

OVERVIEW

Goal—The goal of Module 2 is to educate child welfare professionals about alcohol and drug issues, treatment, and recovery. It provides information and learning opportunities designed to support child welfare professionals in working with families from various cultural groups affected by alcohol- and/or drug-related problems. The module will inform child welfare professionals about the continuum of use, abuse, and dependency; explain signs and symptoms that can indicate the need for a comprehensive assessment of parents; and introduce common screening tools that can be used by child welfare workers in the context of home visitation and social work practice. This module also provides an understanding of the treatment and recovery processes, and discusses specifics of how substance use disorders can affect the interpersonal relationships and family dynamics of the families involved with the child welfare system in the context of safety assessment and safety planning.

Methods: PowerPoint presentations (or overhead/transparencies); large group and small group discussions, with Vignette discussion.

Training Aids: Projector and computer, disk with PowerPoint file (or overhead and transparencies); flip chart with markers; participant notebook.

Time: 3 hours

Learning Objectives—After completing Module 2, child welfare professionals will have an understanding of the following topics:

- Types of substances and their effects
- Methods of usage
- Continuum of use, abuse, dependence
- Pathways from use, abuse, dependence
- Differential impact of substance use disorders on communities of color
- Brain chemistry of addiction
- Signs and symptoms of potential use, abuse, dependence in the context of home visitation and social work practice
- Culturally appropriate screening tools for determining if a further comprehensive assessment by an alcohol and drug treatment professional is needed
- Treatment models, cultural competency in treatment and treatment effectiveness
- Recovery process and progression
- Effects of alcohol and drug issues on interpersonal relationships and family dynamics, care of children, etc.
 - Isolation
 - Negative social network
 - Poor parenting skills
 - Endangering behaviors
 - Emergence of a “don’t tell, don’t trust and don’t feel” complex, reflecting learned behaviors that emerge as a result of the effects of alcohol and drug use and/or abuse.
- Relapse prevention and long-term recovery maintenance in the context of safety assessment and safety planning

Prior to start ***Meet and greet, registration***

Purpose is to give participants access to the space. Each will prepare differently, arrive at different times. Conduct registration and distribute materials. Trainers get ready.

0 – 15 minutes ***Introductions; Purpose; Ground Rules*** **15 min.**

Trainer introduces him or herself. Invite participants to briefly introduce themselves (e.g., name, unit, office location, years in the system, etc.). If group is smaller than 12-15 people, trainer could invite them also to briefly describe their interest in this training. If group is larger than 40-50 people, individual introductions are likely to take too much time.

Describe the purpose of Module 2. Language for this overview is provided at the beginning of the presentation scripts, right before Presentation 4. Emphasize that child welfare professionals often work with families where one or more adults are experiencing treatable substance use disorders and this training is intended to prepare them to better help such adults recover from the effects of their disorder and function appropriately as parent or caregiver. The bottom line goal is safe care of children. The language provided also describes four simple ground rules for the training session. After presenting them, the trainer may ask the group if there are any other ground rules important to them.

Good morning! (afternoon; evening) Thank you for being here today. This training has been designed specifically for child welfare professionals, with important information and opportunities to practice skills useful to your work.

Today you will hear several informative presentations and have several opportunities to talk about this information and its relevance to your work—with each other in small groups and as a whole group. In our time together, I ask that we: 1) treat each other with respect; 2) talk only one at a time; 3) give each person the opportunity to participate; and 4) think about how to take new learning back to your job responsibilities.

PRESENTATION 4

15 – 30 minutes ***Presentation 4: Why do people use drugs? Use, abuse and dependence; alcoholism and alcohol abuse; brain chemistry of addiction*** **15 min.**

Deliver scripted presentation describing parental substance use disorders. Slides II-1 through II-11 At the end of the presentation, the trainer should ask first if there are any brief questions that can be answered before moving on to the following discussion. Keep answers brief and only answer questions to which you know the answer.

**[Slide II-1]: Substance Use Disorders, Mental Disorders and Co-Occurring Disorders
Training: Module 2: Understanding Alcohol and Drug Issues, Treatment and Recovery**

This Module is going to educate you about parental alcohol and drug issues, treatment, and recovery. We'll talk about the continuum of use, abuse, and dependency; signs and symptoms that can indicate the need for a comprehensive assessment of parents; screening tools that you can use at home visits and in your social work practice; the treatment and recovery processes; and how substance use disorders can affect families involved with the child welfare system in terms of safety assessment and safety planning.

We all know that many of the families whose children come into state custody are experiencing the effects of substance use disorders, and that these disorders are treatable. The information you will hear today can help you help these families succeed in treatment.

[Slide II-2] Why Do People Use Alcohol and Other Drugs?

People start using alcohol and other drugs for a lot of reasons. Some are behavioral; others are social or environmental. Still others have to do with risk factors and individual biology.

And what reasons do people give when asked about why they started? Most have to do with a desire to change their mood. They might be trying to experience euphoria, cope with anxious situations, or alleviate emotional or physical pain. Others start using substances with their friends to have fun. There are a variety of ways that alcohol or other drugs can change a person's mood—they can stimulate, depress, or otherwise change natural brain chemicals (Landry, 1995).

I'd like you now to look at the Handout *Factors Influencing Potential for Substance Use*.

[Refer to Handout: Factors Influencing Potential for Substance Use]

[Note to Trainer: These factors influencing potential for substance use could be generated through a facilitated discussion, presenting the handout after participants have brainstormed the various factors.]

The likelihood that a person will develop a substance use disorder can be influenced by *risk factors*, which increase the chance of developing a substance use disorder, and *protective factors*, which protect against the development of a disorder.

It is important that you understand risk factors and protective factors because people who enter substance abuse treatment first use drugs or alcohol in middle to late adolescence (SAMHSA, 2004)—the age of many of the children you serve. Based on SAMHSA's Treatment Episode Data Set (TEDS), the average age of first illicit drug use of those admitted to substance abuse treatment is approximately 18 1/2 years (SAMHSA, 2003). In 2002, 683,000 people, age 21 or older, were admitted to treatment for a primary alcohol addiction. Of these, 88 percent reported that they first used alcohol when they were younger than 21 years old.

[Note to Trainer: Age of first use in SAMHSA's Treatment Episode Data Set (TEDS) is defined differently for alcohol than for other drugs. For alcohol, age of first use is defined as the age of first intoxication. For other drugs, age of first use is defined as the age at which the respective drug was first used.]

If you look at the handout, you will see many behavioral, social, and environmental factors that affect whether and how a person develops a substance use disorder. The handout focuses on risk and protective factors at the child, peer, parenting, and family levels. There are also biological risk and protective factors for substance use disorders. For example, people have differences in brain, sensory, and cognitive functioning (Pandina, 1996). For instance, if a person has a heightened physiological reaction to a substance of abuse (i.e. the combination of brain, sensory and cognitive reactions), they may be more vulnerable to substance use problems, while another person's diminished physiological reaction may make them less vulnerable.

Every person has unique combinations of risk and protective factors, which form a complex interplay that will affect the probability that that person will use or abuse substances.

Children are exposed to both risk and protective factors that can either increase or decrease the likelihood of their developing substance use problems themselves. For instance, child, parenting, and family factors can increase the likelihood of a substance use problem later in life or protect against their occurrence.

[Slide II-3] Spectrum of Addiction: Experiment and Use; Abuse; Dependence

There are different theories about how substance use disorders develop. Scientists are investigating how biological, psychological, social, cultural, and environmental factors can affect the pathway from substance use to a substance use disorder, either abuse or addiction. One thing seems clear--that men and women progress from substance use to abuse and addiction in different ways (CSAT, 2001; NIDA, 2000; CSAT, 1999; Blanchard, 1998).

But in both cases, alcohol and other drug use exist on a continuum that starts with *substance use*, and moves to *abuse*, and then *dependence*. The differences between the categories are based on how many and what type of negative consequences are associated with the substance use. The process starts with experimental use. At this point, the person experiences the positive effects of the substance—effects like euphoria. As the person continues to use, he or she may begin to experience some of the negative physical or psychological consequences. These could include things like a driving intoxicated charge or waking up on New Years day recognizing that they don't remember what happened while they were drinking the night before.

Despite these negative consequences, some people will continue to use, trying to capture that initial euphoria. These people run a risk of becoming dependent. Using more of the substance to get the same effect and in some cases using the substance more often, they will experience many more of the negative physical, psychological and social effects with fewer and less intense positive effects. So, why do people continue to use substances even when the negative effects outweigh any positive effects? Two reasons: physical dependence on the substance and the changes in their brain chemistry (which we will discuss soon).

