MODULE 1

Understanding the Multiple Needs of Families Involved with the Child Welfare System







National Center on Substance Abuse and Child Welfare

Contents

Introduction

The National Center on Substance Abuse and Child Welfare (NCSACW) developed the Child Welfare Training Toolkit to enhance child welfare workers knowledge and understanding about substance use and co-occurring disorders among families involved in the child welfare system. The toolkit is designed to provide foundational knowledge and skills to help advance child welfare casework practice.

The toolkit consists of ten modules—seven foundational and three special topics:

Module 1: Understanding the Multiple Needs of Families Involved with the Child Welfare System

Module 2: Understanding Substance Use Disorders, Treatment & Recovery

Module 3: Understanding Co-Occurring Disorders, Intimate Partner Violence & Trauma

Module 4: Engagement and Intervention of Co-Occurring Substance Use, Mental Disorders & Trauma

Module 5: Case Planning Considerations for Families Affected by Parental Substance Use & Co-Occurring Disorders

Module 6: Understanding the Needs of Children and Adolescents Affected by Parental Substance Use & Co-Occurring Disorders

Module 7: A Coordinated Multi-System Approach to Better Serve Children and Families Affected by Substance Use & Co-Occurring Disorders

Module 8: Special Topic: Considerations for Children and Families Affected by Methamphetamine Use

Module 9: Special Topic: Considerations for Children and Families Affected by Opioid Use

Module 10: Special Topic: Care Coordination Considerations for Children and Families Affected by Prenatal Substance Exposure

In addition, the Child Welfare Training Toolkit is designed to offer states and local jurisdictions flexibility with delivery methods—the 10 modules can be delivered as a series or as standalone in-person or virtual trainings. Note, each module is equivalent to a half day or 3-hour training which should also account for one 15-minute break for learners during instruction.

Each module contains a detailed facilitator's guide outlining identified learning objectives, a presentation slide deck, a comprehensive reference list, and supplemental resources. To better support state and local training capacity, detailed talking points for each slide's content have been included which can be used as a script or a starting point to help acclimate and support facilitator readiness. As with all training curricula, facilitators are also encouraged to infuse their own subject matter expertise, practice-level experience, and knowledge of state or local policy or practice to help reinforce the toolkit's contents and learning objectives.

Lastly and more importantly, the toolkit is designed with careful attention to adult learning theory and principles to maximize child welfare workers learning experience. Each module considers the diverse learning styles and needs including auditory, visual, kinesthetic techniques, as well as individual, small, or large group transfer of learning activities or exercises.

Note, the NCSACW provides a free online tutorial titled, *Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals*. This self-guided online tutorial complements the contents of the Child Welfare Training Toolkit. State and local jurisdictions may encourage their workforce to take the online tutorial to further supplement their knowledge; learners who successfully complete the online tutorial will be eligible for continuing education credits.

Intended Audience

The contents of this training toolkit can be applied across the full child welfare services continuum, enriching the practice of alternative (differential) response, investigations, in-home, out-of-home, and ongoing units. State and local jurisdictions may use the toolkit to supplement their current onboarding (pre-service) or ongoing (in-service) workforce learning opportunities. Use of the training toolkit is also highly encouraged for all cross-training needs—promoting collaboration and system-level change within and between child welfare agencies, substance use and mental health treatment providers, the judicial system, and all other family-serving entities.

Facilitator Qualifications

Facilitators should be knowledgeable about substance use disorders, mental health, and child welfare practice. They should also be familiar with the laws and policies that affect child welfare agency decision-making to ensure that the information is presented in the proper context. If a facilitator does not hold knowledge in one of these identified areas, then partnering with a respective community agency is recommended to augment co-facilitation and/or subject matter expertise. All additional facilitator inquiries can be addressed to ncsacw@cffutures.org.

Language & Terminology

Discipline-specific language and terminology are used throughout this 10-module toolkit. A trainer glossary has been incorporated as part of the toolkit to better support knowledge and understanding of the purpose and intended meanings of commonly referenced terms and recommended use of person-first and non-stigmatizing language.

