Substance Abuse Level I

Training Manual

PROTECTING CHILDREN IN SUBSTANCE ABUSING FAMILIES
Introduction

As the incidence of alcohol and other drug abuse becomes more visible, parental substance abuse is increasingly recognized as a significant factor in cases of child abuse and child neglect. Estimates suggest that 50 to 80 percent of all child abuse and neglect case substantiated by DHS involve some degree of substance abuse by the child’s parent for primary caregiver. Other research suggests that over 7,000 babies are born each year with Fetal Alcohol Syndrome. That number does not take into consideration the babies born with undiagnosed Alcohol and/or Drug Related Neurodevelopmental Disorders.

Infants and children who reside in households where alcohol and other drugs are abused may suffer harm in a variety of ways. A parent's overriding involvement with alcohol and other drugs may leave the parent emotionally and physically unavailable to the child. A parent's mental functioning, judgment, inhibitions, and/or protective capacity may be seriously impaired by alcohol or drug use, placing the child at increased risk of all forms of abuse and neglect. A substance-abusing parent may "disappear" for hours or days, leaving the child alone or with someone unable to meet the child's basic needs. A parent may also spend the household budget on alcohol and/or other drugs, depriving the child of adequate food, clothing, housing, and health care. A child's health and safety may be seriously jeopardized by criminal activity associated with the manufacture and distribution of illicit drugs in the home. Consistent exposure to parental abuse of alcohol and other drugs may contribute to the child's own substance abuse.

As is true in most cases of child maltreatment, parents and caregivers who abuse alcohol and/or other drugs do not intend to harm their children. Most do not stop to consider that even a single incident of substance abuse can result in serious injury to their child. Further, the risks associated with parental substance abuse have no socioeconomic or racial boundaries. Upper- and middle-class parents who abuse alcohol and/or other drugs pose just as much risk of harming their children as parents who abuse drugs and live in poverty. The primary difference lies in the tendency of professionals to overlook or forgive the upper- or middle-class substance abuser, or to offer help more expediently to these families.

Child Welfare Workers need to understand the indicators and dynamics of substance abuse, routinely probe for the problem in families, and be prepared to intervene when the problem is suspected or confirmed. This requires examining one's own attitudes about substances of abuse and substance abusers, the origins of these attitudes, and how one's attitudes influence intervention with families. Workers also need to be sensitive to the cultural context in which the families exist.

Additionally, workers must be informed about the various substances of abuse and their effects on adult behavior, child development, and parenting. They need to be knowledgeable about the nature of substance abuse and the chronic, often relapsing nature of this disorder. They need to learn to recognize the warning signs of substance abuse in a family and know how to ask the "right" questions, how to conduct a comprehensive family assessment, and ways to protect a child from neglect, abuse, and maltreatment. Lastly, workers need to be able to provide culturally sensitive support and guidance to families affected by substance abuse, act as advocates for these families in the service system, and work toward improvements in the prevention and treatment of substance abuse. Without these skills and knowledge, services provided for parents and children may prove inadequate or inappropriate.
Substance Abuse Level 1
PROTECTING CHILDREN IN
SUBSTANCE ABUSING FAMILIES

David Berntson, Trainer

9:30am  Registration
10:00am Welcome – Introductions – Housekeeping Issues (smoking, cell phones, crosstalk, restrooms, other issues)

The theme for this training is “The Safety of Children is our Primary Concern.”

Goals and Objectives:

★ Discussion with workers on why learning about Substance Abuse is important.
  o Identification of “Red Flags” that would indicate a parent/caregiver is endangering children.
  o Reporting Requirements
  o Confidentiality Guidelines

★ Workers will understand the effects of 6 major drugs of abuse: stimulants/methamphetamine, depressants/alcohol, hallucinogens, narcotics, marijuana, prescription drugs.

★ Workers will learn about the Culture of Chemical Dependency

★ Workers will learn about the Methamphetamine Culture and safety issues to consider when working with families who abuse methamphetamine.
  o Poor prognosis of Methamphetamine cases
  o Discussion over how long to expect before recovering Meth clients can function in a productive manner.
  o Consider more permanent placements for children from these homes.
  o Develop concurrent case planning to ensure that the family has every opportunity for reunification.

★ Workers will learn how Parental/Caregiver Substance Abuse impacts the entire family system and the dangers of abuse and neglect in these families.
  o Discussion over how often substance abuse issues are multigenerational
  o Discussion over Mental Health Issues that can lead to Substance Abuse
    • self medicating.

★ Workers will gain skills in dealing with a client in denial of his/her addition.

★ Workers will learn about the disease concept of addiction in adults and adolescents.
  o Gain skills in recognizing the signs and stages of drug use on a continuum

★ Worker will understand the risk factors that can lead to relapse.
  o Discussion over the Therapeutic Relapse.

★ Workers will understand how assessment tools aid in formulating an effective treatment planning - History taking, Addiction Severity Index, 4P’s Plus, SASSI, ASUS, MAST, etc….
  o Utilizing Motivational Interviewing Techniques
★ Workers will learn information regarding each of the different types of treatment programs and what to expect from and what to look for in Treatment Agencies.
  ▪ Detox
  ▪ Residential
  ▪ Intensive Outpatient
  ▪ Outpatient
  ▪ Education

★ Workers will understand key elements of the 12 step recovery program.

★ Workers will learn about testing clients for Drug and Alcohol Use.
  ▪ Adult Drug Testing
    • Urine, Hair, Blood
  ▪ Infant Drug Testing
    • Meconium, Urine, Hair, Blood

★ Workers will learn the practical matters of Harm Reduction and how to help clients develop a Safety Plan.
  o Activity to develop a safety plan

★ Workers will be able to identify and utilize recovery resources within the client’s community.
  o ODMHSAS Yellow Pages

★ Workers will learn what free tools/publications are available to help them work better with their clients.
  o CSAT, SAMHSA, TIPS, TAPS, et al.
1. **WHY IS IT IMPORTANT FOR CHILD WELFARE WORKERS TO LEARN ABOUT SUBSTANCE ABUSE?**

   **Powerpoint Slides 5-14**

1. Children of Alcoholics are 2-4 times more likely to repeat the cycle of addiction in their own lives.
2. The National Institute of Health (NIH) study in January 2000, states that one out of every three kids in the United States is currently living in a family struggling with substance abuse issues.
3. Child Abuse doubled from 1986 to 1997. The reasons are:
   - #3 Poverty
   - #2 Better Reporting
   - #1 Substance Abuse
4. The number one risk factor for a child being abused is alcoholism/addiction in the home.
5. Children of alcoholics are four times more likely to suffer neglect.
6. Medical and Psychiatric concerns:
   - Children of alcoholics had higher rates of admission for:
     - Injuries
     - Poisonings
     - Substance Abuse
     - Mental Disorders
     - Diseases of the gastrointestinal and respiratory systems
7. Substance Abuse is a contributing factor to the abuse of at least 1/3 of the children in the child welfare system.
8. Nearly ¼ of physical abuse and more than half of sexual abuse of children occur at the hands of adults who are not the victim’s birth parents. They may be other relatives, caregivers, or partners. The likelihood of this kind of abuse is far greater when parents are abusing substances and consequently cannot provide adequate care for and supervision of their children (Reid et al., 1999).
9. National estimates suggest that 50 to 80 percent of all child abuse and neglect cases substantiated by DHS involve some degree of substance abuse by the child's parents.
10. Other research suggests that over 7,000 children each year are born with Fetal Alcohol Syndrome.
11. A parent's overriding involvement with alcohol and other drugs may leave the parent emotionally and physically unavailable to the child.
12. A substance-abusing parent may “disappear” for hours or days, leaving the child alone or with someone unable to meet the child's basic needs.
13. A child's health and safety may be seriously jeopardized by criminal activity associated with the manufacture and distribution of illicit drugs in the home.
   - Consistent exposure to parental abuse of alcohol and other drugs may contribute to the child's own substance abuse.
As is true in most cases of child maltreatment, parents and caregivers who abuse alcohol and/or other drugs do not intend to harm their children.
- Most do not stop to consider that even a single incident of substance abuse can result in serious injury to their child.
- Further, the risks associated with parental substance abuse have no socioeconomic or racial boundaries.

14. Upper- and middle-class parents who abuse alcohol and/or other drugs pose just as much risk of harming their children as parents who abuse drugs and live in poverty.

15. They need to be knowledgeable about the nature of substance abuse and the chronic, often relapsing nature of this disorder.

16. They need to learn to recognize the warning signs of substance abuse in a family and know how to ask the “right” questions, how to conduct a comprehensive family assessment, and ways to protect a child from maltreatment.

II. IDENTIFYING ALCOHOL AND/OR OTHER DRUG USE
**RED FLAGS TO LOOK FOR**
Powerpoint Slides 15-18

A. PHYSICAL AND BEHAVIORAL INDICATIONS OF SUBSTANCE ABUSE IN FAMILIES

- personality changes and inconsistent behaviors;
- financial problems despite an adequate income;
- sudden, unexplained wealth;
- frequent automobile or other accidents;
- self-defeating behaviors (e.g., missed appointments, absences from work, repeated lateness);
- repeated changes in friends and associates;
- altered mental status consistent with alcohol or other drug intoxication;
- withdrawal symptoms;
- skin lesions such as abscesses or track marks consistent with injection drug use;
- the presence of drug paraphernalia;
- frequent absences or tardiness of children at school; and
- a family member consistently making excuses for an absent family member.

B. PHYSICAL AND BEHAVIORAL INDICATIONS OF PERINATAL SUBSTANCE ABUSE

- lack of prenatal care,
- previous delivery of a prenatally drug-exposed infant,
- intrauterine growth retardation in the absence of other identifiable causes,
- placental abruption in the absence of other identifiable causes

Additional indicators of possible alcohol or other drug abuse may include:
- women who deliver outside the obstetrical unit (in the emergency room, in the ambulance, or at home)
- women who have abrupt deliveries.

C. OTHER CLUES THAT A PARENT MAY BE ENDANGERING THEIR CHILDREN?
How does the substance abuser relate to his/her children’s behavior?
How does the substance abuser respond to his/her children’s emotional needs?
Do the children make eye contact with the parents?
How does the substance abuser respond to the child’s crying?
How do the substance abuser praise and discipline his/her children?
Are the substance abuser’s expectations, age appropriate for the children?

III. REPORTING OBLIGATIONS IN CASES INVOLVING PARENTAL SUBSTANCE ABUSE

A. Reporting Parental Substance Abuse

★ We are all aware that all reasonable suspicions of child maltreatment must be reported. However, without specific State legislation, parental substance abuse (in and of itself) is not reportable as a form of child maltreatment.
★ Only when there is reason to believe that the parent’s alcohol or other drug abuse is so severe that the child has been or is likely to be harmed due to such substance abuse, should a report to DHS be filed.

★ Oklahoma’s Reporting Laws - Powerpoint Slide 20
  o Oklahoma State Law requires that any newborn that has been prenatally exposed must be reported.
  o Unfortunately this law does not indicate how the hospitals are supposed to determine drug and alcohol exposure.
  o Each Hospital across the State of Oklahoma determines how it will enforce this issue.
  o Currently no agency monitors that Hospitals are abiding by their own policies and procedures regarding prenatally exposed newborns.

~ DISCUSSION ~

HOW MIGHT SOCIAL CLASS – RACE - AGE AFFECT THE HOSPITAL’S BEHAVIOR IN TESTING AND REPORTING SUBSTANCE ABUSE BY A MOTHER OR A DRUG AND ALCOHOL AFFECTED NEWBORN - regardless of hospital policy.

C. Variations in Reporting – Things to consider
Professional mandated to report reasonable suspicions of substance abuse that may cause risk to a child sometimes choose not to report.
★ Private physicians, for instance, may not want to risk the loss of paying clients or the control that they maintain over their patients' care.
★ On the other hand, physicians in public clinics, emergency rooms, or hospitals tend to report a much higher proportion of their patients.
  o While their reports seem to indicate a higher use of substances among poor clients, the settings themselves may in fact be at cause, and clients' help-seeking is often what is measured rather than incidence of abuse.
In a study of reporting practices of mandated reporter professionals, evidence was found that those who believed that reporting would do more harm than good failed to report.

**D. CONFIDENTIALITY GUIDELINES**  
Powerpoint slides 22-25

When referring clients to treatment agencies, be aware of the limits of confidentiality.

If you need to receive reports on your client’s attendance or progress, you have to have your client’s written permission to access his/her records.

Most alcohol and drug treatment providers must comply with the State and Federal Regulations: Client records may be disclosed or information may be released only under the following circumstances:

1. The client grants consent in writing.
2. The disclosure is allowed by a court order.
3. The disclosure is made to medical personnel in a medical emergency.
4. For the purpose of conducting scientific research, audits, or program evaluation.

Sharing medical, mental health, social welfare, substance abuse treatment, criminal, probation, and educational information is crucial to providing protection for a child, especially when the child is living in the home or when a return to the parents is anticipated.