[Slide II-4] Physical and Psychological Effects of Substance Use

For more information on methods of use and effects of substances, refer to Handout *Physical and Psychological Effects of Substance Use*.

[Note to trainer: Depending on the level of experience your audience has with substance use disorders, you can spend as little or as much time needed to cover the physical and psychological effects of substance use and the related short-term and long-term consequences. The intent is to give a general overview. This is not intended to be a comprehensive review of the effects and consequences of each substance. If you are in a community that is experiencing an increase in methamphetamine use in particular, please refer to Module 1, Presentation 2 for information on issues specific to methamphetamine and manufacturing of drugs in the home. You can also refer to Module 6, Presentation 18 for information on the impact of methamphetamine on children.]

Alcohol abuse is a pattern of problem drinking that results in health consequences, social problems, or both. *Alcohol dependence*, or *alcoholism*, is a disease that is characterized by abnormal alcohol-seeking behavior that impairs the ability to control one's drinking.

Methamphetamine is a stimulant drug that is chemically related to amphetamine but with stronger effects on the central nervous system. Street names for methamphetamine include "speed," "meth," and "crank." Methamphetamine is taken as a pill or as a powder that is snorted or injected. Crystallized methamphetamine is called "ice," "crystal," or "glass." It is a smokable and more powerful form of methamphetamine (National Institute on Drug Abuse [NIDA], 2004).

Cocaine is a white powder that comes from the leaves of the South American coca plant. Cocaine is either "snorted" through the nasal passages or injected into the veins. Cocaine belongs to a class of drugs known as stimulants, which can give a temporary illusion of limitless power and energy that leave the user feeling depressed, edgy, and craving more (NIDA, 2004).

Crack is a smokable form of cocaine that has been chemically altered. Cocaine and crack are highly addictive. This addiction can erode physical and mental health and can become so strong that these drugs dominate all aspects of an addict's life (NIDA, 2004).

Hallucinogenic drugs are drugs that distort the perception of objective reality. The most well-known hallucinogens include phencyclidine, otherwise known as PCP, angel dust, or loveboat; lysergic acid diethylamide, commonly known as LSD or acid; mescaline and peyote; and psilocybin, or "magic" mushrooms. When a person is under the influence of hallucinogens, their sense of direction, distance, and time become disoriented. Because of this, people who use these drugs can behave in unpredictable, erratic, and violent ways that can sometimes lead to serious injuries and death. The effect of hallucinogens can last for 12 hours (NIDA, 2004).

LSD, a common type of hallucinogen, produces tolerance, so that users who take the drug repeatedly must take higher and higher doses to reach the same state of intoxication. Because of the unpredictability of LSD, this is extremely dangerous and can increase the risk of convulsions, coma, heart and lung failure, and even death (NIDA, 2004).

Marijuana is the most widely used illicit drug in the United States and tends to be the first illegal drug teens use. It can be either smoked or swallowed (NIDA, 2004).

[Refer to Handout: Alcohol and Drug Use Continuum and Implications for Child Welfare]

Please take a look at the Handout *Alcohol and Drug Use Continuum and Implications for Child Welfare*. This handout describes differences between primary categories of substance use problems (use, abuse and addiction/dependence), the implications for child welfare, and examples of risks to children.

[Note to trainer: If time allows, this handout can be modified to use as an exercise rather than as a presentation. The handout can be modified by leaving the right column blank and asking participants to work in small groups and fill it in. Bring the group back together and ask groups to present, fleshing out with the material presented in the original handout.]

Any level of substance use by a parent can put their children at risk. For example, even where substance use may not appear abusive or at the point of dependence, a parent who drives with children in the car while under the influence will put those children at risk of harm. A person who abuses substances is also at risk of leaving their children in unsafe or unsupervised care. And parents who have an addiction or dependency run the risk of making poor decisions about their children's needs or care.

Generally, the risk is greater when the substances are illegal or when the person uses or is dependent on prescription medications outside of a physician's supervision (prescribed medications, taken under a physician's supervision, are generally not problematic).

As you can see, child welfare workers should always determine whether substance use is a factor in a case of reported abuse or neglect. If it is, assessments must be conducted to determine the nature and severity of the substance use, as identified on the continuum, with appropriate referrals for assessment and/or treatment.

When you do observe risks, child welfare professionals can use substance abuse interventions to reduce those risks and to maintain the parent-child relationship. Even if legal bonds are permanently severed by the court, emotional bonds remain. Substance abuse intervention is an essential element in protecting the long-term well-being of the child.

[Slide II-5] Alcoholism and Alcohol Abuse—1

In many States, the number of people treated for alcohol problems equals the number treated for *all other drugs combined*. When child welfare workers are assessing the risk to and safety of children, they need to consider the amount of alcohol consumed and symptoms of dependence—even when alcohol use does not meet criteria for abuse or dependence.

Key questions to ask include: "How is the drinking affecting the parent's ability to make sound judgments regarding the welfare of the child?" and "What behaviors are resulting or have resulted from the parent's alcohol use that may put the child at risk?"

[Slide II-6] Alcoholism and Alcohol Abuse—2; How much is too much?

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) suggests that health care professionals should be concerned about alcohol addiction if a woman drinks more than 7 drinks per week or 3 drinks at a time or if a man drinks more than 14 drinks per week or 4 per occasion (NIAAA, 2004).

NIAAA identifies four symptoms of alcohol dependence or alcoholism:

- **Craving**—which is a strong need or compulsion to drink;
- **Loss of control**—which is the inability to limit one's drinking;
- **Physical dependence**—which includes withdrawal symptoms, such as nausea, sweating, shakiness, and tremors when the person is not using alcohol; and

- **Tolerance**—which is the need to drink more to get “high.”

Another hallmark of alcoholism is the experience of blackouts, which begin in the early stage of alcoholism. Blackouts are not the same as passing out. A blackout is a type of amnesia or memory loss where the person cannot remember what they did or said. Some people cannot remember how they got home or where they parked their car. If a parent says he or she does not remember an episode of abuse or neglect of the child, it may be that the abuse occurred during a blackout (Substance Abuse and Mental Health Services Administration [SAMHSA], 2004).

If you want to learn more, you should take a look at the National Institute on Alcohol Abuse and Alcoholism (NIAAA) document *Alcoholism: Getting the Facts* and the NIAAA Alcohol Alert on diagnostic criteria. The links to these documents are on your resource sheet.

[Slide II-7] Criteria for Substance Abuse

How do professionals determine if a person has a substance use disorder? Generally, they use substance-related assessment tools based on diagnostic criteria in the American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* (APA, 2000). These APA DSM-IV criteria address both substance abuse and substance dependence (also known as addiction).

According to the DSM-IV criteria, substance abuse is a “maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, and occurring within a 12-month period”:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home. This can include repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; or neglect of children or household.
- Recurrent substance use in situations in which it is physically hazardous (like driving an automobile or operating a machine when impaired by a substance).
- Recurrent substance-related legal problems (like arrests for substance-related disorderly conduct).
- Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (such as arguments with a spouse about the consequences of intoxication, physical fights).

You should know that substance abuse can lead to substance dependence, but these are two different diagnoses. For substance abuse to be diagnosed, a person's symptoms must *not* meet the criteria for substance dependence.

[Slide II-8] Criteria for Substance Dependence

So what are the criteria for substance dependence? The APA defines substance dependence as “a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, and occurring at any time in the same 12-month period”:

- Tolerance, as defined by either of the following:
 - A need for markedly increased amounts of the substance to achieve intoxication or desired effect;

- Markedly diminished effect with continued use of the same amount of the substance;
- Withdrawal, as manifested by either of the following:
 - The characteristic withdrawal syndrome for the substance;
 - The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;
- The substance is often taken in larger amounts or over a longer period than was intended;
- There is a persistent desire or unsuccessful efforts to cut down or control substance use;
- A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., frequenting bars), or recover from its effects;
- Important social, occupational, or recreational activities are given up or reduced because of substance use;
- The substance use is continued despite the knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition of cirrhosis of the liver).

When a person is addicted, they engage in compulsive behavior, even when faced with negative consequences. The person's loss of control in limiting the use of the addictive substance is a major hallmark of addiction.

To learn more about addiction and dependence, review the National Institute on Drug Abuse (NIDA) Criteria for Substance Dependence Diagnosis. The link is provided on your resources list.

Brain Chemistry of Addiction

Alcohol and other psychoactive drugs cause significant changes in brain chemistry and functioning. Because of this, scientists consider substance use disorders to be brain-based diseases.