Materials Needed

In-Person Training Delivery

- Laptop Computer
- A/V Projector or Smart Board
- External Speakers (if needed)
- Internet or Wi-Fi Access
- Presentation Slide Deck
- Facilitator's Guide
- Flip Chart Paper
- Pens and Markers
- Training Fidgets

Virtual Training Delivery

- Laptop Computer
- Internet or Wi-Fi Access
- Virtual Meeting Platform (e.g., Zoom)
- Access to Free Online Word Cloud Generator (e.g., Mentimeter)
- Presentation Slide Deck
- Facilitator's Guide

Module 1 Description and Objectives

The goal of Module 1 is to provide learners with foundational knowledge on a range of co-occurring needs that children and families involved in the child welfare system may experience. This module serves as a primer to the remaining modules and includes a broad-level overview of relevant data; important child welfare laws and considerations; introductory information on substance use and co-occurring disorders, including topic-based discussions on the cumulative effects of trauma and stigma. The module closes with an introduction to a family-centered approach and highlights the benefits and importance of cross-system collaboration for identifying and responding to the diverse needs of children, parents, and families.

After completing this training, child welfare workers will:

- Identify the prevalence of substance use, mental disorders, and trauma in the child welfare population
- Recognize the effects of substance use and co-occurring disorders on children and families
- Describe how stigma and bias perpetuates disparate outcomes for families affected by co-occurring disorders
- Understand the importance of a family-centered approach when working with families affected by co-occurring disorders
- Identify the benefits of collaborating with other systems and service providers to better serve children and families

Presentation Slide Deck and Talking Points

This next section of the facilitator guide provides detailed information about the contents of each slide and is organized uniformly throughout the deck to help with your training preparation. These sections include:

- Facilitator Script: ready to use talking points that can be used in its current form or modified based on a facilitator's training capacity and subject matter expertise.

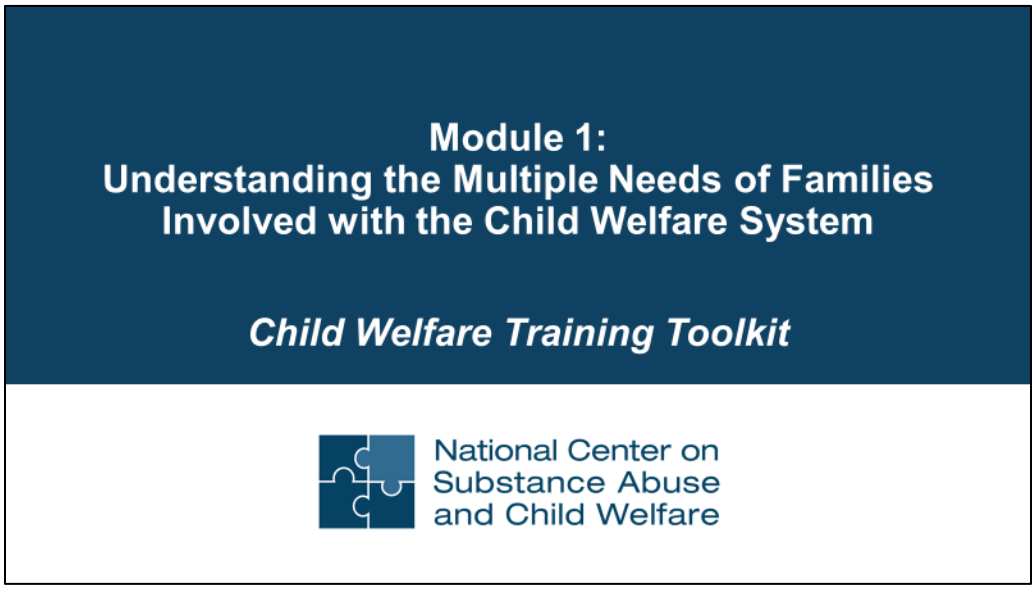
- Facilitative Prompts for Participants: content-specific inquiries developed to engage learners in further discussion and application of knowledge and skills (**bolded for easy reference**).

- Additional Facilitator Notes: contextual information to support the facilitator's knowledge and readiness, or specific mention of supplemental resources available to the learners hyperlinked within the resource section at the end of the presentation slide deck (*italicized for easy reference*).