**Key to remember: COMMUNICATE – appropriately**

**IV. Definition of a Drug**  
Powerpoint Slide 26

Any chemical substance that changes someone mentally, physically, or emotionally.

**Body Chemistry / Allergic Reactions**  
Powerpoint Slide 29

1. Discussion

**V. THE DISEASE CONCEPT OF ADDICTION**  
Powerpoint Slide 28

1955 AMA classifies alcoholism as a primary disease with 3 distinct characteristics: incurable, progressive, and fatal.

1. Incurable
2. Progressive
3. Fatal

**A. ADDICTION CONTINUUM**  
Powerpoint Slide 29-35

1. Non-Use
   - Implications for Child Welfare - None

2. Experimental Use – Why would someone use?
   - Early use is described as experimental.
   - Motivation is curiosity or social pressure
   - Use during this phase is occasional, frequently unplanned, and involves little, if any, reorganization of lifestyle to accommodate it.
   - There may be no detectable deterioration in health, relationships, or ability to function as expected.
★ Implications for Child Welfare - Few
   a. Use during pregnancy can harm the fetus
   b. Can impair a parent’s ability to respond to the needs of his/her children.

3. Recreational Use – Changes
   ★ Implications for Child Welfare - Yes
   ★ Children left in care or unattended while parent is partying
   ★ Parent may neglect regular meals, cleanliness, clothing while partying

4. Regular Use – Changes
   ★ Planned and more frequent than recreational use
   ★ increased amounts of time, thought, energy, and money go into the acts of “scoring” and using
   ★ At this stage, one's social life may revolve around getting high
   ★ Peer relationships often change accordingly.
   ★ The economic and personal costs escalate
      a. ability to function at school or work declines
      b. mood swings become more prominent
   ★ Tolerance to the original drug of choice has developed
   ★ Solitary use increases
   ★ The user is increasingly preoccupied with drug use and may turn to dealing or other criminal activity to support a growing dependency on more potent and more expensive drugs.
   ★ Deterioration in all significant areas of functioning is present
   ★ Implications for Child Welfare - Yes
      a. Driving under the influence with children in the car
      b. Even while at home, parent’s use may leave child unattended
      c. Parent’s behavior towards children may be inconsistent
      d. Parent may neglect regular meals, cleanliness, clothing
      e. Periods of violence then remorse

5. Chemical Dependency/Denial
   ★ User can no longer manage life without getting high.
   Use may occur continuously or in binges
   ★ Substances plays central role in the individual's life
   Serious effects of the alcohol and/or other drug use on health, finances, relationships, and emotional stability
   User finds it increasingly difficult to perform even ordinary tasks
   ★ Judgment at this stage can be severely impaired.
      a. Implications for Child Welfare - Yes
      a. Parent may use money for drugs/alcohol while neglecting food and other items.
      b. Parent is unable to make rational decisions.
      c. Unable to prioritize child’s needs over his/her own need for the substance.
      d. Ultimately they receive TREATMENT, go to JAIL, or DIE.

Discussion over the implications for Child Welfare with each step
B. THE NATURE OF SUBSTANCE ABUSE
   The impact of alcohol and other drug abuse varies widely from individual to individual.

The following characteristics seem fairly universal regardless of the substance or substances of choice, and can help to understand the nature of most chemical dependencies.

1. Alcohol and other drug abuse is progressive -
   ★ People do not set out to become alcoholics or addicts.
   ★ First-time users universally resist the notion that they could ever become dependent on any chemical.

2. The onset of chemical dependency is insidious. powerpoint slide 36-39
   The lines drawn by professionals to note phases of drug and alcohol use (experimental, regular, habitual, and so on) are blurred, and precisely when the user moves from one phase to the next depends on many factors, including:
   i. physiological and psychological makeup,
   ii. drug of choice,
   iii. means of ingestion
   iv. prior history.
   v. A dependency can evolve over a long period of time (months or even years) or, as many crack addicts report, it can occur over the course of a weekend.

3. The earlier the use starts, the more likely that person is to become chemically dependent.
   ★ There are exceptions to this rule, but generally, children who are introduced to drugs while still very young are more susceptible to heavier use and abuse than individuals whose experimentation occurs at a later age.

Understand the importance of working with the entire family system.

4. Anyone can become an addict.
   ★ Chemical dependency cuts across all racial, social, and economic lines.
   ★ No one is immune.
   ★ Exposure to the right substance of abuse under the right circumstances (times of stress, loss, pain, or boredom) has the potential to seduce anyone into a true chemical dependency.

C. DENIAL powerpoint slide 40-43
   ★ Most clients - particularly those who are involuntary, will deny the extent of their abuse of alcohol and/or other drugs.
   ★ The chemically involved parent more often than not will minimize the problem
     o Deny it’s impact on the family, and is resistant to treatment.
     o Often, parents will emphatically deny any drug or alcohol use whatsoever.
   ★ In cases of prenatal substance abuse
     o parents may explain that positive toxicology reports are lab errors or reflect a one-time lapse that occurred, unfortunately……. just prior to delivery or testing.
   ★ At the time of intake/assessment and sometimes well into the course of treatment, it is commonplace for both clients and families to deny the reality of a parent's devastating, long-term, polydrug abuse.
Group Discussion:

- What is your experience in working with a client or family that emphatically denies drug/alcohol use?
- Did you handle anything different with this client?
- How did the denial make you feel?

D. WHEN WORKING WITH DENIAL

★ Given the circumstances that surround allegations of child abuse and the power agencies have to disrupt lives in profound and painful ways, workers should neither be surprised nor take it personally when they are met with a wall of denial and resistance.

★ Denial and resistance, however, are not insurmountable obstacles to treatment. Workers should understand the function and importance that these defenses have played in the lives of parents and families.

★ By building meaningful relationships with parents and taking the time necessary to work through denial and resistance, it is often possible to form a supportive and mutually respectful treatment alliance with the parent and the family.

VI. SUBSTANCE ABUSE IS A FAMILY PROBLEM

★ Substance abuse is a family problem in both a biological and a psychological sense.

★ There is a growing body of evidence that certain people (some children of alcoholics, for instance) are biologically at highest risk of becoming chemically dependent.

★ It is a family problem, also, insofar as coping behaviors are learned within the context of the family.

- Children of substance-abusing parents may learn to cope with unpleasantness in their lives as their parents have done before them, by taking substances into the body to effect a change in mental status.

- It is a family problem because everyone in the family is profoundly affected by the alcohol and/or drug abuse of even one of its members.

- Alcohol and other drug abuse is a systemic problem.

- Substance abuse often afflicts those individuals who are already the most vulnerable, the least equipped to cope.

- Frequently, persons most severely impacted by substance abuse come from families with multiple stresses, including alcohol and/or other drug abuse problems, mental health disorders, failures in school and/or employment, and/or a history of physical and/or sexual abuse.

- These individuals, already struggling to cope, are then further impaired by their drug use. Thus, they tend to come to treatment in very serious condition and typically need a wide range of services.
**Group Discussion**

Break into groups of 4-6 and discuss a family you are familiar with who has experienced Substance Abuse problems.
- Discuss how the use affected each of the family members.
- Discuss Coping behaviors of the family members.
- What other relationships were affected by the use?
- Was denial a part of this family?
- Report back what you discussed.

VII. THE DYNAMICS OF SUBSTANCE ABUSING FAMILIES

A. Family Illness in Children  

<table>
<thead>
<tr>
<th>Visible Qualities</th>
<th>Inner Feelings</th>
<th>Represents to Family</th>
<th>Characteristics</th>
<th>Possible Future Characteristics Without Help</th>
<th>Possible Future Characteristics With Help</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Hero</strong></td>
<td>Visible Success Does what is right</td>
<td>Inadequate</td>
<td>Self-worth Family can be proud</td>
<td>High Achiever -grades -sports -friends</td>
<td>Workaholic, Never Wrong, Responsible for everything, Marry, Dependant</td>
</tr>
<tr>
<td><strong>Problem Child</strong></td>
<td>Hostility Defiance Anger</td>
<td>Hurt Guilt</td>
<td>Take focus off of the addict - alcoholic</td>
<td>Negative Attention</td>
<td>Unplanned Pregnancy, Troublemaker in school, and later in the office, Prison</td>
</tr>
<tr>
<td><strong>Lost Child</strong></td>
<td>Withdrawn Loner Loneliness Not Important</td>
<td>Relief</td>
<td>One child not to worry about</td>
<td>“Invisible” Quiet No friends A follower</td>
<td>Little zest for life, Sexual identity problems, promiscuous or stays alone, often dies at an early age</td>
</tr>
<tr>
<td><strong>Mascot/Family Clown</strong></td>
<td>Fragile Immature Needs Protection</td>
<td>Fear</td>
<td>Fun and humor Comic Relief</td>
<td>Hyperactive Learning disabilities Short Attention Span</td>
<td>Ulcers, can’t handle stress, Compulsive clown, Marry “hero” for care, Remains immature</td>
</tr>
</tbody>
</table>


B. Family Dynamics  

1. Alcoholics are shackled to their self  
   - Cannot see past their own desires and needs  
   - Don’t meet children’s needs consistently  
   - Family members are distant  

2. Inconsistency, Unpredictability, and Chaos  
   - Children are always on guard  
   - Adults not validating their reality  
   - Problem solving issues  

3. Trauma and High Stress  
   - Verbal and/or physical violence  
   - Takes away child’s confidence  
     i. Vicarious Abuse  

4. Kids come to see the world as a hostile place  
   - Seeds of mistrust are planted  
   - COA’s don’t count on words  
   - Actions from adults more effective than words  

5. Children are pushed to grow up too fast  
   - Burdened with family responsibility beyond their years  
   - Self-development not prized  
   - Creates roles to balance family system  

6. Unavailable/intolerant parent  
   - Children experience feelings as bad, wrong, painful  
   - Children learn three rules  
     o DON’T TALK  
     o DON’T TRUST  
     o DON’T FEEL  

7. Activity on Family Dynamics  
   o Co-dependent / Spouse / Significant Other / Family Member  
   o Family Hero  
   o Family Scapegoat  
   o Lost Child  
   o Mascot  

C. Typical Family Members Will:  

- Makes excuses for the substance abuser  
- Keep up appearances, see that the substance abuser wears clean clothes  
- Be sure to wake the substance abuser wakes up in time for work  
- Call employer and tell substance abuser is ill, if they can’t get out of bed  
- Cover up for him/her with friends  
- Make effort to get the substance abuser to eat and stay healthy  

D. They Will Often:  

- Do the chores that should have been done by the substance abuser  
- Pay all the bills, including the ones he/she should have been paying  
- Buy the things needed for the house  
- Control the finances, or at least as much as they can get their hands on  
- Help the substance abuser keep his/her job  

E. They May:  

- Drink or use with the substance abuser so they won’t get so high/drunken  
- Encourage the substance abuser to stay home for safety reasons  

Complain about it

F. Many Family Members will:
- Tell substance abuser to get out of the house because they are tired of them and their using
- Send the children to bring the substance abuser home
- Tell the substance abuser not to hit and yell at the children
- Hit and yell at the children themselves

VIII. THE CULTURE OF CHEMICAL DEPENDENCY

Movie – 10 minute clip

Spun or Meth Movie

A. Upon closer examination, it becomes clear that the culture of chemical dependency meets all the criteria necessary to classify it as a culture. It will help you to understand your clients, their families, and the behaviors you might observe if you understand some of the cultural underpinnings for this group of clients.

- **Interconnection** –
  A defining feature of any culture is that it’s attributes create an interconnection between the members, a camaraderie or friendship. Addicts/Alcoholics experience this kinship. What they share is their addiction and lifestyle.

- **Ceremony and Ritual** –
  Cultures have rituals and ceremonies and the chemical dependency culture is no exception. **There are ceremonies and rituals around acquiring drugs, preparing drugs, and sharing drugs.** The rituals have rules and structure, which are common to specific groups of users.

  One is not easily invited into this culture. **People are often defined as in or out of the culture based on defined rules, rituals, and ceremonies and the ability of the individual to conform.** The police and service providers are seen as invaders and as the enemy, not to be trusted or allowed into the inner sanctum.

- **Time and Distance** –
  Time and distance have special meanings. **This culture’s rhythms and schedules of the day look and are different from what might be considered “normal.”** The activity schedule of the chemically dependant might be more nocturnal in orientation.

- **Code of Ethics** –
  This code includes rules about “snitching,” trustworthiness, secretiveness and much like gang cultures, group protection.

- **Values** –
Individuals in this subculture have their own value system, which at times varies from the “main stream” culture. “Getting over” is part of the “game.” Surviving, getting one’s needs met (getting high) is the goal of each day.

- **Language** –
  
  The culture of chemical dependency even has it’s own language. If you have occasion to listen to members of this subculture, you would, at times have a difficult time understanding exactly what is being discussed.
  