[Note to Trainer: Slides 9-10 present information based on animal models. The results are presented as indications of the ways humans would be similarly impacted.]

[Slide II-9] Natural Rewards Elevate Dopamine Levels

When a person continues to use a substance, the part of the brain responsible for experiencing pleasure—the reward pathway—is affected, which means that the drug-using behavior is rewarded and reinforced. Food and sex also affect the reward pathway. As a result of these rewards, the chemical dopamine is released in the brain. As you can see on this slide, food and sex both substantially increase the level of dopamine in the brain (Di Chiara, Bassareo, Fenu, De Luca, Spina, et al, 2004; Fiorino, D. and Phillips, 1999).

[Slide II-10] Effects of Drugs on Dopamine Levels

Addictive substances also cause parts of the brain to flood with dopamine, creating a brief rush of euphoria. This is what people often refer to as the "high" (Di Chiara, G. and Imperto, 1988). On this slide you can see the varying degrees to which morphine, nicotine, cocaine and amphetamines increase dopamine levels.

Chemical imbalances in the brain that are induced by the use of substances disrupt the normal communication between neurons. This can strongly affect the way that people feel, think, behave, and perceive. This helps to explain why substances of abuse can make people feel depressed, think poorly, behave in ways not normal to them, or misperceive what others say or do.

Substance-induced changes to the brain are complex, serious, and may be permanent. It is important that a parent receives a medical evaluation, and that assessment of future risk and permanency planning for the child addresses parental capacity in a realistic way.

To learn more, review the National Institute on Alcohol Abuse and Alcoholism (NIA AA) publications website. The link is provided on your resources list.

[Slide II-11] Long-Term Effects on the Brain

The brain can be physically injured and changed by drug use, and this injury can last for a long time. The brain scans in this slide illustrate that once an individual is addicted to a drug such as cocaine, the brain can be altered. In these brain scan pictures, the highest levels of brain function activity are indicated in yellow and red (Volkow, Hitzemann, Wang, Fowler, Wolf and Dewey, 1992; Volkow, Fowler, Wang, Hitzemann, Logan, Schlyer, Dewey, and Wolf, 1993).

The top row shows a normal-functioning brain without drugs. In this brain, there are a lot of bright yellow and red areas. This indicates a lot of brain activity. In other words, the neurotransmitters are very active. The middle row shows the brain of a cocaine addict after 10 days of not using any cocaine. As you can see, there is much less brain activity than the brain scan from the drug-free individual, even though the cocaine addict has not used cocaine for 10 days (Volkow, Hitzemann, Wang, Fowler, Wolf and Dewey, 1992; Volkow, Fowler, Wang, Hitzemann, Logan, Schlyer, Dewey, and Wolf, 1993).

The third row shows the brain of the same cocaine addict after 100 days without any cocaine. As you can see, there is some improvement. However, the individual's brain is still not back to a normal level of functioning--more than 3 months after using any cocaine. Think about this in terms of the parents and families you work with. Within the first 3 months of abstinence (not using drugs), their brain functioning is still diminished. How might you change the way you approach working with a parent who is newly abstinent? Think about these things as you consider the vignette that we are going to talk about next (Volkow, Hitzemann, Wang, Fowler, Wolf and Dewey, 1992; Volkow, Fowler, Wang, Hitzemann, Logan, Schlyer, Dewey, and Wolf, 1993).

To learn more, review *The Brain: Understanding Neurobiology Through the Study of Addiction*. The link is provided on your resources list.

30 – 50 minutes *Facilitated Discussion of Case Vignette* 20 min.

Ask participants to organize themselves into smaller discussion groups with 5-7 people in each group. Ask them to carry their materials with them if they move, as they will stay in these groups for two exercises and a presentation. Then ask them to each quietly read Module 2 Vignette Part I, which describes a real family involved with the child welfare

system. Then ask the small groups to discuss the Vignette for a few minutes, specifically talking about 1) levels of seriousness of use of substances and child abuse/neglect indicated in the vignette; 2) apparent amenability to treatment; and 3) appropriate reactions by the child protection system.

After 9-10 minutes, ask them to bring their attention back to the larger group (no need to move seats again) and to share a bit from their small discussion groups. In particular, ask them, “Why did you suggest certain reactions by the system?”

The GOAL of this discussion is to help participants apply the content of the session to a real family situation. Try not to let one participant dominate the discussion; draw in others whenever possible.

To bring final closure to this discussion, emphasize that a child welfare professional may need to make a judgment about the possible presence of a substance use disorder in a parent, leading to a referral for further assessment and possibly treatment. Child welfare professionals would also need to make a decision about immediate removal of the child.

PRESENTATION 5

50 – 65 minutes *Presentation 5: Effects of substance abuse on relationships and families; screening tools;* 15 min.

Deliver scripted presentation on special areas of consideration. Slides II-12 through II-21. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on. Keep answers brief. You should only answer questions to which you know the answer

[Slide II-12] Prevalence of Substance Use Disorders by Race/Ethnicity

To examine the impact of substance use disorders on communities of color, let's look at the rates of treatment need by race and ethnicity. These rates come from the National Survey on Drug Use and Health. Rates of current illicit drug use varied significantly among the major racial and ethnic groups in 2004 (SAMHSA, 2005). The rates presented here are for people who met criteria for substance abuse or dependence. The rate was highest among American Indians or Alaska Natives (20.4 percent) and persons reporting two or more races (13.1 percent). Rates were 9.9 percent for Whites, 10.4 percent for Hispanics, and 9.1 percent for Black/African American. Asians had the lowest rate at 5.3 percent. Native Hawaiians or Other Pacific Islanders were 12.6 percent in 2003, but no estimated were reported in the 2004 data.

To learn more about rates of substance use, review the results from the 2004 National Survey on Drug Use and Health: National Findings. The link is provided on your resource list.

[Slide II-13] 2004 Treatment Admissions by Race/Ethnicity

On this slide you can see the proportion of those by race and ethnicity who received treatment

in 2004. The majority of treatment admissions, 63.2%, were non-Hispanic White (OAS, 2006). Non-Hispanic Black individuals constituted 22.9% of treatment admissions, 13.2% were Hispanic or Latino, 2.3% were American Indian or Alaska Native, 1.0% were Asian/Pacific Islander and 10.6% were reported as “other” or “unknown.”

To assess the differential impact of substance use on communities of color, we need to consider the difference between those who need treatment and those who receive treatment. While the information presented here on past month substance use and current rates of binge and heavy drinking do not get at the need for treatment, you can see the variation across racial and ethnic groups. Compare that variation to the last graph on who receives treatment. Without access to appropriate treatment, communities of color will continue to bear the burden of the negative consequences of substance use disorders.

- To learn more about treatment admissions, review the SAMHSA *Treatment Episode Data Set (TEDS) Highlights 2003*. The link is provided on your resource list.

[Slide II-14] Effects of substance use on parents and families

[Note to trainer: If time allows, information on this slide can be generated through discussion rather than a presentation. For example, the trainer may ask the following questions:

- ***What are some of the negative physical consequences of substance use disorders?***
- ***What are some of the negative cognitive consequences of substance use disorders?]***

The negative consequences of substance use disorders can have an enormous impact on individuals, their families, and their friends—in many aspects of their lives. Here are a few that we need to pay special attention to:

- *Physical:* Substance abuse can cause general feelings of malaise and it is also associated with increases in illness and death.
- *Cognitive:* Substance abuse can impair thinking and judgment, which can lead to a wide variety of additional problems.
- *Psychological:* Suspicion of others, depression, or anxiety, along with many other psychological effects, may result from substance abuse.
- *Emotional:* Substance abuse takes an emotional toll as well and can lead to personal instability and a loss of emotional bonds and supports.
- *Social:* Surrounding one’s self with others who are abusing leads to social isolation and an unhealthy social sphere.
- *Spiritual:* The relationship with inner self and a "higher power" is confused and often lost when a person becomes addicted to substances.
- *Parenting:* Substance abuse can compromise the relationship with children in many ways and to differing degrees.
- *Family Abuse:* Relationships with a partner, spouse, and other significant persons are often strained by substance abuse.
- *Financial:* Spending to support the substance use disorder can lead to financial stress or ruin.
- *Legal:* Criminal activity related to substance abuse can lead to incarceration or other legal consequences—including removal of a child or termination of parental rights.

[Slide II-15] Relational World View

Several Native American tribes teach that health and well-being depend on a balance between mind, body, spirit, and context. This model, known as the relational worldview (Cross, 1997), suggests that life is a complex interplay between all of these factors. Substance abuse affects each of these factors in a unique way, often causing life to spin out of balance. Families often experience escalating problems, along with the progression of the disease. However one understands it, substance use disorders have pervasive effects on the user and on people related to the user.

