

**Let's think of people whom you might talk with about your concerns.** You don't have to feel scared or ashamed or embarrassed. You can talk to your teacher, a close friend, or to an adult in your family that you trust.

### Postnatal Exposure: The 7 Cs of Addiction

The **National Association for Children of Alcoholics** developed the 7 Cs of Addiction, which can help children to understand that they are not responsible for another person's addiction to alcohol or other drugs.

#### Remember the 7 Cs

Some children with moms and dads that drink too much think that it is their fault. Maybe you are one of those children. Well, it's not your fault and you can't control it. But, there are ways that you can deal with it. One important way is to remember the 7 Cs.

I didn't **Cause** it.  
I can't **Cure** it.  
I can't **Control** it.  
I can **Care** for myself by  
**Communicating** my feelings,  
Making healthy **Choices**, and  
By **Celebrating** myself.

Reproduced with permission from the National Association for Children of Alcoholics.

## Transition Planning Basics

When working with parents in the early transition period, help them develop life-long recovery strategies by developing and using the following resources:

**Encourage 12-Step participation.** Use motivational enhancement interventions to encourage ongoing participation in the 12-Step programs and to obtain a 12-Step sponsor.

**Know resources.** Maintain a directory of local community- and faith-based organizations and social support services. Obtain relevant contact information (e.g., phone numbers, addresses, hours of service, and referral requirements). Establish relationships with organization representatives to make ongoing, informed referrals for parents, as needs arise.

**Identify individualized services.** Work with the substance abuse counselor to determine the specific services that parents will need for themselves and their families during the recovery period.

Prior to transitioning the case, use the transition plan to help the parent establish a community network of support and safety planning for parents and children on which they can rely when the case is closed. This network needs to provide linkages, relationships, and benefits.

**Linkages.** Help promote linkages with community-based organizations and resources that will provide ongoing support and assistance to families about issues for which they need help. Reinforce the linkages with contacts, arrange for initial visits while the family is still in the child welfare system, and have follow-up discussions to determine how effectively the linkages met family needs.

**Relationships.** Help families establish relationships with family members, friends, churches or temples, or other social support groups that can support the family members as they make their way through recovery.

**Benefits.** Ensure that parents are receiving the full income and other benefits from the Florida's Temporary Assistance for Needy Families (TANF) Program and are participating in the Earned Income Tax Credit.

## Resources for Module 4: Substance Abuse

### References

Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. (2004). *Understanding substance use disorders, treatment, and family recovery: A guide for child welfare professionals*. Rockville, MD: Author. Available from [www.ncsacw.samhsa.gov](http://www.ncsacw.samhsa.gov)

Breshears, E.M., Yeh, S. & Young, N.K. (2004). *Understanding substance abuse and facilitating recovery: A guide for child welfare workers*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available from [www.ncsacw.samhsa.gov](http://www.ncsacw.samhsa.gov)

National Institute of Drug Abuse, National Institutes of Health, U.S. Dept. of Health and Human Services. (2008, February). *The science of addiction: Drugs, brains, and behavior*. NIH Pub No. 07-5605. Available from [www.drugabuse.gov/ScienceofAddiction](http://www.drugabuse.gov/ScienceofAddiction)

Young, N. K., Nakashian, M., Yeh, S., & Amatetti, S. (2007). *Screening and assessment for family engagement, retention, and recovery (SAFERR)*. DHHS Pub. No. (SMA) 07-4261. Rockville, MD: Substance Abuse and Mental Health Services Administration.

National Institute of Drug Abuse, National Institutes of Health, U.S. Dept. of Health and Human Services. (2009, April). *Principles of drug addiction treatment: A research-based guide (second edition)*. NIH Pub No. 09-4180. Available from [www.drugabuse.gov/PODAT](http://www.drugabuse.gov/PODAT)

National Institute of Drug Abuse, National Institutes of Health, U.S. Dept. of Health and Human Services. (2008, December). *Comorbidity: Addiction and other mental illnesses*. NIH Pub No. 08-5771. Available from [www.drugabuse.gov/researchreports/comorbidity](http://www.drugabuse.gov/researchreports/comorbidity)

### Other Resources

Center for Excellence U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2010, June). *Fetal alcohol spectrum disorders*. <http://fasdcenter.samsha.gov>

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2010). *National center on substance abuse and child welfare*. [www.ncsacw.samsha.gov](http://www.ncsacw.samsha.gov)

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services. (2010). *Administration center for substance abuse treatment*. [www.csat.samsha.gov](http://www.csat.samsha.gov)