  - These cultural differences may cause the outsider to feel discomfort.
  - This culture often feels chaotic and unstructured.
  - It may appear as if the members were weak or unintelligent, that their children are ill kept, and that one on is in control.
  - This doesn’t mean that the parents don’t care about their children and even love them. It does mean that their primary relationship is the addiction.
  - Our job is to get past the addiction to the person inside.
  - Our cultural biases can prevent us from achieving this goal.

**B. THE METHAMPHETAMINE CULTURE**  

- Violence
- Guns
- Pornography
- Surveillance Cameras
- Booby Traps
- Compulsive Behaviors – Tweaker Habits
- What is a realistic case plan for these families?

In approaching members of this culture, it helps if you act and respond as you would when entering any other home of someone from another society or culture that had different values and rituals from your own.

1. How would you learn about their culture?
2. How would you come to know the family?
3. How can you become included enough to initiate an effective intervention?
4. How would you demonstrate respect for the person while attempting to support change in his/her behavior?
IX. MAJOR SUBSTANCES OF ABUSE  Powerpoint slide 72-94

A. HOW DRUGS ARE USED  powerpoint slide 72

B. THE SYNAPSE  powerpoint slide 73
D. Alcohol (Ethyl Alcohol)
   ★ Legal and widely accepted in our society.
   ★ Is one of the most popular drugs among adults in the United States.
   ★ Some studies estimate that about 10 percent of the population suffers from alcohol abuse and alcoholism.
   ★ Research suggests that there may be a genetic predisposition to alcoholism and that a child of an alcoholic parent is at a greater risk of becoming an alcoholic than a child of a nonalcoholic parent.
   ★ Alcoholic beverages vary in alcoholic content.
      o Beer is generally 4 percent, wine 12 percent, and “hard liquor” up to 50 percent alcohol.
   ★ Once absorbed into the blood stream, alcohol acts on the central nervous system (CNS) as a depressant affecting speech, vision, and coordination.

   **Effects**-
   ★ Physical effects of acute alcohol intoxication include altered perception, impaired muscular coordination, staggering gait, dulled sensations, blurred vision, bloodshot eyes, flushing, dizziness, slurred speech, nausea, and vomiting.
   ★ Chronic alcohol abuse also has been linked to heart disease, high blood pressure, gastrointestinal bleeding, liver damage, and brain damage.
   ★ Withdrawal from excessive and prolonged use can cause a violent delirium with tremors called delirium tremens (the “DT’s”).

   **Overdose**-
   ★ Alcohol overdose can cause unconsciousness, respiratory failure, and death.

**Everclear Egg Experiment**

E. Narcotics
   ★ Narcotics (opioids) are drugs that dull the senses.
Examples include morphine, codeine, oxycontin, loratab, and heroin that are derived from the opium poppy, as well as synthetic chemicals such as Darvon®, Demerol®, and methadone (used in the treatment of heroin addicts).

Medicinal uses for narcotics include relief of pain, cough suppression, and the control of severe diarrhea.

Effects-
- With regular use the body demands more of the drug in order to achieve the same effects.
- When chronic use is abruptly stopped, withdrawal symptoms such as runny nose, watery eyes, perspiration, and yawning can develop 6 to 8 hours following the last use of the drug.
- Depending on the duration of activity of the particular narcotic used, more severe withdrawal symptoms can develop, including restlessness, irritability, tremors, loss of appetite, stomach cramps, diarrhea, and chills alternating with heavy sweating.
- Typically, it can take 10 to 14 days for these acute symptoms to abate.
- Narcotics may be injected, sniffed, or ingested in tablet, capsule, or liquid form.

a. Heroin
- First produced in 1874 as an alternative to morphine, but it proved even more addictive.
- Generally sold as a white to very dark brown powder or as a brown or black chunky, tarlike substance that smells like vinegar.
- Packaged in small foil or cellophane packets or in small rubber or plastic balloons that have been closed off and folded over into a ball (known as a “spoon” or “balloon”).
- The most common form of use is by injection (called “mainlining” or “shooting”), but in its powder form, heroin can be snorted or smoked.
- Can be taken orally or by rectal suppository.
- Many addicts will “chip” (use infrequently) for extended periods of time before becoming “righteously” (severely) addicted.

Street names-
- “smack,” “junk,” “horse,” “stuff,” “boy,” “eleven-fifty” (the code number under which police make an arrest for heroin possession), “H,” “Harry,” “Helen,” “dynamite,” “doo-jee,” “China white,” “Mexican brown,” “mud,” and “black tar.”

Paraphernalia-
- Hypodermic needle, small cotton balls to strain the drug, tourniquet, matches, water, and spoons or bottle caps used for “cooking” or liquefying the heroin.
- Paraphernalia for snorting or smoking includes razor blades, straws, and pipes.

Effects-
- Brief and intense feeling of euphoria called a “rush;”
- The high usually lasts 4 to 6 hours.
- Following the rush, the user experiences muscle relaxation (manifested by a slow gait, sleepy appearance, slurred speech, and droopy eyelids) as well as constricted pupils and a decrease in pulse, reflexes, blood pressure, and respiration rate.

Overdose-
- Overdose can cause slow and shallow breathing, clammy skin, convulsions, coma, cardiac arrest, or death.
b. Methadone

- German scientists first synthesized methadone during World War II because of a morphine shortage.
- Methadone was introduced as an analgesic in the United States in 1947 and became widely used in the 1960's as a treatment for narcotic addicts.
- When used to treat heroin addiction, methadone is administered orally.
- Methadone is considered to be a safe and effective treatment for opiate addiction when used as prescribed by a physician.
- Methadone differs significantly from heroin in that it has a longer duration of action.
  - A single dose can last up to 24 hours,
  - Methadone can be administered once a day in heroin detoxification and maintenance programs.

Street names-

- Users commonly refer to methadone as “dolly” or “dome.”

Effects-

- When used appropriately in adequate doses under medical supervision, methadone has few significant adverse side effects.
- When abused, the effects are similar to those associated with addiction to other narcotics.
- Compared to heroin, the symptoms associated with methadone withdrawal are slower in onset and longer in duration.

Overdose-

- Methadone overdose can result in respiratory depression, coma, or cardiac arrest.

F. Sedatives – Barbiturates and Benzodiazepines

- Commonly known as tranquilizers and sleeping pills.
- They have legitimate therapeutic uses when prescribed by physicians to treat anxiety, tension, insomnia, and muscle spasms.
- Often abused because of their intoxicating effects, as self-medication to allay the effects of stimulant drugs, to ease the anxiety of flashbacks associated with prior hallucinogen use, to treat heroin withdrawal symptoms, or, in some cases, as a means to commit suicide.
- Barbiturates (Nembutal©, Seconal©, and Amytal©), chloral hydrate, glutethimide (Doriden©)
- Benzodiazepines (Valium©, Librium©, and Xanax©)
- May be intravenously injected, are most frequently ingested as pills, tablets, or capsules that generally are sold illicitly in plastic bags or bottles.
- Tolerance can develop rapidly, leading to a progressive narrowing of the margin of safety between an intoxicating and a lethal dose.
- The risk is compounded when used in combination with alcohol or other substances.
- Withdrawal from Sedatives can be serious and should be treated as a medical emergency.
- Withdrawal from sedatives and hypnotics can lead to convulsions, delirium, and, in some instances, death; therefore, medical supervision is often required.
- Unrecognized and untreated withdrawal may be fatal.

Hazards -

- Symptoms of sedative abuse vary from person to person, and from time to time in the same individual.
- Abusers may appear to be in a state of intoxication much like that of alcohol abuse, with impaired judgment, slurred speech, staggering gait, and loss of motor coordination.
- Other symptoms may include dilated pupils, weak and rapid pulse, slow or rapid but shallow breathing, trembling hands, impaired reflexes, drowsiness, and fainting.
- Sedatives also can produce mood swings ranging from euphoria to confusion, disorientation, quarrelsome ness, depression, and apathy.

Overdose -

- Sedative overdose can cause the user to progress through successive states of sedation, sleep, coma to death from respiratory arrest and cardiovascular complications.

G. Hallucinogens

- Hallucinogens are psychotropic drugs that cause hallucinations by distorting the perception of objective reality.
- They include phencyclidine (PCP), (LSD), certain psychoactive mushrooms, and mescaline (present in the peyote cactus).

a. PCP

- PCP was investigated in the 1950's as an anesthetic, but because of extreme side effects (including topic psychosis schizophrenia), it was discontinued for human use.
- In its pure form, PCP is a white crystalline powder that readily dissolves in water.
- Street PCP color ranges from tan to brown;
- Sold in tablets, pills, and gelatin capsules, but is most commonly found in powder and clear liquid form.
- It may be inhaled, injected, or ingested, and frequently is applied to dark brown cigarettes (“Shermans”) or a leafy material (parsley, mint, oregano, or marijuana) and smoked.
- PCP is also readily absorbed through the skin.
- In its liquid form, PCP is packaged and stored in small vials or other small glass containers.

Street names -

- “angel dust,” “crystal,” “supergrass,” “killer weed,” “KJ,” “sherms,” “embalming fluid,” “hog,” and “rocket fuel.”

Effects -

- The effects are as variable as its appearance;
Scrambles stimuli within the brain and alters how the user perceives and deals with the environment. 

It can act as an anesthetic, stimulant, and/or hallucinogenic drug. 

Moderate amounts can produce a sense of drowsiness, detachment, and estrangement or isolation from surroundings. 

Numbness, muscle rigidity, slurred speech or an inability to speak coherently, loss of coordination, and feelings of extreme excitement and invulnerability. A blank stare, rapid and involuntary eye movements (nystagmus), and an exaggerated gait. 

Some users may experience auditory hallucinations, double vision, image distortion (comparable to a funhouse mirror), a rise in blood pressure and heart rate, and profuse sweating. 

Severe mood disorders also may occur, producing in some users acute anxiety and a feeling of impending doom, in others paranoia and violent, aggressive behavior. 

**Overdose-**

PCP overdose can result in psychosis (delusional disorder, mood disorder), fever, convulsions, coma (often prolonged, from 12 hours to days), and death from respiratory repression.

**b. LSD**

First synthesized in 1938 

odorless and colorless substance derived from the ergot fungus that grows on rye and from a chemical found in morning glory seeds. 

Because LSD is so potent, the dosage can be incredibly small. 

A microscopic drop can be put on any absorbent material and swallowed. 

Generally sold in tablet or capsule form or placed into thin squares of gelatin (called “window panes”), paper (“blotter acid”), sugar cubes, chewing gum, hard candy, or crackers. 

**Street names-**

“acid,” “blotter acid,” “microdot,” “cubes,” “big D,” “trips,” “sugar,” “purple haze,” and “white lightning.”

**Effects-**

The duration of the hallucinogenic effect is commonly called a “trip,” 

This high can last from 2 to 12 hours. 

Physical effects include dilated pupils; elevated body temperature; high blood pressure; hallucinations; and a disoriented sense of direction, distance, and time. 

“Bad trips” can result in panic, paranoia, anxiety, confusion, and psychosis. 

**Overdose-**

Overdose can result in longer trip episodes, psychosis (delusional disorder, mood disorder, panic disorder), and potential death.
c. **Psilocybin and Psilocyn (Mushrooms)**

- Mushrooms have been used for centuries in traditional North American Indian religious rites.
- Affects mood and perception in a manner similar to that of LSD.
- Active ingredients, psilocybin and psilocyn, are chemically related to LSD.
- These mushrooms can be chewed, smoked, or infused in hot water to make tea.

**Effects-**
- The effects of mushroom ingestion may include dilated pupils, sweating, hyperventilation, rambling speech, hyperactivity, increased blood pressure, elevated temperature, vomiting, and tremors.
- Users may experience impaired memory or attention span, anxiety, paranoia, depression, panic, delusions, and hallucinations.

**Overdose-**
- Overdose can result in longer trip episodes, psychosis, and potential death.

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H. **Cannabis**

- Cannabis refers to the Indian hemp plant, *Cannabis sativa*.
- The ingredient responsible for its psychoactive effect (the high) is THC, which is concentrated in the resin of the plant.
- Most of the resin is found in the flowering tops, with less in the leaves, and almost none in the fibrous stalks.
- The amount of THC determines the potency of the drug. Both marijuana and hashish are produced from the hemp plant.
**Paraphernalia**
- Cigarette papers (e.g., “ZigZags”), small wooden or clay pipes, water-filled pipes (called “bongs”), plastic bags, “roach clips” (small clips that may be made from tweezers, electrical clips, or other items to hold a partially smoked marijuana cigarette), and decorative boxes (“stash boxes”) designed to conceal and store the drug.

**Effects**
- In low doses, cannabis can induce restlessness and a dreamy relaxed state
- Stronger doses can cause shifting sensory images, rapidly fluctuating emotions, and hallucinations or image distortions.
- Physical effects include red or bloodshot eyes, dryness of the mouth and throat, increased appetite, impaired muscular coordination, increased heart rate, and lowering of body temperature.
- Users may exhibit intensified concentration on their surroundings, reduced reactions, decreased ability to concentrate on tasks, an altered sense of time, impaired short-term memory, meaningless giggly conversation, anxiety, and psychological dependency.