- To learn more, review *Understanding the Relational Worldview in Indian Families*. The link is provided in your resources list.

[Slide II-16] Effects of Substance Use on Parents and Families

Children need parents and caregivers to perform basic functions to support their physical, social, emotional, intellectual, and spiritual development. When a parent has a substance use disorder, it can reduce their ability to perform many parenting functions and fully meet their children's needs. Frequently, life becomes topsy-turvy and chaotic for the children (Young, 1997).

Parenting is particularly difficult when children have been prenatally exposed to substances and exhibit neurological and behavioral effects of this exposure. As infants, these children may be fretful and cry continuously. Toddlers and young children who have been exposed may have emotional and developmental delays or disabilities, such as a failure to attach or hyperactivity. Older children and adolescents may have behavioral management problems. Without behavioral and/or medical treatment, these problems can make parenting even more difficult.

The long-term effects of prenatal exposure to alcohol and other drugs may include lower IQ; reasoning problems, such as difficulties in higher executive functioning, fine motor, or visual-perceptual-motor deficits; and communication/language problems (Young, 1997).

I'd like you to look at the handout called *The Effects of Substances of Abuse on Behavior and Parenting*. This handout provides information on the general effects of specific substances and illustrates ways that use of specific substances may affect parenting.

[Note to trainer: If time allows, information on this handout can be generated through discussion rather than a presentation. For example, the trainer may ask the following questions:

- ***What are some ways that substances might affect a person's behavior?***
- ***What are some ways that substance might affect a person's parenting?]***

As you can see, there are many ways that drugs and alcohol – legal or illegal, stimulants or depressants – can impact parenting (Dore, 1998; Gold, 1992; National Institute on Drug Abuse [NIDA], 2001; NIDA, 2003). Keep in mind that this list is not exhaustive, and that substances can have a wide range of effects on parenting.

[Slide II-17] In-Home Indicators of Potential Substance Abuse-1

We will begin this next section by discussing indications of possible use, abuse, and dependence that you need to be looking for when you conduct a home or on-site visit or investigation (Young & Gardner, 2002):

- A report of substance use in the child protective services call or report;
- Observations or reports of paraphernalia in the home. This can include things such as a syringe kit, pipes, a charred spoon, foils, a large number of liquor or beer bottles, etc.
- The parent (or the home) smells of alcohol, marijuana, or other drugs.
- A child reports use by parent(s) or other adults in the home.

[Slide II-18] In-Home Indicators of Potential Substance Abuse-2

These are some additional signs of possible substance abuse:

- A parent exhibits physical behavior that suggests that they are under the influence of alcohol or drugs. This might include slurred speech, an inability to mentally focus, poor physical balance, or extreme lethargy or hyperactivity, and so on.
- A parent shows signs of addiction, such as 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, including withdrawal (nausea, euphoria, slowed thinking, hallucinations, or other symptoms).

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

[Slide II-19] Screening: The Role of Child Welfare Professionals

What is the role of child welfare professionals in screening for substance use disorders?

When a report of child abuse or neglect has to be investigated, emergency response workers or investigators are generally the first ones to see the parents. These child welfare professionals may have the first opportunity and the primary responsibility to conduct the initial screening of parents for potential substance use disorders. They may observe overt signs and symptoms as part of the initial screening and assessment for child abuse and neglect. Screening can also be performed by other agencies that may be working with parents such as mental health agencies, maternal and child health agencies, or the criminal justice system. Treatment programs do not usually perform screening.

If you or another professional identifies possible substance abuse in a screening, the next step is to refer the parent to a substance abuse treatment provider for further assessment. And then, if necessary, the substance abuse treatment provider may provide further referral to the most appropriate treatment program.

[Note to Trainer: Check your Child Welfare Agency handbook or manual regarding the specific protocols and procedures used in your agency.]

[Slide II-20] The Purpose of Screening

Who needs to be screened? Substance abuse screenings tend to be viewed in two main ways. In one approach, child welfare professionals try to determine which parents might have a problem with substance abuse and conduct the screening for those parents they have identified to determine if their hunch is true. Alternatively, child welfare professionals can assume that everyone involved with child maltreatment may be at high risk for substance-related problems

and therefore screen everyone, and then rule out individuals who do not appear to be at risk for substance-related problems.

Evidence demonstrates that the second approach should be followed. It is recommended that child welfare professionals screen everyone, identify those who may be at risk, and rule out those who appear not to be at risk. Although caseworkers should follow agency protocol as much as possible, all individuals should be screened for substance-related problems.

Screening is a combination of observation, interviews, and the use of a standardized set of questions, such as those that are included in many effective screening tools. The purpose of a substance-related screening is to determine the need for assessment—that is, determine the risk or probability that a parent has a substance use disorder, and whether more in-depth assessment by treatment professionals is needed. Many effective screening tools are available for use by child welfare professionals, and your agency may already have one they use.

[Slide II-21] Effective Screening Tools

In general, an effective screening tool has the following characteristics (Brown, Leonard, Saunders and Papasouliotis, 1997; DeHart and Hoffmann, 1995, 1997; Ewing, 1984):

- It is easy to administer – for example, it can be memorized and administered orally without reference to a written form; it can be administered separately or worked into other screening checklists or tools, as appropriate; and it contains no more than four to six questions.
- It is capable of detecting a problem – because it contains the types of key questions that are best known to indicate the presence of a substance use disorder, such as:
 - Questions that address unintended use or a desire to restrict one's own use. For example: "Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?" "Can you stop drinking without a struggle after one or two drinks?"
 - Questions about some form of consequences of use or concerns about such consequences. For example: "Have people annoyed you by criticizing your drinking or drug use?" "Have you ever felt bad or guilty about your drinking?" or "Have you ever lost a job because of drinking or drug use?"
- It is inexpensive and does not require much time to administer—or much paperwork to record.
- It is fast and simple—and can be completed quickly without need of explanations and directions.
- It is designed for use with a broad range of individuals—including those with all types of substance use disorders and diverse populations. Many screening tools focus only on alcohol and may not be appropriate for screening for other substance use disorders.

Please turn to the Handout *Example of Screening Questions: The UNCOPE*. The UNCOPE is an example of a screening instrument (Hoffmann, Hunt, Rhodes and Riley, 2003).

- U** – Have you continued to use alcohol or drugs longer 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 cut down or stop using alcohol or drugs but couldn't?
- 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 wanted to use alcohol or drugs?

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 (Hoffman, 2006).

Child welfare professionals can use this screening tool as well. In recent studies, the UNCOPE performed comparably on gender and ethnic subgroups as well as subgroups identified by education level (Hoffmann et al, 2003; Campbell, Hoffmann, Hoffmann, and Gillaspay, 2005). How and when you use this type of screening instrument depends on your agency's policies and procedures. It may not be appropriate to screen during an emergency response call, but it could be appropriate to use during the investigation process.

65 – 85 minutes *Facilitated Group Discussion* 15 min.

Once questions have been addressed, move the whole group into a discussion about cultural aspects of substance abuse and treatment by asking, “How do cultural issues, meaning the family’s beliefs, traditions and values, impact the child welfare system’s responses to substance use disorders among the families you are serving?”

If additional questions are needed to stimulate discussion, you might ask any of the following questions:

- ***What kinds of cultural groups exist in the community(ies) you serve?***
- ***For those varying groups, what do you know about their cultural beliefs about substance use, abuse and dependence?***
- ***What culturally based groups or organizations exist in the community(ies) you serve that may offer assistance for families?***
- ***How can you access and make use of such organizations?***

The GOAL of this discussion is to help participants think deliberately about the cultures of the families they serve and the potential resources that may be offered to their recovery process by those beliefs, traditions and values. For many parents, their personal or family culture may play a key role in their recovery and it is important for child welfare professionals to think about how to support that role.

To bring closure to this discussion you may want to ask them to think about how their own personal cultural beliefs, traditions and values may impact their work with families of different cultures. Encourage them, in particular, to learn as much as they can about culturally based groups and organizations within their community that may offer support to the families they serve.

If time allows, review the Additional Resource: The National Clearinghouse for Alcohol and Drug Information Technical Assistance Bulletin: Following Specific Guidelines Will Help You Assess Cultural Competence in Program Design, Application, and Management. Discuss which agencies in the community offer services that meet these criteria.

PRESENTATION 6

100 – 125 minutes *Presentation 6: Treatment models; treatment effectiveness; helping parents obtain treatment*

25 min.