- Underlined Content: a tool used to draw attention or emphasize specific content within the facilitator script.

Slide 1

Module 1: Understanding the Multiple Needs of Families Involved with the Child Welfare System

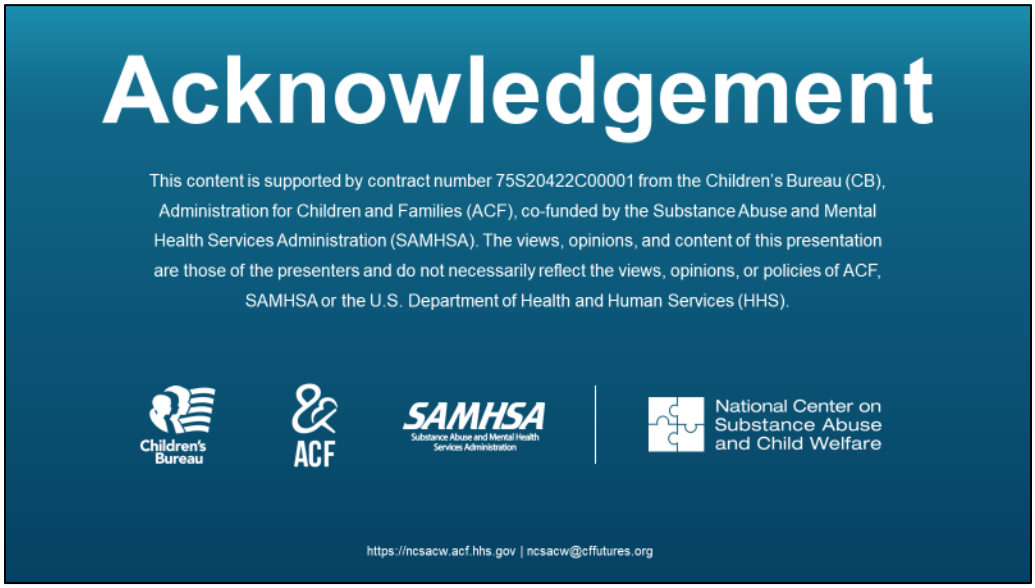


Facilitator Script:

Hello and welcome! Thank you for creating time in your schedule for today's training discussion. The next three hours were carefully designed to be a robust learning experience. We encourage your active participation in the various adult learning exercises leading to a more in-depth understanding about the multiple needs of families involved with the child welfare system.

Slide 2

Acknowledgement

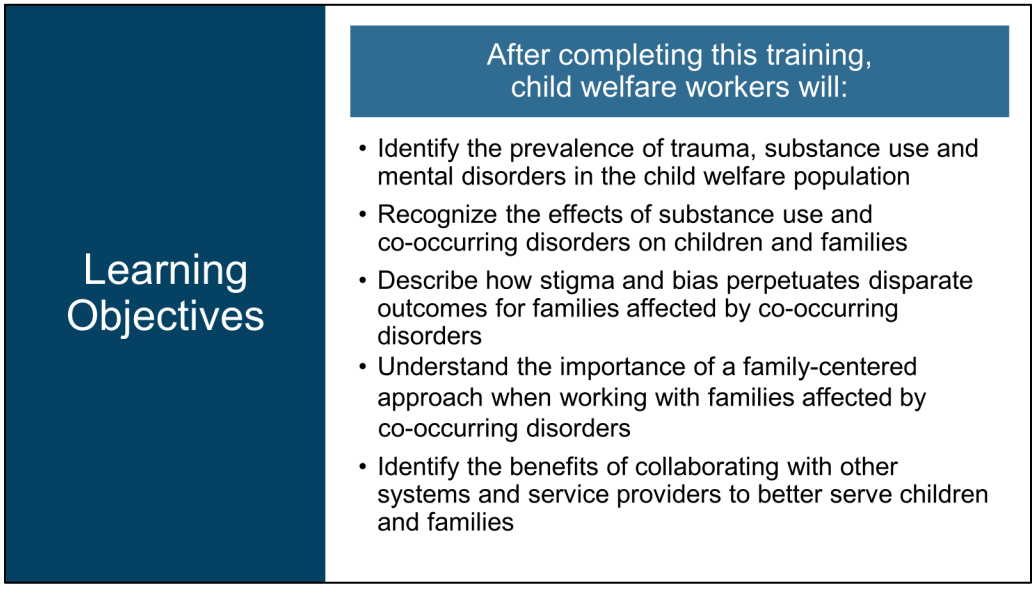


Facilitator Script:

Before we begin, we have an acknowledgement slide to go over. The contents of this training toolkit, including today's module, was developed by the National Center on Substance Abuse and Child Welfare—an initiative of the U.S. Department of Health and Human Services that is co-funded by the Children's Bureau, Administration for Children and Families, and the Substance Abuse and Mental Health Services Administration.

Slide 3

Learning Objectives



Facilitator Script:

The goal of Module 1 is to provide learners with foundational knowledge on a range of co-occurring needs that children and families involved in the child welfare system may experience. This module serves as a primer to the remaining modules and includes a broad-level overview of relevant data, important child welfare laws and considerations, introductory information on substance use and co-occurring disorders– including topic-based discussions on the cumulative effects of trauma and stigma. The module closes with an introduction to a family-centered approach and highlights the benefits and importance of cross-system collaboration for identifying and responding to the diverse needs of children, parents, and families.

Slide 4

What the Data Tells Us About Parental Substance Use

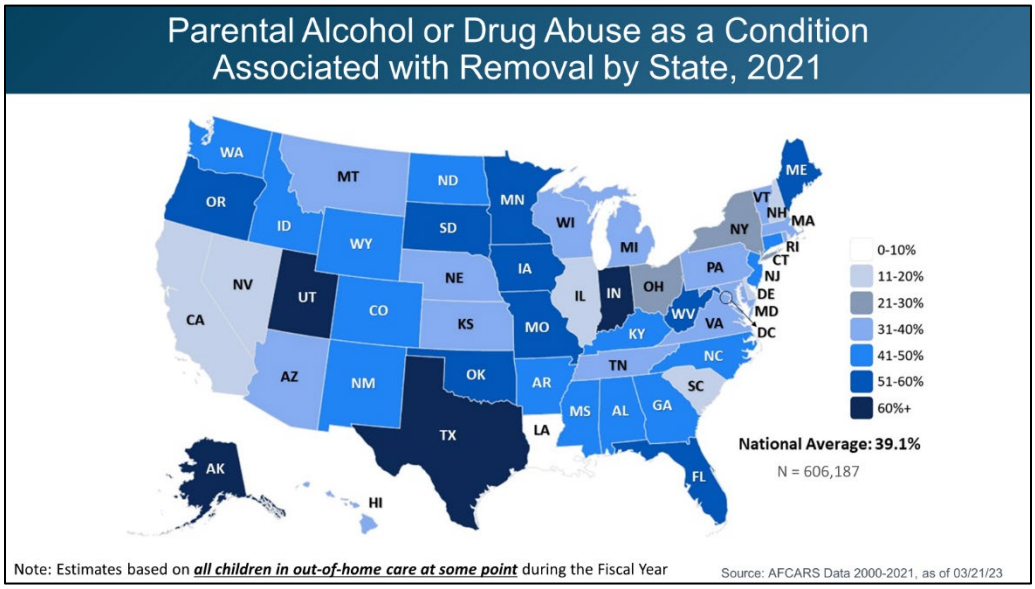
Facilitator Script:

Let's begin today's training session by reviewing more closely what the data tells us about parental substance use. An estimated 8.7 million children live with at least one parent affected by a substance use disorder but only roughly 10% of these families receive treatment services. Now understandably not all 8.7 million children will come to the attention of child welfare services but for the subset that do, let's take a closer examination of what those numbers entail…

Source: (Lipari et al., 2017)

Slide 5

Parental Alcohol or Drug Abuse as a Condition Associated with Removal by State, 2021



Facilitator Script:

According to the Adoption and Foster Care Analysis and Reporting System (also known and commonly referred to as AFCARS), there were a total of 603,823 children in out-of-home care at some point during the 2021 fiscal year (an adjusted figure from the total numerator shown on the heat map due to 2,364 children who had alcohol or other drug (AOD) information missing from their dataset). Of the adjusted 603,823 children, 236,143 had parental substance use listed as a condition associated with their removal (either alone or in combination with another reason)—totaling a national average of 39%.