**Overdose**
- Overdose can result in fatigue, paranoia, and possible psychosis/mental disorder (delusional disorder).

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**a. Marijuana**
- Marijuana consists of the leaves, flowers, stems, and seeds of the Indian hemp plant, which are dried and crushed or chopped into small pieces.
- Marijuana appears on the street as a greenish or brownish material that may be full of seeds or stems, or it may be cleaned and “manicured” (seeds and stems removed).
- Usually is sold and stored in plastic bags, aluminum foil, or small hand-rolled cigarettes called “joints” or “reefers.”
- Generally smoked in cigarettes or in pipes
- Has a strong, pungent odor when ignited.
- Can be blended into food and then cooked and eaten.
- The average period of intoxication following use of one marijuana cigarette is approximately 2 hours, although the residual chemicals may remain in the body for up to 1 month.
I. **Inhalants**
- Inhalants are a diverse group of substances that normally may not be thought of as drugs.
- Most are legal substances found in everyday household products, and they are sniffed or inhaled.
- Fumes from aerosol sprays such as spray paint, hair spray and cleaning fluid as well as hydrocarbons such as model airplane glue, gasoline, paint thinner, and dry cleaning solution may be abused.

**Paraphernalia-**
- Paraphernalia associated with abuse of inhalants may include spray cans, glue containers, and saturated cloths.

**Effects-**
- Effects of inhalant use include dilated pupils, runny nose, watery eyes, loss of coordination, slurred speech, stupor, and vomiting.
- Users may experience a buzzing sensation in the ears, dizziness, severe headache, double vision, drowsiness, lightheadedness, loss of memory, and weight loss.

**Overdose-**
- Overdose can result in CNS system depression or cardiac arrhythmia.

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J. **Stimulants**
- Stimulants are drugs that stimulate the CNS and produce an increase in alertness and physical activity.
- Cocaine and amphetamines are two of the most widely abused stimulants.

  a. **Cocaine**
The most potent stimulant of natural origin, cocaine, is extracted from the leaves of the coca plant (*Erythroxylon coca*).

This plant has been grown since prehistoric times in the highlands of the South American Andes, where its leaves are chewed for refreshment and relief from fatigue.

Pure cocaine, the principal psychoactive ingredient, was first isolated in the 1880's.

Cocaine is usually distributed illicitly as an odorless white crystalline or chunky powder (cocaine hydrochloride).

Sometimes, other substances (baking soda, sugars such as lactose and mannitol, or local anesthetics such as lidocaine) are used to “cut” cocaine in order to dilute the drug and increase the quantity for sale.

Most often, cocaine is sold in aluminum foil, plastic or paper packets, or small vials.

Cocaine may be inhaled into the nose.

Powdered cocaine also can be dissolved in water and injected into the blood stream.

Conversion of powdered cocaine to cocaine base ("crack" or "rock" cocaine) yields a substance that can be heated and smoked.

This cocaine base, in the form of white or tan pellets, chips, chunks, or "rocks," is vaporized in a pipe or smoked with plant material, such as marijuana, in a "geek joint."

When smoked, “crack” cocaine makes a crackling sound when ignited.

Street names-


Paraphernalia-

- mirrors, razor blades, and straws;
- syringes, needles, spoons, cotton, and tourniquets (bandannas, belts, or surgical tubing used to constrict the veins);
- Triple beam scales are used by dealers to weigh the drug.
- glass pipes (base pipes), homemade pipes such as used beer or soda cans, and small vials used to sell and store the drug.

Effects-

- The high from a typical snorted dose of cocaine lasts about 20 minutes.
- During the high the user appears very alert, confident, and energetic.
- He/she may experience decreased inhibition and the perception of more acute hearing.
- Physical signs include dilated pupils, runny nose, rapid speech, more active reflexes, accelerated heart rate, elevated respiration rate, higher body temperature, tremors, sweating, itching, and little or no appetite.
- The high is followed by depression, an intense desire for another dose, mental fatigue, restlessness, and irritability.
- Chronic users may experience severe weight loss, paranoia, depression, and hallucinations, particularly about having bugs on or under their skin.
- Crack cocaine is absorbed into the blood stream through the lungs in just a few seconds, and the user experiences a brief but intense period of extreme euphoria, alertness, and increased energy.
- However, the Crack high lasts only a few minutes, leaving a severe depression called a "crash" and an immediate desire for more of the drug.
- The intense craving associated with crack stems not only from a desire for the euphoria of the high, but also from a desire to escape the "crash."
- Often, alcohol, opioids, or sedative-hypnotic drugs are used to dampen the severity of these symptoms.

Overdose-

- A cocaine overdose can result in extreme agitation, convulsions, respiratory failure, heart failure, stroke, coma, or death.
b. **Amphetamines**

★ Amphetamines were first used medically in the mid-1930s to treat narcolepsy.
★ Currently they are used primarily in the treatment of obesity in adults and attention deficit disorders with hyperactivity (ADDH) in children.
★ Pharmaceutical amphetamines include Dexedrine© (capsules, tablet, and liquid); Dexamyl© (capsules, tablets, liquid); Benzedrine© (capsules, tablets); Eskatrol© (capsules); Biphetamine© (capsules); Desoxyn© (tablets); Preludin© (tablets); and Ritalin© (tablets).

**Street names**-
★ “Uppers,” “pep pills,” “bennies,” “dexies,” or “black beauties”
c. **Methamphetamine**

- Methamphetamine is a powerfully addictive stimulant that dramatically affects the central nervous system.
- The drug is made easily in clandestine laboratories with relatively inexpensive over-the-counter ingredients. These factors combine to make methamphetamine a drug with high potential for widespread abuse.
- A 2003 survey found that approximately 12.3 million Americans ages 12 and older, or 5.2% of the population, reported trying methamphetamine at least once during their lifetimes.
- The 2003 survey also showed that approximately 1.3 million (0.6%) reported methamphetamine use in the past year and 607,000 (0.3%) reported using methamphetamine in the past month.
- It is a white, odorless, bitter-tasting crystalline powder that easily dissolves in water or alcohol.
- The drug was developed early in this century from its parent drug, amphetamine, and was used originally in nasal decongestants and bronchial inhalers.
- The chemical structure is similar to that of amphetamine, but it has more pronounced effects on the central nervous system.
- Like amphetamine, it causes increased activity, decreased appetite, and a general sense of well-being.
- Methamphetamine is a Schedule II stimulant, which means it has a high potential for abuse and is available only through a prescription that cannot be refilled.
- Can be swallowed, inhaled through the nose, smoked, or injected.
- Sold in small plastic or paper packets or in plastic bags.
- “Ice” is a smokable form of methamphetamine.
- The street term “Ice” refers to the drug’s transparent appearance.
  - Shiny crystals may be as small as rice grains or as large as peas. Although it is usually smoked, Ice can be injected or ground into a powder and snorted.

**Street names**

- “speed,” “meth,” “moth,” “crank,” “water,” “crystal” or “crystal meth;” Ice is also known as “ice cream,” “batu,” or “shabu.”

**Effects**

- The physical effects of amphetamines include increased alertness, hyperactivity, euphoria, appetite loss, dilated pupils, rapid speech, accelerated heart rate, increased respiration, and elevated body temperature.
- Other symptoms may include acne that resembles a measles rash, dry mucous membranes, sweating, headache, insomnia, and restlessness.
- Blurred vision, hallucinations, dizziness, loss of coordination, insomnia, anxiety, paranoia, mood swings, dramatic weight loss, malnutrition, and collapse can occur following prolonged use.
- The effects of methamphetamine can last 6 to 8 hours. After the initial "rush," there is typically a state of high agitation that in some individuals can lead to violent behavior.
- There are a few accepted medical reasons for its use, such as the treatment of narcolepsy, attention deficit disorder, and - for short-term use - obesity; but these medical uses are limited.
- After cessation of extended use, withdrawal symptoms often occur.
  - Signs include profound depression, apathy, fatigue, long periods of sleep, a lingering impairment of perception, disorientation, and anxiety.
- Alcohol, opioids, or sedative hypnotics frequently are used to dampen the severity of these withdrawal symptoms.

**Overdose**
Overdose of amphetamines can result in convulsions, high blood pressure, coma, stroke, heart failure, and death.

- Paraphernalia -
1. LIST 3 DRUGS THAT CAN BE USED INTRAVENOUSLY.

_______________________  ________________________  _______________________

2. Amphetamines were first used medically in the mid-1930's to treat what?
   a. high blood pressure  b. narcolepsy  c. mood swings

3. Withdrawal from ________________________________ should be treated as a medical emergency. Withdrawal can lead to convulsions, delirium, and, in some instances, death; therefore, medical supervision is often required.
1. Substance Abuse and Mental Health Services Administration
   SAMHSA
   www.drugabusestatistics.samhsa.org/

2. Treatment Facility Locator – SAMHSA
   www.findtreatment.samhsa.gov/

3. Center for Substance Abuse Treatment

4. National Institute of Drug Abuse
   www.nida.nih.gov/

5. Office of National Drug Control Policy (ONDCP)
   www.whitehousedrugpolicy.gov/statelocal/ok

6. Drug Court Programs Office
   www.dcpo.gov/

7. Addiction Studies Program for Journalists
   www.addictionstudies.org/links.html

8. Oklahoma Department of Mental Health and Substance Abuse Services
   www.odmhsas.org

9. Oklahoma DHS Employee Assistance Program
   http://s99web01/eap

10. Physicians Desk Reference
    http://pdr.net/HomePage_Template.jsp
X. CHILDREN OF CHEMICALLY INVOLVED PARENTS: SPECIAL RISKS (Discuss if Time Permits)

This section describes the health and development of children exposed prenatally to alcohol and/or other drugs. The neurodevelopmental consequences of such exposure, particularly in the long term, are not all known. Research is currently being conducted to help us better understand these consequences. In discussing the common health concerns and developmental patterns that have been observed in this population, it is important for professionals to consider the following issues:

K. Polysubstance abuse-
- Most substance abusers use multiple drugs or drugs and alcohol in combination.
- In some cases, this polysubstance abuse may occur without the user's knowledge - it is common practice among street dealers to substitute drugs and to “cut” the purity of illicit substances with a variety of adulterants.
- Although parents may report use of only alcohol, nicotine, or a single drug, such statements regarding drug and alcohol use during pregnancy are often unreliable, in part because of parental inaccuracy in recalling their actual drinking or drug use during periods of intoxication.

B. Range of outcomes-
- Any use during pregnancy potentially can affect fetal health and well-being.
- There are no known “safe” levels of prenatal drug and alcohol.
- However, among infants who have been prenatally exposed to these substances, a wide range of health and developmental patterns have been observed.
- There is a broad continuum of effects of prenatal drug and alcohol exposure (varying from severe to mild to no apparent effect), outcomes for individual children cannot be predicted.

C. Environmental impact-
- Children in substance-abusing families are at double jeopardy—they are both biologically and environmentally at risk.
- The interplay between biological and environmental factors is extremely significant because biological problems can be exacerbated or mitigated by environmental influences.
  - For example, a home environment that is responsive and nurturing can help reduce the negative developmental effects of low birth weight.
  - On the other hand, an environment that does not provide adequate nurturing can increase the risk of negative developmental outcomes associated with low birth weight.

D. Limitations of research-
- Most documentation about the serious side effects of prenatal exposure in infants and children has been noted in cases of alcoholic and drug-dependent mothers.
- Little is known regarding the effects of experimental or sporadic drug and alcohol use during pregnancy
  - In part because the identification of occasional users is much more difficult.
- Concerns about individual children need to be discussed with the child's pediatrician, a child psychiatrist, other health care providers, family members, and any other professionals who are involved in providing care.
XI. NEONATAL AND INFANT COMPLICATIONS

- There are a number of pediatric medical complications associated with prenatal substance abuse.
- Neurological disturbances, prematurity, infectious diseases,
- Fetal Alcohol Syndrome (FAS), Sudden Infant Death Syndrome (SIDS),
- Failure to thrive (FTT), intrauterine growth retardation (IUGR),
- Central nervous system (CNS) disorders.

A. Fetal Alcohol Spectrum Disorder (FASD) - slide 96
- An umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities.
  - Bertrand et al, 2004

B. Fetal Alcohol Syndrome (FAS) - slide 97
- The diagnosis of FAS is based on three factors:
  - Prenatal and postnatal growth retardation, including low birth weight
  - Microcephaly (abnormally small head) - CNS Abnormalities
    o including intellectual impairment,
    o developmental delays,
    o behavior dysfunction,
    o neurological abnormalities;
  - Abnormalities of the face

C. Alcohol-Related Neurodevelopmental Disorder (ARND) and Drug Related Neurodevelopmental Disorder (DRND) - slide 104
- Replaces Term FASD (Fetal Alcohol Spectrum Disorder)
  - Used child does not meet all 3 of the criteria for FAS?
Children with a confirmed history of prenatal alcohol exposure, who demonstrate central nervous system abnormalities, including small head size, and has evidence of a complex pattern of behavior and cognitive abnormalities are diagnosed with Alcohol-Related Neurodevelopmental Disorder (ARND) and/or Drug Related Neurodevelopmental Disorder (DRND).