Deliver scripted presentation on substance use, abuse and dependence, screening and treatment. Slides II-22 through II-41. At the conclusion of the presentation, the trainer should ask first if there are any brief questions that can be answered before moving on. Keep answers brief. You should only answer questions to which you know the answer.

[Slide II-22] Addiction Treatment

Variation is the name of the game in addiction treatment. There are many substances that people use and abuse, and treatments for specific substances can differ. In addition, treatment varies depending on the age, race, and other characteristics of the person as well as the severity of the disorder.

People with substance use disorders come from all walks of life—and the problems they face can vary significantly. Many experience mental health, health, or social problems that make their substance use disorders much more difficult to treat.

There are also a variety of scientifically based approaches to treatment. Treatment can include behavioral therapy (such as counseling, cognitive therapy, or psychotherapy), medications, or a combination of the two. Behavioral therapies give people strategies for coping with their cravings, teach them how they can avoid substances and prevent relapse, and help them deal with relapse if it occurs. When a person's substance-related behavior puts them at risk for AIDS or other infectious diseases, behavioral therapies can also help them reduce the risk of disease transmission. Case management and referral to other medical, psychological, and social services are crucial components of treatment for many people. Treatment can also include referral and linkages to mutual support groups like Alcoholics Anonymous and Narcotics Anonymous.

It has been shown that the best programs provide a combination of therapies and other services that meet the unique needs of each patient, needs that are related to characteristics like age, race, culture, sexual orientation, gender, pregnancy, parenting, housing, and employment, as well as any history of physical and sexual abuse or other trauma (NIDA, 1999).

[Slide II-23] Gender-Specific Components

Whenever child welfare workers are looking for treatment for a mother with a substance abuse problem, they should consider programs that can address the specific issues that these women often face.

For example, women in treatment for substance use disorders may have co-occurring mental disorders that require professional treatment. Many women with substance use problems have

experienced childhood abuse--as physical, sexual, and/or emotional trauma (Covington & Kohen, 1984; Miller, et al., 1993; Rohsenow, et al., 1988; Hein & Scheier, 1996; Langeland & Hartger, 1998; CSAT 1997a). These experiences can lead to post-traumatic stress disorder (PTSD) or other mental health problems that require professional intervention (Brady, et al., 1994; Hien & Levin, 1994; Bernstein, 2000).

In addition, women with substance use disorders are more likely to become victims of domestic violence, and female victims of domestic violence are more likely to have substance use disorders (Miller, et al., 1989; Start & Flitcraft, 1988).

Women in treatment also may need to address parenting issues, which might have been compromised because of their substance use.

Relationships are integral to recovery. For women in treatment, relationships with counselors and therapists, peer relationships with other women, and a relationship with a higher power (a component of Alcoholics Anonymous and Narcotics Anonymous) can play a large role in recovery.

[Note to Trainer: Refer to Module 1, Presentation 2 for information on unique considerations of women, women's experiences of co-occurring disorders, trauma, and domestic violence, and key research-based approaches to treatment for women]

It may be helpful to think in terms of a comprehensive treatment model with the following three levels of services for women with substance abuse:

- Clinical treatment services: This includes a whole range of services, including outreach and engagement, screening, detoxification, crisis intervention, assessment, treatment planning, case management, substance abuse counseling and education, trauma specific services, medical care, mental health services, drug monitoring, and continuing care.
- Clinical support services: Clinical support services include things like primary health care services, life skills, parenting and child development education, family programs, educational remediation and support, employment readiness services, linkages with legal system and child welfare system, housing support, advocacy, and recovery community support services.
- Community support services: The following, when available in the community, support long-term recovery: Recovery management, recovery community support services, housing services, family strengthening, child care, transportation, Temporary Assistance for Needy Families (TANF) linkages, employer support services, vocational and academic education services, and faith-based organization support.

[Slide II-24] Culturally Relevant Treatment

In addition to being gender-specific, substance abuse treatment should also be culturally relevant. This means that roles, values, and beliefs should be respected, and the treatment milieu should be compatible with those, whenever possible. For example, some cultures have healing practices and traditions that are important to families. These traditional healing practices may be important tools in treatment and recovery.

Effective treatment programs also routinely identify and remove potential barriers to treatment and provide treatment in the language most comfortable to the client.

Because it is important that treatment be geographically accessible, the child welfare and alcohol and drug services programs may need to collaborate on transportation, visitation with children, and other issues related to distance.

And finally, for parents involved with the child welfare system, treatment must be family focused. Issues of intergenerational substance abuse, family relationships and dynamics, and parenting are just a few of the concerns that need to be addressed.

- To learn more, review NIDA's Principles of Drug Addiction Treatment and CSAT's Quick Guide to Finding Effective Alcohol and Drug Addiction Treatment. The links are provided on your resource list.

[Slide II-25] When Treatment Is Unavailable

Sometimes you might not be able to place a parent into treatment right away. When this happens, there are still things you can do to help:

- Provide parents with lists of local 12-Step meetings and encourage them to go.
- Remain familiar with the various levels of care and treatment options in the local community.
- While parents are waiting for optimal treatment, help them develop safety plans to not drink or use drugs, develop a plan to regularly speak and meet, and suggest lower levels of care.

[Slide II-26] The Treatment Process

Substance abuse treatment is an individualized and dynamic process and is designed to meet the specific and unique treatment needs of each individual. As a person's treatment needs change, different treatment services are provided to meet those needs. But, because the availability of treatment services depends on local resources, you should become familiar with treatment services available in your community.

Some common processes happen as an individual begins treatment. These include (Center for Substance Abuse Treatment [CSAT], 1997):

- *Screening*—identifies those who have or are at risk for developing substance-related problems and individuals who may require a more formal assessment. Screenings consist of brief, rapidly administered tools that can be administered by social workers, counselors, or treatment professionals.
- *Brief Substance Abuse Assessment*—this assessment is conducted by a substance abuse treatment professional—and forms the basis for a diagnosis of substance use disorder.
- *Diagnosis*—of the substance use disorder, is made by a substance abuse treatment professional, using the DSM-IV criteria for "substance abuse" and "substance dependence."
- *Comprehensive Assessment*—These are also conducted by substance abuse treatment professionals. Comprehensive assessments are "biopsychosocial," which means that it looks at biological, psychological, and social aspects of a person's life. conducted many times throughout treatment. These assessments are used to determine current treatment needs and level of care, which need to be monitored on a regular basis to determine if the level of care needs to be changed and if so, how. These assessments are therefore repeated often.

- *Development of Treatment Plan*—These ongoing assessments of treatment needs are used to clarify treatment priorities at different points in time. Treatment planning looks at treatment needs, recommended level of care, proposed interventions, and plans for continuing care after the client has completed that particular phase of treatment. The treatment plan is a living document, reflecting the dynamic and changing nature of addiction, treatment, and recovery.
- To learn more, review *A Guide to Substance Abuse Services for Primary Care Clinicians*. The link is provided on your resource list.

[Slide II-27] Determining Treatment Placement

Two issues must be considered in determining which treatment program will meet a person's needs: treatment placement and treatment approaches. *Treatment placement* refers to the level of structure and support offered in the program. Placements can be thought of as lying on a continuum of intensity, from medically managed inpatient hospitalization (most intense) to outpatient sessions (least intense). *Treatment approaches* refers to the type of clinical intervention, such as behavior modification or medication-assisted therapy (CSAT, 1997).

[Slide II-28] Treatment Placement

People are placed in the appropriate level of addiction treatment by matching their treatment needs with services that are designed to meet those needs. Patient placement tools can help to make sure this matching process goes well. The tool that is most widely used to determine and appropriate treatment placement is the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC) (ASAM, 1996).

The ASAM PPC describes several levels of treatment services, which are listed on this slide:

- *Level 0.5: Early Intervention*
Settings for this level of treatment may include clinical offices or permanent facilities, schools, worksites, community centers, or an individual's home (ASAM PPC: Page 49).
- *Level I: Outpatient Services*
Organized nonresidential services provided by professional clinicians are included in this level of intervention (ASAM PPC: Page 55).
- *Level II: Intensive Outpatient/Partial Hospitalization Services*
A structured day or evening program that may be provided before or after work or school is covered at this level (ASAM PPC: Page 63).
- *Level III: Residential/Inpatient Services*
This level consists of residential settings designed to achieve stability and foster recovery skills (ASAM PPC: Page 77).
- *Level IV: Medically Managed Intensive Inpatient Services*
Level IV services include intensive, 24-hour care in a medically managed setting (ASAM PPC: Page 107).
- *Opioid Maintenance Therapy*
This category covers various pharmacologic and nonpharmacologic treatment modalities for treating opioid addiction. It is a separate service that can be provided at any level of care (ASAM PPC: Page 115).