Prompts for Participants:

- **Any initial reactions to this data?**
- **Do the state percentages align with what you are experiencing in your frontline practice?**
- **If not, what could be contributing to these discrepancies?**

Additional Notes:

States typically don't agree with what this slide says in terms of their prevalence – it's part of the You Can't Fix What You Don't Count messaging. This issue is related to:

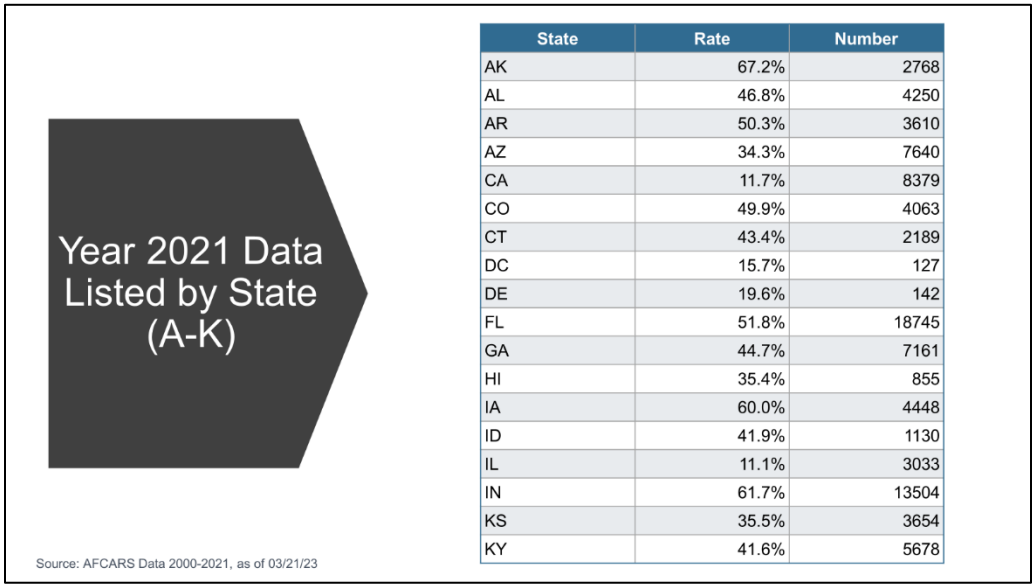
- *Lack of protocols re. identification (screening and assessment)* and *data entry*
- *Variation in data systems*
- *How AOD is captured in data systems (e.g.: neglect; is there an AOD box?)*
- *Point in time in which the AOD is identified; and then entered in the data system*

- *Often, at the local level, multiple child abuse/neglect (CA/N) reasons are reported and sometimes only the primary reason is reported to the Fed system(s)*
- *Good ending points/reason to share these slides;*
- *Opens the conversation on data collection and what that means for resources, sustainability, etc.*

Source: AFCARS Data 2000-2021, as of 03/21/23

Slide 6

Year 2021 Data Listed by State (A-K)



State	Rate	Number
AK	67.2%	2768
AL	46.8%	4250
AR	50.3%	3610
AZ	34.3%	7640
CA	11.7%	8379
CO	49.9%	4063
CT	43.4%	2189
DC	15.7%	127
DE	19.6%	142
FL	51.8%	18745
GA	44.7%	7161
HI	35.4%	855
IA	60.0%	4448
ID	41.9%	1130
IL	11.1%	3033
IN	61.7%	13504
KS	35.5%	3654
KY	41.6%	5678

Source: AFCARS Data 2000-2021, as of 03/21/23

Facilitator Script:

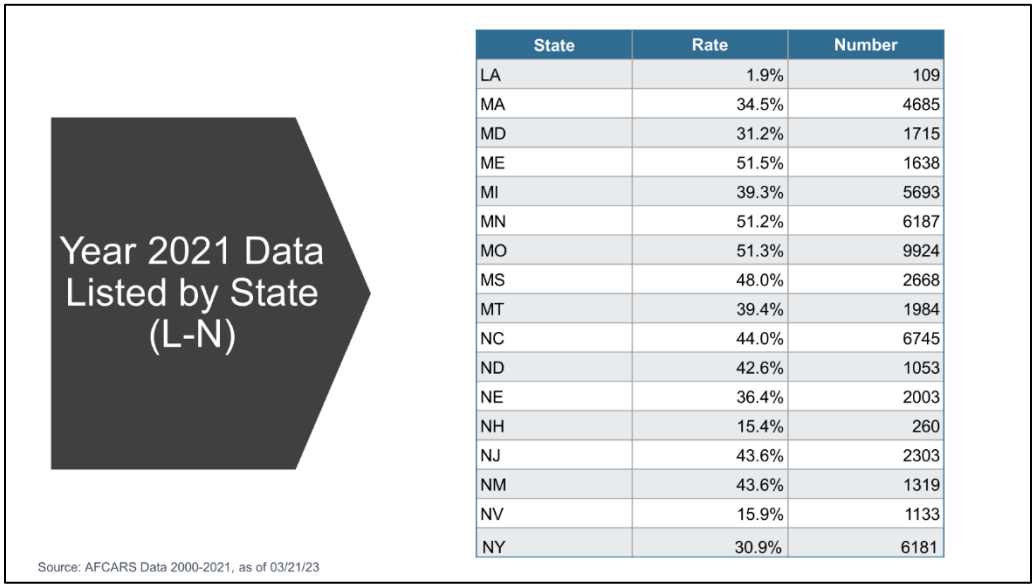
Facilitator Notes:

This slide details state-specific data organized alphabetically for the year 2021. Based on where you are training, this presents an opportunity to take a closer review of the data to help provide additional context and increased awareness of state and/or regional data trends.

Source: AFCARS Data 2000-2021, as of 03/21/23

Slide 7

Year 2021 Data Listed by State (L-N)



State	Rate	Number
LA	1.9%	109
MA	34.5%	4685
MD	31.2%	1715
ME	51.5%	1638
MI	39.3%	5693
MN	51.2%	6187
MO	51.3%	9924
MS	48.0%	2668
MT	39.4%	1984
NC	44.0%	6745
ND	42.6%	1053
NE	36.4%	2003
NH	15.4%	260
NJ	43.6%	2303
NM	43.6%	1319
NV	15.9%	1133
NY	30.9%	6181

Facilitator Script:

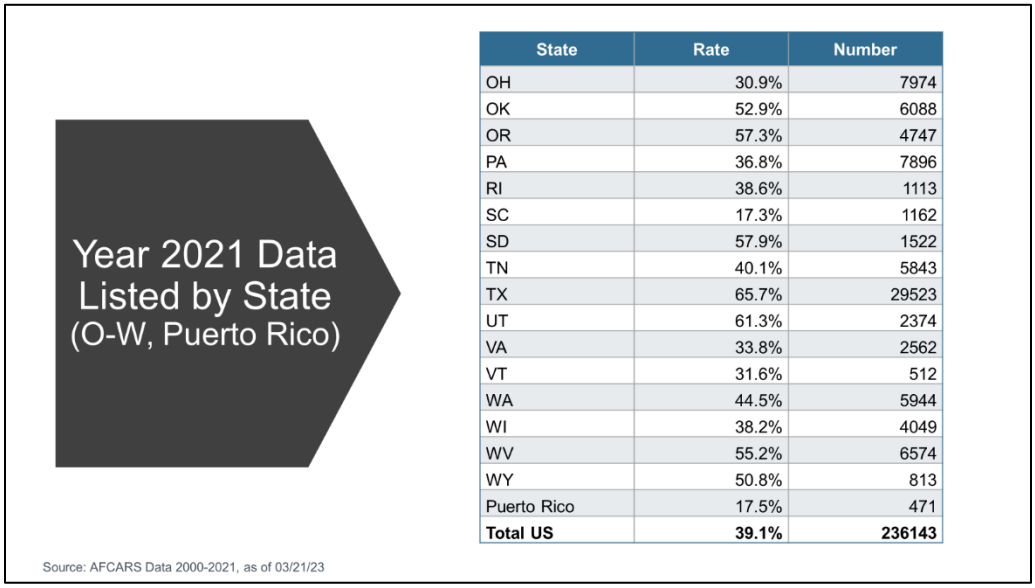
Facilitator Notes:

This slide details state-specific data organized alphabetically for the year 2021. Based on where you are training, this presents an opportunity to take a closer review of the data to help provide additional context and increased awareness of state and/or regional data trends.