- As the child matures, problems with:
  - learning, attention, memory, and problem solving are common, along with coordination, impulsiveness, and hyperactivity.

- Facial characteristics associated with FAS include:
  - small eyes, short eye openings, epicanthic folds, flat upturned nose, indistinct philtrum (groove in the midline of the upper lip), thin upper lip, crossed eyes, droopy eyelids, and malformation of the external ear.

- Careful monitoring of growth as well as screening for any additional physical problems that may accompany either FAS or ANRD is required for all affected children so that appropriate services can be provided.

- Involvement in an early intervention program designed for children with special needs is also recommended for children who exhibit developmental delays.

~ DISCUSSION ~

Dr. Ira Chasnoff with the Children’s Research Triangle in Chicago, IL, is currently one of the leading researchers of prenatal exposure to drugs and alcohol.

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~ Discussion ~

Often children with undiagnosed ARND or DRND (Drug Related Neurodevelopmental Disorder) are diagnosed with ADHD and placed on the usual medications to help control their behaviors.

- Given the plausible common neurological basis of ADHD and prenatal drug/alcohol exposure, it may be difficult to differentiate between the behaviors of children with known prenatal exposure and children who are diagnosed with ADHD.

- It is very important to understand that due to the biological causes of ARND and DRND, the medications prescribed to children who have ADHD as a result of prenatal drug or alcohol exposure may not effect these children in the same manner that they will effect children who have genetic ADHD.
In working with a child that has ADHD whose medications do not appear to be effective, Professionals (Child Welfare Workers and Doctors) should examine the possibility that the child may have been exposed prenatally to drugs or alcohol. In this event the use of other medications might need to be explored.

XII. THE CHILD AT RISK - LIST OF CHARACTERISTICS  slide 105-107

A. Developmental Characteristics
- Has difficulty organizing play
- Show less self-initiation
- Less follow through in play, learning and self help activities
- More distracted and less focused than peers
- Difficulty with special relationships
- Motor coordination is poor
- Sporadic memory (needs to relearn again and again)
- Low stress threshold
- Over reactive to stimuli
- Lack close relationships with adults

B. Behavioral Characteristics
- Exhibits behavioral extremes
- Easily overly stimulated
- Low tolerance for change
- Constantly testing the limits
- Difficulty in reading social clues
- Difficulty with peer relationships

C. Learning Characteristics
- Language delays
- Sporadic mastery of perceptual-spatial-motor tasks
- Inconsistent problem solving strategies
- Auditory processing and word retrieval difficulties
- Decreased capacity to initiate and organize play
- Decreased focused attention and concentration

All of these characteristics must be weighed against a careful consideration of the child’s ethnic, cultural, and unique family background and experiences.

Adapted from: Schools Meet the Challenge: Educational Needs of Children at Risk Due to Prenatal Substance Exposure. Marie K. Poulsen, PhD

XIII. MEDICAL FOLLOWUP RECOMMENDATIONS  slide 110-114

- All newborns who have been prenatally exposed to alcohol or other drugs require careful medical follow-up.
- Below is an array of medical conditions that are not infrequently present in children who were prenatally substance-exposed and that require careful observation.
- Pediatric well-baby care should be provided more frequently than is customary with infants and children.
An initial appointment should be made with the child's pediatrician within 2 weeks after discharge. Subsequent well-baby appointments should be scheduled at 1, 2, 4, 6, 8, 10, and 12 months.

- This increased frequency is desirable in order to give parents/caregivers increased support and to provide needed anticipatory guidance.
- Frequent medical follow-up also enables better monitoring of a child's ongoing physical care.
- Pediatric well-baby care is especially critical for medically fragile infants. In addition to subspecialty follow-up, such infants also require regular well-baby follow-up with a primary physician to ensure appropriate immunizations and preventive health care services.

- Supportive follow-up services, including home visits, parenting education, and counseling are essential to maintain and enhance the parent-child relationship.

~ DISCUSSION ~

The University of Oklahoma Health Sciences Center, Child Study Center currently has several programs available to work with children exposed prenatally to drugs and alcohol and their families from birth to age 7.

*The Oklahoma Infants Assistance Program (OIAP).* The OIAP is a comprehensive treatment program for children from birth to age 6 who were prenatally exposed to alcohol or other drugs. It is funded by a grant from the Children's Bureau, a division of the Administration on Children, Youth and Families of the Department of Health and Human Services. OIAP is directed by Sharon Simpson, PhD.

*The Oklahoma Parenting Project (OPP).* The OPP is a program for the parents of infants who were prenatally exposed to cocaine. It was designed by a committee from the Center on Child Abuse and Neglect, the Oklahoma Department of Human Services, and the Oklahoma County Juvenile Court. It is funded by a grant from the Oklahoma Department of Human Services and is directed by Sharon Simpson, PhD.

*A Better Chance,* directed by Robin Gurwitch, PhD.

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XIV. TREATMENT INTERVENTIONS

A. SEIZE THE MOMENT

★ “The Moment” is when someone is ready to change.
★ Chemically dependant people have many “moments.”
★ When someone hits their “bottom,” they may experience “the moment.”
★ Some “bottoms” are higher than others, depending on the person.

B. ASSESSMENT TOOLS

1. SASSI -
   ★ Must be certified to administer
   ★ Quick and easy to administer
   ★ Psychological screening measure
   ★ Used to identify high probability/low probability of having a substance use disorder
   ★ The Adult version 93% accurate
   ★ The Adolescent 94% accurate
   ★ Both versions are composed of face valid items as well as subtle items that do not address substance misuse in a direct or apparent manner.
   ★ The intent is to be able to identify some substance dependent individuals who may be unable or unwilling to acknowledge relevant substance-related behavior.
   ★ Some clinical inferences suggested by examining SASSI profiles include:
      ★ Indication of defensiveness
      ★ Level of insight and awareness of the effects of substance misuse
      ★ Evidence of emotional pain
      ★ Relative risk of involvement with the legal/judicial system

2. ASI – Addiction Severity Index
   ★ Must be certified to administer.
   ★ Assessment instrument administered in a semi-structured interview in one hour or less to patients who present for substance abuse treatment.
   ★ Gathers information about 7 areas of a patient’s life:
      - medical - employment/support – drug/alcohol use – legal
      - family history - family/social relationships - psychiatric problems.
   ★ Uses a ten point scale from 0 to 9 to indicate the degree of patient problems in each area, based on historical and current information.
   ★ Many treatment agencies use this as one of their screening/assessment “tools.”

3. MAST
   ★ The Michigan Alcohol Screening Test (MAST) is a simple and widely used screening instrument for the detection of alcoholism in adults.
   ★ 25 face-valid questions that require a simple "yes" or "no" answer
   ★ The MAST focuses on the consequences of problem drinking and on the subjects’ own perceptions of their alcohol problems. It has been widely used in a variety of settings with varied populations
   ★ The MAST can be self-administered or administered by an interviewer and takes approximately 10 minutes to complete.
   ★ No training is required for administration.

4. CAGE
   ★ No training is required for administration.
   ★ Simple questionnaire.
Have you ever tried to \textit{cut down} on your drinking?

Have you ever become \textit{annoyed} when told you were drinking too much?

Have you ever felt \textit{guilty} about your drinking?

Have you ever needed an \textit{eye-opener} in the morning?

5. NET
   ★ No training is required for administration.
   ★ Simple questionnaire.
   ★ Do you consider yourself a \textit{Normal} drinker?
   ★ Have you ever needed an \textit{Eye-opener} in the morning?
   ★ How many drinks does it \textit{Take} to get you high? \textit{(tolerance)}

6. T-ACE
   ★ No training is required for administration.
   ★ Simple questionnaire.
   ★ How many drinks does it take to get you high? \textit{(tolerance)}
   ★ Have you ever become \textit{annoyed} when told you were drinking too much?
   ★ Have you ever tried to \textit{cut down} on your drinking?
   ★ Have you ever needed an \textit{eye-opener} in the morning?

7. 4-P’s Plus – Research indicates ideal for use with Pregnant Women
   ★ No training is required for administration.
   ★ Simple questionnaire.
   ★ \textit{Parents} - Did either of your parents ever have a problem with alcohol or drugs?
   ★ \textit{Partner} - Does your partner have a problem with alcohol or drugs?
   ★ \textit{Past} - Have you ever drunk alcohol?
   ★ \textit{Pregnancy} -
     ○ In the month before you knew you were pregnant, how many \textit{cigarettes} did you smoke?
     ○ In the month before you knew you were pregnant, how many \textit{beers} did you drink?

**There are other “FREE” Assessment tools that you can learn about and use with your clients.**

C. AREAS OF ASSESSMENT

★ Appropriate planning and intervention with substance-abusing families begins with a careful assessment of a number factors
  ○ infant/child
  ○ parental
  ○ and environmental.

★ It is the combination and interaction among these factors that can help the worker evaluate the child's safety in the home and determine the types of services needed by the family.

★ The following factors should be explored as part of a comprehensive family assessment.

1. Assessment of the Infant and Child
   ★ Children prenatally exposed to alcohol and other drugs, and children living with substance-abusing parents are vulnerable populations.
   ★ Often, such children are both biologically and environmentally at risk of developmental lags; many have special needs.
a) **Infant Assessment**

Because the minimum standards for adequate parenting may be higher for an infant prenatally exposed to drugs, it is especially important for the worker to assess carefully the infant's health and care requirements.

In assessing the infant's needs consider the following:
- Does the newborn exhibit symptoms of drug exposure? (These may occur within several hours of birth, although some newborns may not show symptoms until much later.) Of particular concern are infants who have diarrhea, sleep poorly, are lethargic or irritable, or are on medication for drug-related symptomatology.
- Were toxicology screens conducted? When were they conducted? What were the results?
- Was the infant born prematurely (before 37 weeks of gestational age)? Symptoms related to prenatal substance exposure may be masked by the infant's degree of illness or the immaturity of the CNS.
- Will the infant require special medication and/or equipment such as an apnea monitor or oxygen?
- Does the infant have medical or physical problems that could significantly impact critical life functions or long-term physical and intellectual development?
  - For example, does the infant have a cardiac defect, seizures, or other congenital anomalies?
  - Will the infant require close medical monitoring and frequent pediatric visits?

If so, does it appear that the parents' substance abuse may interfere with their ability to provide the needed level of care and to obtain the medical follow-up required?

b) **Child Assessment**

Often, the basic care of children is inadequate in households with chemically involved caregivers.

In comparison with the general population, child maltreatment occurs with greater frequency in substance-abusing families.

Professionals should consider the following:
- How many children are there in the home? What are their ages?
- With whom do the children spend most of their time? What are their activities as well as their relationships with their parents, peers, and other adults?

Chemically involved parents/caregivers frequently provide inadequate supervision. Without appropriate parental oversight, young children are at increased risk for victimization and injury.

- Are there adequate and appropriate supplies and provisions for the children?
- Are the children receiving ongoing health care?
- Do any children have chronic illnesses?
- Are immunizations current?
- Are there any untreated medical conditions?
- Do any children have histories of prior injuries, and if so, were these accidental or inflicted?
- Are the children's growth patterns within expected ranges or is there evidence of failure to thrive?

Are the children enrolled in school? Do the parents meet with school personnel when indicated? Do the children generally appear clean and appropriately dressed when they go to school?

How are the children functioning academically?
When a chemically involved family has had repeated disruptions in daily routine or frequent changes of address, the children may have missed much school or had to change schools often. Because learning deficits and short attention spans may occur as a result of prenatal substance exposure or environmental instability, it is important to assess all children living in the home with respect to these problems. Children may appear to be physically healthy but may nonetheless have developmental and educational deficiencies. Because role reversal is common in chemically involved families, has a child assumed the role of a parent by performing adult caregiver tasks? Careful observation of all children in a chemically involved family is essential in assessing and planning for the family as a whole, and for making appropriate health care and educational referrals for the children.

c) Assessment of the Parent  slide 129

It is imperative that workers learn to recognize, identify, and assess for substance abuse and to determine how substance abuse is perceived within the family and within the context of the family's culture. Only then can they develop a service/treatment plan that is appropriate to the needs of the family. As part of the comprehensive assessment, the following parental factors should always be evaluated:
- substance abuse history,
- drug and alcohol treatment history,
- health and health care,
- mental health and history of psychiatric treatment,
- criminal history,
- level of cooperation,
- awareness of the impact of alcohol and other drug use on the child,
- parenting skills and responsiveness to the child,
- history of abuse and/or neglect,
- work history and education.