[Slide II-29] Treatment Needs Change

It is important to know that treatment needs change over time. People often progress from a more intensive setting to a less intensive setting as their treatment needs are met. Conversely, people may move to a more intensive setting if they aren't successful in a less intensive program. Treatment needs also change according to financial resources and the limits of insurance coverage. Those who do not have insurance or money to pay for treatment may have other options to find affordable treatment services. However, limited financial resources may mean that time is lost while the person is waiting for treatment authorization.

[Note to trainer: The type and extent of options for finding affordable treatment services vary from State to State, county to county, and potentially on a local community level as well. Investigate what resources are available in your State, county or local community. Call a local treatment provider and ask how their clients typically receive funding for treatment.]

Substance-related treatment services can be described in relation to the setting and locations in which services are provided, the types of services provided, and other characteristics. Please refer to your Handout *Treatment Setting, Services and Locations*. The handout describes major categories of treatment settings, grouped from most to least intensive.

[Refer to Handout: *Treatment Setting, Services, and Locations*.]

As I just mentioned, treatment can be viewed on a continuum of intensity. The least intense setting is outpatient treatment, which can be anywhere from 1-8 hours per week of services, in a variety of locations. But even within outpatient treatment, there are varying levels of intensity, depending on how often the services are offered and the individual's treatment needs. Intensive outpatient treatment requires more time – anywhere from 9 to 70 hours per week – and can also be offered in a variety of locations. In both outpatient settings, the individual receives treatment while living at home (Landry, 1995).

The next level of treatment is residential treatment. In this setting, the individual lives in the treatment facility and receives 24-hour care. Therapeutic communities and transitional living settings are also residential in the sense that individuals live in the treatment facility, but these settings may have less structured treatment requirements. Inpatient hospitalization is the most intense level of care and provides 24-hour care with stringent safety measures and monitoring (Landry, 1995).

[Slide II-30] Addiction Treatment: American Indian Communities

There are a couple of things you need to understand when it comes to addiction treatment for people who belong to our American Indian Communities. First, a Federal trust relationship exists between federally recognized Tribes and the Federal Government that guides policies and resources available to Native Americans and Alaskan Natives, including many that are related to substance abuse and child welfare.

As part of this trust, the Government established the Indian Health Service (IHS). The goal of the IHS is "to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people." One way the IHS does this is by working to make sure that these folks have access to effective substance abuse treatment when they need it. In some locations, substance abuse treatment is available through the IHS delivery network and, in others, through an Indian nonprofit agency under contract with the IHS.

In addition, in 1978, Congress passed the Indian Child Welfare Act (ICWA) to “protect the interests of Indian children and to promote the stability and security of Indian tribes and Native families.” The Act gives jurisdiction to the Tribe in child custody matters involving Indian children residing on reservations. In fact, most Tribes operate their own child welfare services, which can range from having a family advocate position to a full-service child welfare agency. Native Americans who are enrolled members of federally recognized Tribes can receive these services in coordination with other community resources.

Therefore, it is important that child welfare workers ask questions about a child's ethnicity in order to determine whether the ICWA or services available through the IHS should be used if a case is opened after an investigation.

- To learn more, visit the following websites for information on treatment services for American Indian Communities. The links are provided on your resource list.
 - National Indian Health Board
 - Indian Health Service
 - One Sky Center
 - SAMHSA

[Slide II-31] Types of Treatment Approaches

[If time allows, information on this slide can be generated through discussion rather than a presentation. For example, the trainer may ask the following questions:

- ***What types of approaches may parents encounter in treatment?***
- ***What types of approaches have you seen that are available in this community?]***

What kinds of approaches can parents expect to encounter when they are in treatment? Each person's unique treatment needs, the resources of the treatment program and in the community, and insurance limitations will drive the number, the type, and the intensity of treatment services. A parent can also receive many different types of approaches, therapies and associated services throughout the treatment process. These may include any or a combination of the following—a combination is typically called an "integrated" approach (CSAT, 1997; Landry, 1995):

- *Pharmacotherapies* – The components of pharmacotherapy include medications to manage withdrawal, medications to discourage substance use, drug replacement and maintenance therapy; and medications to manage other mental disorders (such as anxiety or depression).
- *Psychosocial or Psychological Interventions* – the components of these interventions can include individual therapy, group therapy, or family therapy.
- *Behavioral Therapies* – Behavioral therapy includes treatments such as behavioral contracting or contingency management, relapse prevention, behavioral relationship therapy, and stress management.
- *Mutual Support Groups* – Mutual support groups include programs like 12-Step and other group sessions that can provide peer support.
- To learn more, review information about the use and effectiveness of different treatment approaches from NIDA's *Principles of Drug Addiction Treatment*. The link is provided on your resource list.

[Slide II-32] Medications for Opiate Addiction-Methadone Maintenance

Parents who use heroin can present some challenges for child welfare workers, particularly in relation to risks associated with IV drug use and HIV infection. Therefore, it is important that you understand how medication is used to treat heroin and other opiate addictions.

Of all of the substance abuse treatments, treatment for opiate addiction is one of the most researched—with a multitude of studies over 35 years demonstrating that opiate replacement therapy is effective. One of the most common effective treatments for heroin dependency is methadone maintenance. In addition to controlling heroin use, methadone maintenance has been shown to reduce HIV risk behavior, crime, and violence—and improve child rearing and employment.

Because methadone is also an opiate, many people will say that methadone maintenance is just another addiction. It is true that both heroin and methadone create physical dependence and tolerance (which means that there are physical withdrawal symptoms when a person stops using them or uses less of them), However, methadone does not cause the behavioral syndrome of addiction that is characterized by the repeated, compulsive seeking or use despite negative consequences. And methadone does not make the person feel “high.”

In addition, methadone is highly regulated by Federal and State laws—and can only be dispensed by federally approved Opioid Treatment Programs (e.g., methadone clinics).

[Slide II-33] Other Medications for Opiate Addiction: LAAM and Buprenorphine

More recently, two other medications have been approved to treat opiate addiction: LAAM and Buprenorphine.

In 2000, Federal laws were changed so that these medications can be prescribed and dispensed by qualified physicians who have been specially trained to work with this population. These physicians may work in Opioid Treatment Programs or may see patients in their private practices.

Risks to children of medication-assisted parents should be assessed in the context of the other safety and risk factors associated with child abuse and neglect.

[Slide II-34] Goals of Treatment

What happens as people go through treatment? Typically, people in substance abuse treatment are getting a variety of services, delivered in an array of intensities, in a variety of settings, and with recognizable steps at certain junctures. Although substance abuse treatment needs to be customized for the unique treatment needs of each individual, treatment programs generally share common overall goals, including the following (Landry, 1995; Schukit, 1994; APA, 1995; CSAT, 1997):

- Improvements in biopsychosocial functioning;
 - Reductions in substance use and increases in sobriety; and
 - Prevention or reduction of the frequency and severity of relapse.
-
- To learn more about the goals of substance abuse treatment, review *Addiction Treatment Outcome Measures*. The link is provided on your resource list.

[Slide II-35] Treatment Effectiveness: National Treatment Improvement Evaluation Study

National research demonstrates that substance abuse treatment is effective. The National Treatment Improvement Evaluation Study (NTIES) was one of the largest and most rigorous studies of substance abuse treatment ever conducted. The study was commissioned by CSAT, and revealed that (SAMHSA, 1997):

- People served by CSAT-funded programs significantly reduced their alcohol and other drug use.
- Treatment has lasting benefits. Significant reductions in drug and alcohol use were reported a full year after treatment.
- One year after treatment, participants reported increases in employment and income, improvements in mental and physical health, decreases in criminal activity, decreases in homelessness, and decreases in behaviors that put them at risk for HIV infection.

[Slide II-36] Treatment Effectiveness: National Institute on Drug Abuse

The National Institute on Drug Abuse (1999) indicates that 90 days of residential or outpatient treatment is generally the minimum for effective outcomes. For methadone maintenance, 12 months of treatment is usually the minimum. People typically need more than one episode of treatment to be successful, and, for a lot of people, these treatment experiences can have a cumulative effect. This means that the more times a person participates in treatment, the greater their chances of success. This is why engagement, retention and length of stay are so important.

- To learn more, review the National Treatment Improvement Evaluation Study (NTIES) Highlights
- You might also refer to the Additional Resource *The Drug Abuse Treatment Outcome Studies (DATOS)*, another large-scale study funded by NIDA, which studied the effectiveness of different treatment modalities—including (1) Outpatient Methadone Treatment; (2) Long-Term Residential Treatment; (3) Outpatient Drug-Free Treatment, and (4) Short-Term Inpatient Treatment. Key findings from the 1-year follow-up are shown in the graphs provided in the Additional Resource.