1. Substance Abuse History

Exploring a parent's history of alcohol or other drug use provides the worker with an understanding of the chronicity of the problem, and also helps in determining which treatment resources are most appropriate for individual parents. Although the information obtained during an initial interview may not be complete, talking with parents over time frequently reveals accurate information regarding substance abuse. Communication with members of the extended family, significant others, and professionals from other agencies can be particularly helpful in gathering a parent's substance abuse history.

For many reasons, parents frequently deny the length and severity of their drug or alcohol use. In assessing a suspected alcohol and/or other drug abuse problem, it is important to keep questions open-ended and assume use in order to elicit more realistic responses. The following are possible questions a worker might ask to gather information about patterns of use and the parent's perceptions about use:

- How often do you drink beer, wine, liquor?
- How many drinks do you generally have when you are drinking?
Do you remember how old were you when you had your first drink?
When do you tend to want a drink - when alone or with others?
If you drink with others, with whom? When bored or when you want to “party”? When you are angry, frustrated, or stressed?
What drugs have you tried?
How often do you use?
How do/did you use/take it?
How long have you been using? How long did you use?
How much do you smoke?
When do you usually want a cigarette?
When you were pregnant, what was your drinking/use like?
How does your behavior change when you drink/use?
How do you feel when you drink/use?
What impact has alcohol and/or other drug use had on your health?
What legal problems have you encountered as a result of your alcohol and/or drug use?
How has the use of alcohol and/or other drugs affected your employment?
How has your use of alcohol and/or other drugs affected your relationships?
Has the use of alcohol and/or other drugs resulted in violence or abuse?
What concerns do you have about your use of alcohol and/or other drugs?

It is also helpful to assess the impact of use on the family, since this information can be used in developing an effective intervention plan.

The following are areas a worker can explore with other family members to gather information about a parent's alcohol and/or other drug abuse problem:

- How do family members view alcohol and/or other drug use?
- Do family members deny use and/or its impact?
- Do family members drink alcohol and/or use drugs?
- Do family members express worry about the user?
- Do family members feel tense, anxious, or overly responsible?
- Are family members angry with the user?
- Do children in the family exhibit adult behaviors or assume adult parenting roles?

2. **Drug and Alcohol Treatment History**

Workers also need to explore parents' attempts at substance abuse treatment in order to understand how parents have dealt previously with their abuse of alcohol or other drugs.

Obtaining the parents' treatment history helps ensure that current treatment referrals will be appropriate.

- For example, parents who have been repeatedly unsuccessful in outpatient treatment may benefit more from a referral to a residential setting than from a referral to yet another outpatient program.

Workers should determine the following:

- Have the parents ever been in a drug or alcohol treatment program?
- If so, where and for how long?
- What was the motivation for seeking treatment, and what were the circumstances under which the parents left treatment?
- Any indication of motivation should be pursued as a possible strength.
- For parents currently participating in a treatment program, what is the frequency and extent of their participation?
Some parents, for example, may attend a treatment program only sporadically, whereas others may attend regularly but still continue to abuse drugs or alcohol. Other parents may be appropriately engaged in treatment.

- In evaluating compliance, it is important to remember that, although the parents' participation may provide a clue to their level of commitment, it also may indicate the need for different or supplemental treatment approaches.

3. Health and Health Care

- Often, substance-abusing parents have health problems related to their alcohol and other drug use.
- Such problems can adversely affect the parents' ability to care for both themselves and their children. Thus assessing the following is important:
  - What is the parents' general state of health? Are there any untreated medical problems or chronic illnesses?
    - Chemically involved parents are at high-risk for communicable diseases such as tuberculosis and sexually transmitted diseases, including acquired immunodeficiency syndrome (AIDS), and may need to be referred for medical evaluations.
  - If medical care is needed, does the parent have financial and logistical access to services?
    - In situations of perinatal substance abuse, the worker should determine whether prenatal care or drug treatment services were available to the mother during pregnancy.
    - It then is important to learn whether the mother obtained regular and consistent care; this information can reflect a parent's ability to use health care systems and also may be an indicator of the mother's ability to plan and obtain appropriate medical care for her infant.
    - In this respect, it is important to communicate with health clinic personnel or private physicians who may have treated a mother during pregnancy.
    - Although it would be of concern if a mother had obtained no prenatal care, this information could be viewed quite differently if the woman had sought services and none existed, or if services were difficult to access.

4. Mental Health and History of Psychiatric Treatment

- Parental mental health problems require careful evaluation but may be difficult to assess due to current intoxication or chronic substance abuse.
- Identification and assessment for coexisting psychiatric problems is essential for appropriate case management.
- In evaluating mental status, it is imperative for professionals to determine the following:
  - Have the parents ever obtained assistance from a mental health counselor? Have they ever been hospitalized for psychiatric reasons?
  - If so, the history of hospitalization, length of stay, and reasons for admission should be explored.
  - Have psychotropic medications been prescribed for the parents?
  - If so, why were they prescribed, and are the parents currently taking the medications?
- This information is particularly relevant to making an appropriate substance abuse treatment referral because some chemical dependency treatment programs may be reluctant to accept clients who are currently taking psychotropic medications.
In addition, a lapse in taking necessary medications or the mixing of psychotropic medications with other substances may exacerbate psychiatric symptoms that can place a child at risk of maltreatment.
  o Do the parents have a history of violence toward others? Is there a history of domestic violence?
  o Substance abuse, psychiatric problems, and problems with impulse control can be closely intertwined.

**Discussion over “Self Medicating” behaviors.**

5. Criminal History

Because chronic substance abuse often entails contact with law enforcement agencies, reviewing a parent's criminal record is an important part of the assessment process. Workers should determine the following:
  o Does the parent have a criminal record? If so, what was the charge?
  o Is the parent currently on probation or parole?
  o Is the parent currently participating in a Drug Court or Mental Health Court?
  o Has the parent ever served time in jail or prison?
    ▪ Parental incarcerations mean that a child has been separated from a parent and also may have been left with nonparental caregivers.

Exploration of a criminal history can help workers gain further information about the parent's lifestyle and about unhealthy situations and illegal activities to which children in the family may have been exposed.

Further, information about how the family handled periods of incarceration (including visitation and reunification) can help workers determine family members' sensitivity to the child's feelings and need for security.

6. Level of Cooperation

Parents' willingness to work with professionals to strengthen the family and protect their children is of considerable importance.
  • A parent who initially seems disinterested, evasive, or hostile may, in fact, prove uncooperative with service/treatment plans.
  • A parent's initial uncooperativeness may also indicate feelings of guilt about substance abuse and defensiveness about the assessment process.
  • Parents may be angry or feel vulnerable because of the power differential between themselves and the professional, and they may perceive a loss of control.
  • Parents also may be fearful of legal consequences.
  • To evaluate cooperation, professionals should consider the following areas:
    o Does the parent verbalize a willingness to work with the agency?
    o Does the parent generally follow through with various aspects of the service/treatment plan?
  • Subsequent behavior and follow through are critical in accurately evaluating cooperation.
    o A parent may appear to be compliant and yet, in fact, may be unable or unwilling to meaningfully engage in the service/treatment plan.

7. Awareness of the Impact of Alcohol and Other Drug Use on the Child

It is important to assess parents' understanding of the relationship between their substance abuse and their children's care.
Parents' willingness to acknowledge the impact of their substance abuse may indicate their receptivity to services for themselves as well as for their children.

Workers should consider the following:
- If the parents were under the influence when the suspected child abuse or neglect occurred, do the parents acknowledge this relationship?
- Are they willing to make the changes necessary to avoid repeated injury or neglect?
- How have the parents provided for their children's needs in situations of relapse?
- It is helpful to determine whether parents have exercised the judgment to leave their children in the care of responsible relatives or friends, or whether the children have been left with strangers or brought along with the parents into dangerous situations.

In cases of prenatal substance abuse, how do the parents view the infant's symptoms?
- Initially, parents may deny that symptoms or developmental problems exist.
  - Although this initial denial can serve as a protective coping mechanism for parents, continual denial may interfere with the parents' obtaining needed services for their children.

8. Parenting Skills and Responsiveness to Child

Evaluation of parents' caregiving skills and responsiveness to their children's needs is a particularly critical aspect of the assessment process.

Because many chemically involved parents themselves were poorly parented as children, they may lack healthy role models for parenting their own children.

The worker can obtain much information by listening sensitively to parental comments and by observing parent-child interactions.

Such information can help the professional determine the need for parents' involvement in parenting education programs or individualized counseling.
- How do the parents react to the children's behavior?
- How do they provide praise and discipline?
- Are the parents' expectations age-appropriate?
  - When the parents' expectations are incongruent with the children's capacities or when parents are prone to extremes in physical discipline, the children's risk for abuse may be increased.
- How do the parents respond to their children's emotional needs?
  - For example, how do the parents respond to the children's crying? Do the parents and children make eye contact? For a hospitalized child, how frequent are parental visits?
- Such information may be used to determine the need for therapeutic counseling and educational services to strengthen the attachment between parent and child.

9. History of Abuse and/or Neglect

Chemically involved parents may already be involved with child welfare agencies, have children in foster care, or have suspected or substantiated histories of child abuse or neglect.

Workers need to determine the following:
- Have there been previous child abuse or neglect investigations, substantiated reports of abuse or neglect, and/or other children under juvenile court jurisdiction?
  - The facts surrounding these situations should be obtained and integrated into the total assessment so that plans and decisions can be made on the basis of long-term patterns rather than on the basis of an isolated and perhaps ambiguous situation.
- If the parents have other children in out-of-home care, what were the reasons for placement?
- What arrangements have been made to support parental visitation?
- What has the parents' level of participation with these children been?
- Do the parents phone or visit the children?
- Do they respond appropriately to their children and the foster parents during home visits?
- Have the parents ever visited while under the influence?

10. Work History and Education
   ★ Information regarding parents' work histories and educational backgrounds can help workers better understand the parents' level of literacy and survival skills, as well as the extent to which their substance abuse has had an impact on their day-to-day responsibilities.
   - What are the parents' occupations?
   - When were the parents last employed?
   - What are the parents' educational levels?
   - How do they describe their school years?
   - Do the parents have difficulty with reading, writing, and/or comprehension?
     - This is critical to understanding parents' ability to function within community programs and will help minimize barriers to appropriate treatment and services.

d) Assessment of the Home Environment
   ★ Environmental Conditions of the Home
   ★ Partners or Parent Substitutes Within the Home

e) Family Support Systems
   ★ Another important part of the assessment process includes learning about the family's support systems.
   ★ As a result of their substance abuse, some chemically involved parents lead isolated lives or have few friends, relatives, or contacts within community groups who can be helpful to them.
   ★ Parents who have more resources upon which to rely during difficult times are more often able to provide a "safety net" for their children.
   ★ Community and family supports are particularly significant for this population of vulnerable parents and children.
   ★ Workers should determine the following:
     - What are the parents' relationships with extended family, friends, and neighbors?
     - Do family members live in the area? Are they a source of support or stress?
     - Are the parents involved with a church, temple, or community or social group?
     - Is there a member of the clergy who can become involved in strengthening and counseling family members?
     - Are the individuals identified by the parents as supports alcoholics or involved with other drugs? (Workers can explore this factor by asking about these individuals' employment and lifestyle, as well as about the kinds of support they provide.)
     - How do relatives and friends support parental attempts to make lifestyle changes? Do they collude in the parents' denial?
   ★ In assessing the family support system, it is critical for the professional to talk with relatives and friends to determine their level of commitment and the circumstances under which they can be available to help and support the family.
Because of the intergenerational nature of substance abuse and child maltreatment, workers should also assess the following for out of home placements/kinship care:

1. Parenting Skills and History of Abuse, Neglect, or Violence
2. Alcohol and/or Other Drug Use
3. Quality of the Relationship With the Parent and Ability to Protect and Nurture the Child
4. Cooperation, Receptivity, and Access to Services

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XV. DIAGNOSTIC TESTING for DRUGS and ALCOHOL

A. ALCOHOL USE

- After drugs or alcohol have been ingested, they pass via the bloodstream to various parts of the body, such as the liver and kidneys, where they are converted into substances called metabolites.
- Different drugs and their metabolites leave the body at different rates affected by:
  - the amount of alcohol or other drug taken;
  - the frequency of use;
  - the user's daily liquid intake
  - health status
  - exercise
  - age
  - sex
  - body weight
  - metabolic rate
  - concurrent use of other drugs, including alcohol and/or nicotine.
- The most common tests for alcohol use include an evaluation of blood alcohol levels and a breath analyzer.
  - Both of these are routinely used to determine whether an individual is driving while under the influence.
  - Because alcohol passes rapidly through the system, these tests must be conducted very quickly in order to ensure any degree of accuracy regarding alcohol consumption.
  - For this same reason, the urine drug toxicology screens described below are generally not helpful in detecting alcohol use.

B. TOXICOLOGY SCREENING FOR DRUG USE

- Urine is the body fluid most commonly used for drug screening.
- For infants:
  - Meconium can also be used for toxicology screening
  - Compared with urine, the recovery rate and concentration of drug metabolites often are higher in meconium.
  - Can identify the substances the mother used throughout the 3rd trimester of pregnancy.
  - When doing this it is recommended that the entire excrement is collected and sent for testing.
Because the meconium is produced during the last 3 months of a pregnancy it is possible that some sections of meconium could possess drug metabolites while other sections might not.

- Depending upon how the meconium is collected depends upon how accurate the test results are.
- Collection of a newborn's first stool is not always possible because some meconium is eliminated during delivery.
- Is expensive and often results come back after the baby has been discharged from the hospital.

Hair analysis is another method currently being used to test for drug metabolites.

- Hair is reported to provide a longer term of history of drug use – 3 months of use.
  - Hair testing can be done on infants to determine the mother’s use pattern for the three months prior to birth.
- The urine screening methods can generally detect drug metabolites for 48 to 72 hours following drug use.
  - Drugs such as marijuana and phencyclidine (PCP) are fat soluble and are stored in fat, liver, lung, and brain tissue; these substances or their metabolites often can be found in the urine several days after use.
  - Other drugs such as cocaine and amphetamine are water soluble and are excreted from the body more rapidly.

When requesting and interpreting toxicology results, workers must remember the two types of testing procedures.

1. Screening Tests - such as thin layer chromatography (TLC) and immune assay tests (EMIT).
2. Confirmatory Tests - such as gas chromatography.

- Screening tests are highly sensitive, whereas confirmatory tests are more specific.
- Because screening tests may yield false positive results, it is recommended that, when a positive result is obtained with a general screening procedure, it be confirmed by a less sensitive but more specific confirmatory method.
- There may be considerable variation in what drugs are routinely included in the laboratory screening process.
  - Workers need to be specific in communicating to the lab what drugs they suspect the parent to be using and what drugs they would like the parent screened for.
- A negative toxicology result does not apply to a drug that was not included in the screen. For example, many laboratories do not routinely screen for PCP or marijuana. Thus, without a special request for PCP or marijuana screening, these substances, even if present in the urine, would not be identified.
- The quality of control over specimen handling and collection procedures greatly influence toxicology results. There are a number of ways to alter toxicology tests
  - providing someone else's urine
  - diluting the urine sample
★ It is important that the person collecting the urine sample monitor the specimen collection process closely.

★ Because test results also can be affected by water intake and temporary abstinence, random screening without prior notice may provide a more accurate indication of drug use.

★ When screening newborns, it is important to collect the first voided urine. Late collection of urine can yield negative results because metabolites may not be present at a level high enough for detection.

★ In cases of prenatal substance abuse, it is helpful to test both mother and newborn to provide an accurate picture of prenatal exposure.
  o It is unwise to rely exclusively on toxicology screening to identify use of illicit substances.
  o Rather - toxicology screening should be used in conjunction with history taking and observation for signs and symptoms to corroborate suspected use.
  o Toxicology testing during pregnancy and at the time of delivery can provide useful diagnostic information for health care purposes.
  o The results of toxicology screens often are used by hospital personnel as a part of a suspected child abuse report. Although they indicate use of, or exposure to, a substance at some prior time, positive toxicology test results do not substantiate child abuse.
  o It is also important to understand the “cutoff levels” when screening clients for drugs of abuse.
    o Some testing facilities will tell you if there were drugs present below the “cutoff level.”

Remember to ask about cutoff levels!!

C. SOMETHING TO CONSIDER: slide 141
★ With the delayed ability of the neonatal renal system to concentrate urine, concentration of the substance in the urine of a newborn may fall below the federally established threshold for detection.

★ A drug screen may report as negative even though the infant was exposed to significant amounts of a drug.

D. DETECTION PERIODS slide 142

<table>
<thead>
<tr>
<th>Substance</th>
<th>Blood</th>
<th>Saliva</th>
<th>Sweat</th>
<th>Urine</th>
<th>Hair</th>
</tr>
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<tbody>
<tr>
<td>Alcohol</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
<td>6-24 hrs</td>
<td>n/a</td>
</tr>
<tr>
<td>Amphet</td>
<td>Unknown</td>
<td>3 days</td>
<td>Unknown</td>
<td>1-4 days</td>
<td>Up to 90</td>
</tr>
<tr>
<td>Benz/Barb</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
<td>1-42 days</td>
<td>Unknown</td>
</tr>
<tr>
<td>Substance</td>
<td>Duration</td>
<td>Window</td>
<td>Method</td>
<td>Duration</td>
<td>Window</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
<td>--------</td>
<td>--------</td>
<td>----------</td>
<td>--------</td>
</tr>
<tr>
<td>THC</td>
<td>2-3 days</td>
<td>14hrs</td>
<td>Unknown</td>
<td>2-3 days</td>
<td>Up to 90</td>
</tr>
<tr>
<td>THC-frequent</td>
<td>2 weeks</td>
<td>14hrs</td>
<td>Unknown</td>
<td>Up to 12wks</td>
<td>Up to 90</td>
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<tr>
<td>Cocaine</td>
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<td>1 day</td>
<td>Unknown</td>
<td>4-5 days</td>
<td>Up to 90</td>
</tr>
<tr>
<td>Opiates</td>
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<td>7-21 hrs</td>
<td>Unknown</td>
<td>2-4 days</td>
<td>Up to 90</td>
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<tr>
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<td>Unknown</td>
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<td>8hrs</td>
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<td>Unknown</td>
<td>3-5 days</td>
<td>Up to 90</td>
</tr>
<tr>
<td>PCP</td>
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<td>3 days</td>
<td>Unknown</td>
<td>3-7 days</td>
<td>Up to 90</td>
</tr>
</tbody>
</table>

E. TAMPERING  

Clients will use “WHATEVER MEANS NECESSARY” to try and fool a drug test.

- Some examples of this are……..
- “Detox Pills - Detox pills work well with drug screens and drug tests. Detox pills will help clean out your system within just a few hours.”
- “Synthetic Urine, Synthetic Urine is the most failsafe method to pass a drug test or a drug screen. Synthetic urine is easy to use and made with discretion in mind.”
- Urine Luck...
- The “Whizinator”
- Drinking enormous amounts of water
- Drinking bleach
- Drinking pickle juice or vinegar
- Etc....................

XVI. APPROACHES TO INTERVENTION: IMPROVING THE ODDS

- Since the 1960's, the scope of the problem of substance abuse and its devastating consequences for families has become increasingly apparent. However, our understanding of the phenomenon of chemical dependency and what constitutes effective treatment for substance abusers and their children remains limited.
- Better information is needed about what treatment efforts are most successful in helping mothers and fathers to stop abusing alcohol and other drugs, what supportive services are most effective in helping chemically involved families stay together, and what approaches are most effective in promoting family reunification.
We also need to learn more about how to best intervene to help children whose health and development have been compromised by their parents' substance abuse, how to better support and encourage extended family care, and how to recruit and retain appropriate foster homes for children unable to remain with their parents.

These programs represent innovative and hopeful approaches for dealing with the complexities of parental substance abuse and demonstrate that chemically involved families can indeed be helped to become more functional with appropriate interventions and adequate resources.

It is important to remember that because of their unique needs, substance-abusing parents and their children often also require additional services or adaptations of conventional service approaches.

A. Utilizing Motivational Interviewing techniques when working with families

Four basic principles of Motivational Interviewing (MI) slide 148-151

1. Express empathy. This is the client-centered heart of MI.
2. Develop discrepancy. Elicit conflict between behavior and goals; the strategic heart of MI.
3. Roll with resistance. Do no harm. Use their momentum to help move them toward change.
4. Support self-efficacy. They must believe they can change.

1. Structure of MI

MI proceeds in two basic phases:
   I. Building motivation for change
      a. Opening strategies
         i. Ask open-ended questions
         ii. Listen reflectively
         iii. Affirm
         iv. Summarize
         v. Elicit change talk
      b. Special strategies
         i. Setting the stage
         ii. Providing feedback
         iii. Rolling with resistance

To locate more information regarding MI:
- Bill Miller's page: www.unm.edu/~psych/faculty/miller.html
- Stephen Rollnick's page: www.stephenrollnick.com
- HabitSmart's pages on MI, ambivalence and the Transtheoretical Model of Change: www.habitsmart.com/tip2.htm
- Info on NIAAA's Project MATCH: http://www.commed.ucd.edu/match/
- NOVA Southeastern Guided Self-Change Clinic: http://www.nova.edu/gsc/
- NOVA Souttheastern Guided Self-Change Clinic online materials: http://www.nova.edu/gsc/online_files.html
- The University of Rhode Island's Cancer Prevention Center: www.uri.edu/research/cprc/ (home of the URICA)

Slide 152
B. COMPREHENSIVE TREATMENT APPROACHES  slide 155-161

🌟 The Continuum of Treatment

🌟 Treatment is like a ladder with different levels of care.
🌟 Each rung is a different level.
🌟 The higher up the ladder-the more intensive the program.

1. Programs for Pregnant and Parenting Women with Children

🌟 Innovative treatment programs have been developed to address the specific and unique needs of pregnant and parenting women caring for young children.
These programs commonly provide health care, social services, and substance abuse treatment as well as a continuum of rehabilitative and case management services that focus on both the mother and the child.

In general, programs for pregnant and parenting women differ from traditional treatment modalities in several respects.

- First, key services are integrated to reduce the fragmentation that commonly occurs when families are involved with multiple agencies.
- Second, in contrast to conventional approaches that tend to emphasize the treatment needs of single males and use confrontational methods, programs for pregnant and parenting women commonly use a supportive approach that is family focused.
- For chemically involved women, the supportive approach is more effective in addressing their backgrounds, which often include physical and sexual abuse, as well as their shared feelings of low self-esteem and powerlessness.
- Programs for pregnant and parenting women also provide a wide range of ancillary services, including transportation and child care, to further reduce the logistical barriers that are known to prevent women from seeking treatment.
- Unlike conventional programs, model projects provide aggressive community outreach that commonly includes home visits and enhanced after-care to reduce recidivism.
- The range of services typically provided by model programs includes:
  - prenatal care (obstetrical services, health education, and nutritional counseling);
  - chemical dependency treatment (individual and family therapy, group counseling and support, urine testing, 12-step participation, and pharmacologic intervention);
  - parent education and training;
  - pediatric care (medical services, developmental testing, and psychological assessments);
  - social services (assistance with housing, legal, welfare, and basic survival needs); and
  - supportive services (onsite child care, transportation or bus passes, vocational counseling).

2. DETOX

- Determining Factors
  - Drinks more than a fifth of alcohol a day
  - Has medical complications
  - Has seizures
  - Long term, heavy and consistent use
  - Inability to go without using
  - Drug of choice (alcohol, heroin/opiates, prescription drugs)
  - Length of Stay 3-12 days

3. Residential Treatment

- Residential treatment facilities designed specifically for pregnant women and women with children allow mothers and children to remain together during the course of the family's treatment.
- As an intensive intervention modality, residential programs serve those chemically involved families with the most severe substance abuse problems and
the fewest social supports as well as those for whom outpatient treatment has proven unsuccessful.

★ For families involved with the child welfare system, residential treatment may offer an alternative to the children's out-of-home placement.

★ Through highly structured programming, residential treatment facilities attempt to promote lifestyle changes that support sobriety and healthier patterns of family interaction.

★ Although this intensive treatment approach is costly, in comparison with outpatient programs, residential care offers several important advantages for families. These include:
  - consistent, safe, and supportive environment for children
  - drug-free housing, and removal of the family from the destructive environments that may have contributed to or supported parental addiction.

★ Length of Stay – generally 28+ days

4. **Intensive Outpatient Treatment** - Sometimes called Day Treatment
   ★ Intensive Outpatient Treatment is designed for individuals who do not qualify for residential treatment but still need a higher level of care than normal outpatient treatment provides.
   ★ Intensive Outpatient generally consists of daily treatment that is not less than 9 hours per week.
   ★ Different programs are offered with an IOP program. Some of these programs are:
     - Early Recovery Skills, Relapse Prevention, Women’s Programs, Parenting Skills.
   ★ Length of Stay – 4 -6 weeks +

4. **Outpatient Treatment**
   ★ Outpatient Treatment is designed for individuals who have a stronger internal motivation than those individuals needing IOP.
   ★ This type of treatment is ideal for someone who has some understanding of addiction and recovery and has no medical risks for withdrawal complications.
   ★ For Outpatient Treatment to be effective individuals should have: stable housing, stable employment that is flexible with treatment schedules, and some structure in their lives.
   ★ Length of Stay – 4-10 weeks +

5. **Twelve-Step Programs**
   ★ *I can live my life only one day at a time.* . . . .
   ★ All 12-step programs are based on the principles and traditions of the original 12-step program created by Alcoholics Anonymous (AA).
   ★ AA is, to use the program's own language, “a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from alcoholism.”
   ★ AA is a peer support program with a strong spiritual foundation.
   ★ It uses the strength of the group and the wisdom of the 12 steps to encourage the kinds of behavioral and cognitive changes that can support the acquisition and maintenance of a sober lifestyle for both fathers and mothers.
   ★ The original 12-step programs for alcoholics have been adopted and adapted to the purposes of various other populations grappling with addictions, both their own and those of loved ones.
   ★ Other 12-step programs include:
Narcotics Anonymous (NA) is a 12-step program that was founded in the 1950's by and for people addicted to drugs other than alcohol.