[Slide II-37] Helping Parents Access Treatment

Child welfare professionals really need to be familiar with the different types of effective treatment programs to help parents receive an optimal level of support for their treatment and recovery. To identify treatment in your community, use the SAMHSA Substance Abuse Treatment Facility Locator. This is the searchable directory of substance abuse treatment programs throughout the country mentioned earlier. It's an easy-to-use online resource that includes more than 11,000 addiction treatment programs, including residential treatment centers, outpatient treatment programs, and hospital inpatient programs for drug addiction and alcoholism.

The first option is to use the SAMHSA Substance Abuse Treatment Facility Locator
Go to www.findtreatment.samhsa.gov/facilitylocator.doc.htm

Once you enter the Website, select either "Detailed Search" or "List Search" from the menu, and check the boxes for "sliding fee scale" and "other assistance." Then phone the facilities that are listed to determine their policies.

The second option is to contact your State Substance Abuse Agency. To do this, use the same Treatment Facility Locator. Select "State Substance Agencies" from the menu. Most have Websites, and they all have contact information, such as phone numbers.

The third option is to call one of the CSAT/SAMHSA Referral Helplines:

- 1-800-662-HELP
- 1-800-662-9832 (Spanish language)
- 1-800-228-0427 (TDD)

[Note to trainer: Investigate what treatment programs are available in your State, county or local community. Use the SAMHSA Substance Abuse Treatment Facility Locator to generate a preliminary list. This list may be used as a handout. The Child Welfare agency may have a list of treatment programs. Compare the Child Welfare agency's list with the treatment programs found using the SAMHSA Substance Abuse Treatment Facility Locator. If time allows, use this opportunity to generate suggestions on available treatment programs that workers have used to provide referrals for clients. For example, the trainer may ask the following questions:

- ***Have you ever referred someone to a local treatment program? If so, which one?***
- ***What kinds of services does that treatment program provide?***

[Slide II-38] Identifying Treatment in Your Community

I'd like you to refer to two Handouts: *Treatment Program Worksheet* and *Key Questions to Consider When Selecting a Program*. These worksheets can be used to document information about each treatment provider. The first page of the worksheet provides space to document information about each program. The second page provides some key questions to consider in securing appropriate treatment programs for parents.

I also recommend that you create a worksheet for each treatment program. As you compile the worksheets into a binder, the information will become an easy reference to help you recommend appropriate treatment placements for parents with substance use disorders and other mental health needs. This is going to help you make referrals and recommendations more efficiently and consistently.

Please be sure that parents are aware of these options to help them identify and contact substance abuse treatment programs.

[Slide II-39] Services that Parents in Treatment Need

Treatment for substance use disorders should be individualized. However, there are services that most parents in the child welfare system will commonly need at various points in the treatment process. Child welfare professionals can work with treatment providers to ensure that these parents in treatment get these critical services:

- Access to physical necessities, such as food, housing, and transportation;
- Medical care;
- Substance abuse prevention counseling;
- Parenting and child development training;
- Child care;
- Training in childcare techniques (like bathing, holding, packing a diaper bag, or giving medication);

- Social services, social support, psychological assessment, and mental health care; Family therapy and health education;
- Family planning services;

[Slide II-40] Services that Parents in Treatment Need (Cont.)

- 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;
- Job training, placement and support strategies;
- Planned, continuing care after program completion;
- Support in sustaining frequent and continued visitation with children;
- Consistent, frequent, and safe visitation with their children; and
- Case Management.

[Note to trainer: For substance abuse treatment professionals, case management refers to identifying treatment and community resource needs; developing, implementing, and revising the treatment plan; and providing linkages to a full range of service providers. Some trainees may respond that they are already extremely overwhelmed by the duties their jobs require and can't imagine attempting to establish an array of services for families in addition to what they already do. Establishing relationships with service providers in your community, knowing who does what, who knows what, and who is willing to help, takes some time. However those relationships can make accessing services and the social support for recovery much easier.]

[Slide II-41] Contact With Children

While parents are in treatment, they may or may not have contact with their children. This often depends on the guidelines of the treatment program. In cases where the court has jurisdiction, court orders may or may not allow visitation, or they may put restrictions on supervision, frequency, or duration of visits. Visitation is important to both the children and the parents, and research suggests that interventions that are designed to break the cycle of substance abuse, child neglect, and maltreatment are more effective when they are family-centered (Magura & Laudet, 1996)

The child welfare professional must prepare the children, in developmentally appropriate ways, for a visit with a parent who is in inpatient treatment and take into account the possible effects on both the parent and the child.

125 – 140 minutes *Facilitated Discussion of Case Vignette* **20 min.**

Participants should still be sitting with the small discussion groups of 5-7 people. Ask them to each quietly read Module 2 Vignette Part II, still describing a real family involved with the child welfare system. Then ask the small groups to discuss appropriate treatment goals for each of the parents in the vignette.

After just 9-10 minutes, ask them to bring their attention back to the larger group and ask them to share a bit from their small discussion groups. In particular, ask them, "How would the treatment goals you are suggesting interact with the reunification or permanency goals in the child welfare plan?"

The GOAL of this discussion is to help participants apply the content of the session to a real family situation. Try not to let one participant dominate the discussion; draw in others whenever possible.

To bring closure to this discussion, emphasize that a child welfare professional should be actively involved in treatment planning and monitoring to make sure treatment goals are aligned with child welfare goals, thus giving each family the best possible chance of reunification and safe care of their children. Then announce a brief break to give people a chance to stretch, use facilities, get coffee, etc. Ask them to come back together in no more than 15 minutes, and let them know that they can return to their original seats or stay with their smaller groups, whichever they prefer.

PRESENTATION 7

140 – 155 minutes *Presentation 7: Recovery; assessing progress; relapse; long-term recovery planning and support* 15 min.

Deliver scripted presentation on recovery, assessment of progress, relapse, and long-term planning and support. Slides II-42 through II-50. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on. Keep answers brief. Only answer questions to which you know the answer. Remember that the GOAL of this presentation is to enable child welfare professionals to better support recovery among the parents of the children they serve.

[Slide II-42] Developmental Model of Recovery: Six Stages

This presentation provides more information on the recovery process and preparing for what happens after substance abuse treatment.

The Developmental Model of Recovery describes stages and tasks as part of recovery (Gorskey & Kelley, 1996). If you look at the Handout *Stages of Treatment or Recovery and Tasks for Child Welfare Professionals*, you'll see the Developmental Model of Recovery is the basis for describing support strategies child welfare professionals can emphasize with the parents. For example, in the Transition Stage, the parent recognizes that her or his attempts to "control" or stop substance use are not working. During this stage, you can foster strong linkages between parent and appropriate assessment and treatment resources and emphasize a need for the children's protection and for family involvement.

In the Stabilization Stage, the parent goes through physical withdrawal and begins to regain control of her or his thinking and behavior. During this stage, a child welfare professional can assure the parent that children are being cared for, which can allow the parent to focus on securing help for her or his addiction.

In the Early Recovery Stage, child welfare professionals can help parents begin to rationally consider the safety and nurturing needs of their children and the timetables and requirements they have to meet. Child welfare professionals can also assist with frequent and ongoing visitation between parents and children.

In the Middle Recovery Stage, the child welfare professional can support the family's transition to parent-child reunification or placement of the children through ongoing family interventions.

In the Late Recovery Stage, the child welfare professional can help to facilitate access to educational opportunities for parenting improvement and family strengthening.

And in the Maintenance Stage, the child welfare professional can continue to support linkages with appropriate resources, like housing, self-help groups, and employment.

[Note to trainer: Have participants discuss instances in which they have observed a mismatch between the level of readiness to change and the intervention being used. How might the mismatch have been rectified positively? From where do those mismatches stem?]

[Note to trainer: Refer to Module 4, Presentation 12 for more information on the Stages of Change. While the Stages of Treatment and Recovery presented here provides information on what a parent may experience as he or she enters treatment and move toward recovery, the Stages of Change theory provides an additional context for understanding how someone becomes motivated to enter treatment.]