- NA should not to be confused with NarcAnon, which is a separate program affiliated with the Church of Scientology.

AlAnon and Families Anonymous were developed to help family members cope with the addictions of parents, partners, children, and other loved ones and family members.

- AlAteen, Children of Alcoholics (COA), and AlAtot are programs for teenagers, school-aged children, and younger children whose parents are addicted to drugs and/or alcohol.
- Cocaine Anonymous (CA) is a support program for cocaine abusers.
- Adult Children of Alcoholics (ACA or ACOA) is a 12-step program for adult children of alcoholics.

Each of these programs is autonomous, but all share the same 12 steps and traditions, and all rely on the fellowship of the group and a commitment to anonymity as fundamental to recovery.

- There are 12-step programs in almost every community.
- There are no membership dues or charges are associated with attending meetings.
- Because the social characteristics of individual groups vary, workers are encouraged to attend open meetings to become familiar with the membership of the various 12-step groups within their local areas.

Length of Stay - LIFETIME

6. What treatments are effective for methamphetamine abusers?

- Long-term treatment of 12-36 months is recommended.
- Consider a Detoxification program followed by Inpatient then Outpatient treatment.
- 12 meetings in a healthy environment can assist the client in developing sober relationships.
- At this time the most effective treatments for methamphetamine addiction are cognitive behavioral interventions.
- These approaches are designed to help modify the patient's thinking, expectancies, and behaviors and to increase skills in coping with various life stressors.
- Methamphetamine recovery support groups also appear to be effective adjuncts to behavioral interventions that can lead to long-term drug-free recovery.
- Antidepressant medications are helpful in combating the depressive symptoms frequently seen in methamphetamine users who recently have become abstinent.
- Acute methamphetamine intoxication can often be handled by observation in a safe, quiet environment.
- In cases of extreme excitement or panic, treatment with antianxiety agents such as benzodiazepines has been helpful, and in cases of methamphetamine-induced psychoses, short-term use of neuroleptics has proven successful.

7. Grandparent Support Groups

- You'd think it's time for me to enjoy my life and work and eventually get my little pension. . . . But I'm stuck with children all over again.
- Increasingly, grandparents are caring for grandchildren.
- In many instances, those grandparents are elderly or have health problems that limit their stamina or restrict their mobility.
- Many also live on fixed incomes and have few resources for providing for their grandchildren's special needs.
- Even middle-aged grandparents, however, frequently find themselves overwhelmed by the responsibility of assuming full-time care for a young child.
To assist these caregivers cope with this inordinate burden of responsibility, grandparent support groups have been developed specifically for grandparents caring for drug- and alcohol-affected children. Typically, such programs provide a range of services designed to assist grandparents in caring for their dependent grandchildren while still maintaining their own physical and psychological health. Such services generally include education about addiction, codependency, and stress management, and information related to child development, nutrition, and parenting. Grandparent programs can also offer specific training to help grandparents acquire skills to care for grandchildren who may have special medical or behavioral needs. In addition, programs typically provide information about community resources and practical help with such things as how to obtain legal custody of grandchildren and how to apply for extra food stamps. Grandparent support groups also serve as advocates for caregivers and assist them in dealing with complex and unfamiliar bureaucracies. Finally, these support networks provide mutual assistance and peer counseling that can help decrease grandparents' isolation and thus better support them in times of personal and family crisis.

C. RELAPSE  
Relapse is a fact. For someone in recovery, the following behavioral signs/symptoms may indicate the imminent risk of relapse:
- Self-pity, - “the poor me client”
- Depression,
- Setting expectations that are too numerous or unrealistic,
- Feelings of being “all-powerful” or not needing support,
- Distancing from friends who are clean and sober.
  - “I don’t need meetings anymore – I’ve go this sobriety thing figured out.”

D. THERAPEUTIC RELAPSE  
Helps break through denial  
Helps move client that may be stuck

~PLANNING FOR RECOVERY~

Research has shown that a TEAM approach to treatment is essential.  
Do you use this type of approach in your area?  
How can you encourage this kind of interaction?  
How does confidentiality play into the treatment of your clients?

E. HARM REDUCTION  
Developing a Safety Plan with your client.  
What would a safety plan look like?

F. THINGS TO CONSIDER  
Who will assist with transportation for the parent  
Who will assist with child care for parent
Does the parent have help if the child is ill – (treatment does not stop due to illness of child or parent)

Does the parent have a safety-plan in place for the care of the child in case of relapse

What other agencies are involved with the parent/family?
- GED program, Drug Court, Mental Health Court
- Probation and Parole, VIP, Job Training, etc.

Working with the parent to determine daily and weekly activities……
- What will be parent’s reactions to a new STRUCTURED scheduled?
- It is important for workers to understand the stresses and tasks that come with recovery and the requirements that will be placed on the parent.
  - A parent could relapse or escalate drug use if frustration is felt or failure is sensed
  - It is important for worker to help client prioritize their responsibilities and tasks and recognize the need to ask for help if needed

G. WORKING WITH PARENTS WHO DO NOT HAVE CUSTODY OF THEIR CHILDREN

Workers should always work with counselors, but in this case it is especially important to work with the counselor when developing a realistic family reunification plan.

Workers should communicate with the Treatment provider and the parent the specific requirements for family reunification, such as time allowed clients to begin abstinence, the visitation schedule with court-appointed caregivers, parenting classes and the completion of the plan.
- WHY - ?

What does realistic mean?
- ASFA
- Realistic with Meth addicted parent
- Realistic with Alcohol addicted parent
- Realistic with Marijuana addicted parent

H. THING TO CONSIDER WHEN A PARENT IS IN TREATMENT

If a parent was raised in a substance abusing environment they may lack the skills needed to be successful at parenting their own child.

The parent may need the basic skills and knowledge needed including:
- Realistic knowledge about child development
  - At risk parents may believe that very young children (i.e., 2 or 3 year olds), can stop crying on command, take care of themselves, and respond maturely to the caregiver’s needs.
- Parenting skills
  - At risk parents may need help with basic child rearing skills, such as effective discipline, how to reward, and how to effect desired responses.
- An understanding of the impact of child abuse on a person
  - If at risk parents were also victims, they should understand why they were abused if they are not to become abusers themselves.
- Good relationships with spouse and other adults
- Strengthening a parent’s relationships with family members, spouse, and other adults helps to increase the possibility of improved caregiver behavior.
  - Other personal development and social skills development
    - Stress Management, assertiveness training, and the development of self-confidence.
- Treatment plans should include support groups for both the parents and the children.
- Data suggests that interventions aimed at breaking the cycle of substance abuse, child neglect, and maltreatment are more successful when they are family centered.

For clients to receive appropriate help it is essential that the treatment plans match their current abilities to function rationally and to be good parents.
- Other factors such as culture, social class, and resources must also be considered.
- In early recovery – family education and recovery counseling is helpful
- In later recovery – more in depth therapy may be called for and a “systems approach” can be taken.

I. WORKING WITH FAMILIES WHO HAVE DOMESTIC VIOLENCE ISSUES

- When Domestic Violence is occurring, Professionals do not recommend Family Counseling and/or Anger Management for the batterer.
- Research indicates that a Batterer’s Intervention Program should be recommended instead. Contact your local DV office or the state DV Office for information on what services are offered in your area. Domestic Violence cases have turned deadly after family counseling sessions.
XVII. COURT INVOLVEMENT WITH CHEMICALLY INVOLVED FAMILIES
(Discuss if time permits)

A. WORKING WITH THE COURT – things to remember to better support your case

- In considering the level of protection needed by children in chemically involved families and the treatment services required by their parents, a number of factors typically are weighed by the court.
- These include the child's health, development, and educational status; the child's age; parental history of alcohol or other drug abuse and substance abuse treatment; parenting profile; safety of the home; family supports; and treatment resources.
- Decisions regarding the family's functioning and progress must be based on the comprehensive assessment information contributed by a variety of disciplines and agencies, as described in the previous chapters.
- The following recommendation can assist workers who are providing reports and testimony specifically for the court.

1. Child's Health, Development, and Educational Status

- Reports containing specific information regarding a child's medical, developmental, and educational needs provide guidance for the court in determining the level of caregiving skills required to meet the child's needs.
- If a child has special needs, the court considers the caregiver's ability to provide this specialized care before releasing the child into the care of parents, extended family members, or foster parents.
- Testimony or court reports should specify:
  1. the child's general health status, medical care requirements, and special care needs;
  2. in the case of newborns, toxicology screen results and/or the presence or absence of withdrawal symptoms and/or signs and symptoms that are consistent with prenatal drug or alcohol exposure
  3. the child's developmental status and educational needs
  4. school attendance patterns and records
  5. known behavioral problems or emotional disorders

2. Child's Age

- The child's age is an important factor in making a decision regarding the child's custody.
- Infants and preschoolers are highly dependent on their parents to meet basic needs and provide protection from harm.
- Until children reach school age, they often are “invisible” to social service and educational agencies. Thus, abuse or neglect may go unnoticed.
- In preparing reports for the court, workers should note:
  - ages of all dependent children within the home
  - availability of day care or preschool services that could provide daily monitoring of the child's care as well as developmental and social enrichment
  - availability of supportive and therapeutic in-home services

3. Parental History of Substance Abuse and Treatment
The parent's record of substance abuse and treatment can provide information that assists the court in evaluating the degree of risk to the child as well as the parent's treatment needs and level of commitment to dealing with his/her substance abuse problem.

The more severe and extensive the history of parental substance abuse, the more serious the threat may be to a child's safety.

Workers providing information for the court should include descriptions of:

- the parent's substance abuse problem (substances abused, length of abuse, and frequency of use)
- the parent's typical behavior when under the influence (e.g., violent, absent, or dazed and bizarre)
- parental participation in substance abuse treatment (attendance patterns, level of involvement in treatment, and indicators of progress)
- parental acknowledgment of alcohol and/or other drug abuse as a problem
- urine toxicology results (a series of results is preferable to a single report)
- behavioral indicators of sobriety or continued alcohol and/or other drug use

4. Parenting Profile

The court is interested in information that demonstrates parents' concern for their children's welfare as well as their ability to provide protection and proper care.

Reports or testimony from neighbors, family, or others should include information relevant to:

- records of prior child abuse and neglect allegations and investigations
- significant physical or mental health impairments that interfere with the parents' ability to care for their children
- parents' perceptions of the impact of their substance abuse on family life and parenting
- parents' participation in parenting education classes or response to in-home instruction (attendance patterns, level of involvement, and indicators of progress)
- observations of parent–child interactions
- parents' behavior toward their children when using drugs or alcohol
- visitation patterns, if a child is in out-of-home care

5. Home Environment

The condition of the family home environment is critical to determining a child's need for protection.

Obviously, the use, sale, or manufacture of drugs by parents or others within the home will significantly impact the child's safety.

The risk to the child is also increased when homelessness or lack of food and basic necessities are the consequences of a parent's use of family resources to purchase drugs or alcohol.

The court is particularly interested in the following types of information concerning the home environment:

- indications of illegal activity or violence within the home
- environmental conditions within the home (hygiene, food, furnishings, and the functioning of utilities)
- steps taken by parents to remedy environmental hazards
- relationship of other adults in the household to the child and parent,
  - their responsibility for child care, and their knowledge of and involvement with the parent's substance use
6. **Family Supports**

⭐ The strength of the family's support system can be pivotal in providing protection for the child, maintaining the family unit, and supporting the parent's treatment.

⭐ When communicating with the court, workers should include information relevant to:

- willingness and ability of extended family members and significant others to help with the care of dependent children who remain in parental care;
- extended family's ability to provide care and protection for the child if out-of-home care is required; and
- family involvement with church, temple, or other community groups.

7. **Treatment and Support Services**

⭐ The court depends on child welfare, health and mental health care, substance abuse treatment, and educational professionals to:

- assess the treatment needs of children and parents
- identify appropriate treatment resources
- to provide evaluations of the progress made by parents and children in treatment

⭐ In communicating with the court, it is important that workers specify:

- specific treatment needs, including the recommended frequency and duration of treatment;
- available and appropriate resources (e.g., treatment for pregnant or postpartum women and their infants and children or treatment programs for clients who require medical supervision);
- involvement and progress in treatment (patterns of attendance, level of participation and indicators of progress);
- a description of therapeutic and supportive services provided for the family, including housing; day care; transportation; clothing; food stamps; child support and the Women, Infants, and Children (WIC) program;
- outreach efforts made to engage resistant clients in treatment; and
- documentation that noncompliance with treatment is not related to waiting lists, cultural or language barriers, or transportation problems.