[Slide II-43] Monitoring Treatment and Assessing Progress

Monitoring treatment and assessing a parent's progress in recovery is one of the critical pieces to consider when making decisions in child welfare practice. There are several factors that can be useful in determining whether parents are making progress and reports from treatment agencies should include information on these issues including:

- The level of participation in treatment services.
- Knowledge they have gained through substance abuse education.
- The level of participation in recovery support systems.
- Compliance with the child welfare services plan.
- Visitation with children (when appropriate).
- Parenting skills and functioning.
- Interpersonal relationships.
- Keeping appointments and being on time
- Abstinence from substances

[Slide II-44] Drug Testing

You can monitor abstinence through drug testing. There are many biological specimens that can be collected and tested to detect drug use, including urine, hair, sweat, and blood. Each of the specimens and testing methods detect use over various lengths of time. But generally they only detect recent use and cannot measure frequency or patterns of use or the route of administration. Without this information, it is difficult to tell where the client is on the spectrum of addiction (recall Slide I-3).

Drug testing is used in a variety of settings and for various purposes. Many times it is an appropriate adjunct to treatment services, used to reinforce positive behavior and to ensure that the parent is able to maintain abstinence in the treatment setting and structure that he or she is participating in. Agencies have a number of abstinence monitoring protocols, including monitored specimen gathering or observed specimen gathering. You should know parents can

provide false specimens for testing—for this reason, even though they are the most easily quantifiable, urinalysis results alone should not be used to measure progress in recovery.

As part of your case coordination, you will find that you are going to need to work with the treatment agency to agree on the type, frequency and duration of drug testing (Office of Justice Programs, 2000). The frequency of drug testing required by child welfare case plans may depend on the type of program that the parent is participating in. For example, many residential programs only use drug testing when the client has been away from the residence or when staff suspect that there has been drug use. Outpatient programs often set up random drug testing procedures and base the frequency of the testing on the phase of treatment or on how long a person has been abstinent.

- To learn more, review *Drug Testing in a Drug Court Environment: Common Issues to Address*, Drug Court Resource Series of the U.S. Department of Justice, Office of Justice Programs, Drug Courts Program Office. The link is provided on your resource list.

[Slide II-45] Discharge from Treatment-1

When a parent demonstrates significant progress in achieving treatment goals and other associated supports are in place, he or she may be ready to be discharged from residential or intensive treatment services. The next few slides show criteria that may be used in evaluating whether a parent is ready to be discharged:

- Substantial progress in achieving individual treatment goals;
- Sobriety, with evidence that the parent knows how to avoid relapse and live a sober life, which can include things such as having a sponsor or regularly attending Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings;
- Stabilization or resolution of any serious medical or mental health problems, with appropriate plans for continuing or reentering treatment, as needed;
- Demonstration of appropriate parenting skills, including discipline and affection;

[Slide II-46] Discharge from Treatment-2

And here are some more criteria:

- Evidence that the parent can take responsibility for himself or herself and for the children. This includes evidence that the children will live in a safe environment (including approval from child protective services if the parent has an open custody case). It also includes planned arrangements for appropriate child care and continuing medical appointments, as necessary;
- Promotion through the program's treatment phases, at least to a specified level;
- Evidence of a well-developed support system that may include positive relationships with a spouse or significant other, family members, and/or friends;
- Employment or enrollment in a program for adult education, literacy, or vocational training;

[Slide II-47] Discharge from Treatment-3

And the four last criteria to consider when deciding if a person is ready to leave treatment:

- A legitimate income source, with sufficient money saved to meet immediate expenses, a budget, and a savings plan;
- Safe, affordable housing;
- A self-developed exit plan that specifies activities in which the parent expects to participate—this includes aftercare services—and other arrangements with community-based agencies, and goals for the future;

- Evidence that the parent is linked with, or can find, family services they are going to need and negotiate for these with community agencies and other resources.

[Note to Trainer: It is important to note that geography, location and availability of both residential and outpatient services can have a critical impact upon the attainability of these items above.]

[Slide II-48] Continuing Care or Aftercare - 1

After being discharged, people enter the stage of change known as “maintenance,” and formal treatment gives way to continuing care or aftercare. In practice, many programs do not offer formal continuing care. In many cases, continuing care is an ongoing process of self-management and participation in voluntary, community-based recovery support networks.

However, there are a number of ways to provide support for recovery. Substance abuse treatment professionals and child welfare professionals play key roles in connecting parents and families to services that can support recovery and family healing. Some of the many important services that professionals may link parents to include:

- Alumni group meetings at the treatment facility
- Home visits from counselors
- Case management
- Parenting education and support services
- Employment services
- Safe and sober housing resources
- Legal aid clinics or services

[Slide II-49] Continuing Care or Aftercare - 2

You may also help connect a parent to these services as well:

- Mental health services
- Medical and healthcare referrals, including HIV testing and prevention programs
- Dental health care
- Income supports, including when applicable the Earned Income Tax Credit
- Self-help groups, including 12-Step programs, such as AA and NA
- Individual and family counseling

Use the Handout *Recommended Resources Worksheet* to help document resources that a parent should contact, the points of contact, and the actions that they should take.

[Slide II-50] Post-Treatment Expectations

What can a child welfare professional expect of a parent after treatment in the Recovery Stage? The possibility of relapse is always present, as recovery is a dynamic process that might also include re-engagement with community life. Recovery is often thought of as “one day at a time,” for the rest of a person's life.

However, it is important for child welfare workers to differentiate between a “lapse” and “relapse.” A lapse may include a temporary return to substance use but the parent returns to treatment, re-engages in the recovery process and does not return to a pattern of drug-seeking behaviors and detrimental consequences (Annis, 1990; Larimer, Palmer and Marlatt, 1999). Many parents in child welfare lapse and when child safety has not been compromised, the lapse can be used as a critical intervention point in the parent's longer-term recovery. A relapse is

characterized by an on-going pattern of continued alcohol or drug use despite experiencing negative consequences.

Maintaining sobriety and sustaining a life of recovery are fundamental and profound biopsychosocial and spiritual processes for an individual. The individual in recovery is making lifestyle changes to support healing and regain control of his or her life, and accepting responsibility for his or her behavior. He or she may have a new job, a different living situation and/or location, and a new set of friends. The new friends may be peer group and self-help group members instead of former substance-using friends.

In providing ongoing support, the importance of a range of on-going services, including economic support, vocational and employment services, housing, parenting skills, medical care, and community and social supports for a parent in early recovery and through the stresses associated with reunification cannot be underestimated. These ongoing supports may help to prevent relapse and may also facilitate re-engagement in the recovery process should relapse occur.

One factor in relapse may be that the treatment plan did not adequately address cultural, ethnic, or language issues. Both child welfare and alcohol and drug services programs should work to recruit staff with backgrounds similar to those of parents receiving services. Staff should be trained in cultural issues and be able to identify and eliminate discriminatory language and behaviors. Agencies should offer specialized programming and bilingual counselors. The therapeutic environment should be sensitive to spiritual beliefs and values. Recovery can often be enhanced and sustained by incorporating healing and support systems from the parent's culture.

155 – 175 minutes *Facilitated Group Discussion* 20 min.

Once questions have been addressed, move the whole group into a discussion about the lapse and relapse processes by asking, " How does the distinction between "lapse" (isolated events) and "relapse" (returning to a pattern) impact child welfare responsibilities to protect children?"

What would a lapse mean for the recommendations you made regarding the vignette we considered? What would a relapse mean for the recommendations you made regarding the vignette we considered?

If additional questions are needed to stimulate discussion, you might ask any of the following questions:

- ***What family and community supports are available in the community(ies) you serve?***
- ***How do you help families access such supports?***
- ***How does the possibility of caregiver relapse fit into federal (ASFA) reunification and permanency timelines?***
- ***Where does the child welfare worker look to find natural supports for a specific family?***
- ***How are those potential supporters linked to the family plan?***
- ***What is the role of the courts in this scenario?***

The GOAL of this discussion is to help participants recognize the many strategies available to them to assist in the recovery process for parents of children they serve. These concepts can be applied to the vignette for a higher level of learning. Child welfare professionals may be the key supporter in developing a successful support system around a parent. Try not to let one participant dominate the discussion; draw in others whenever possible.

To bring final closure to this discussion, emphasize that hope – for the parent, for their children, for the family as a whole – is one of the most important tools available to them and many strategies can be employed to develop and sustain such hope. Encourage them to recognize that a relapse does not have to mean the end of hope.

175 – 180 minutes Closing Discussion

5 min.

Briefly review the areas that have been covered in this training session, focused on developing a better understanding of parents with substance use disorders. Ask the group what new things they have learned in this session that they can take with them and apply to their work with families. Ask the group about the most useful knowledge they gained and can apply to their work. The GOAL of this brief discussion is to help participants think about what they will take away from the session. At the end, thank them all for participating. If they will be receiving more modules in this series, you might remind them of what comes next, and when.