Source: AFCARS Data 2000-2021, as of 03/21/23

Slide 8

Year 2021 Data Listed by State (O-W, Puerto Rico)



State	Rate	Number
OH	30.9%	7974
OK	52.9%	6088
OR	57.3%	4747
PA	36.8%	7896
RI	38.6%	1113
SC	17.3%	1162
SD	57.9%	1522
TN	40.1%	5843
TX	65.7%	29523
UT	61.3%	2374
VA	33.8%	2562
VT	31.6%	512
WA	44.5%	5944
WI	38.2%	4049
WV	55.2%	6574
WY	50.8%	813
Puerto Rico	17.5%	471
Total US	**39.1%**	**236143**

Source: AFCARS Data 2000-2021, as of 03/21/23

Facilitator Script:

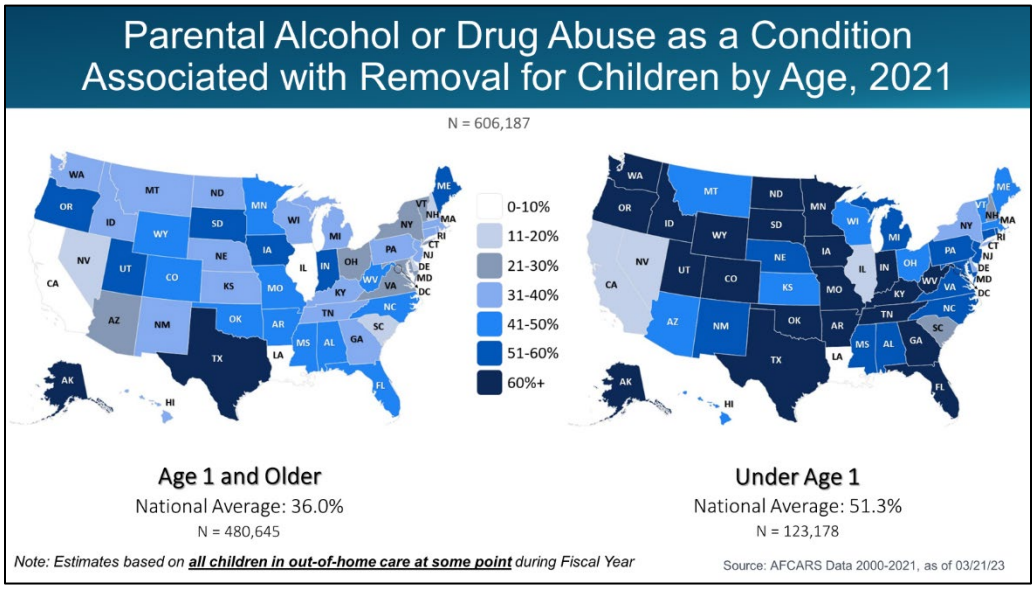
Facilitator Notes:

This slide details state-specific data organized alphabetically for the year 2021. Based on where you are training, this presents an opportunity to take a closer review of the data to help provide additional context and increased awareness of state and/or regional data trends.

Source: AFCARS Data 2000-2021, as of 03/21/23

Slide 9

Parental Alcohol or Drug Abuse as a Condition Associated with Removal for Children by Age, 2021



Facilitator Script:

Let's now take a closer review at this same dataset just now broken out by age categories. On the left-side heat map we have national and state-specific percentages for children ages 1 and older compared to the percentages on the right-side heat map for children under age 1. As a reminder the number of children who entered out-of-home care in fiscal year 2021 totaled 606,187; however, the numerators listed on the slide account for the 2,364 children who had missing AOD information. So, of the 480,645 children aged 1 and older, there were 173,013 with parental AOD listed as an identified condition associated with their removal– totaling a national average of 36%. Whereas of the 123,178 children under age 1, there were 63,130 with parental AOD listed—totaling a national average of 51%

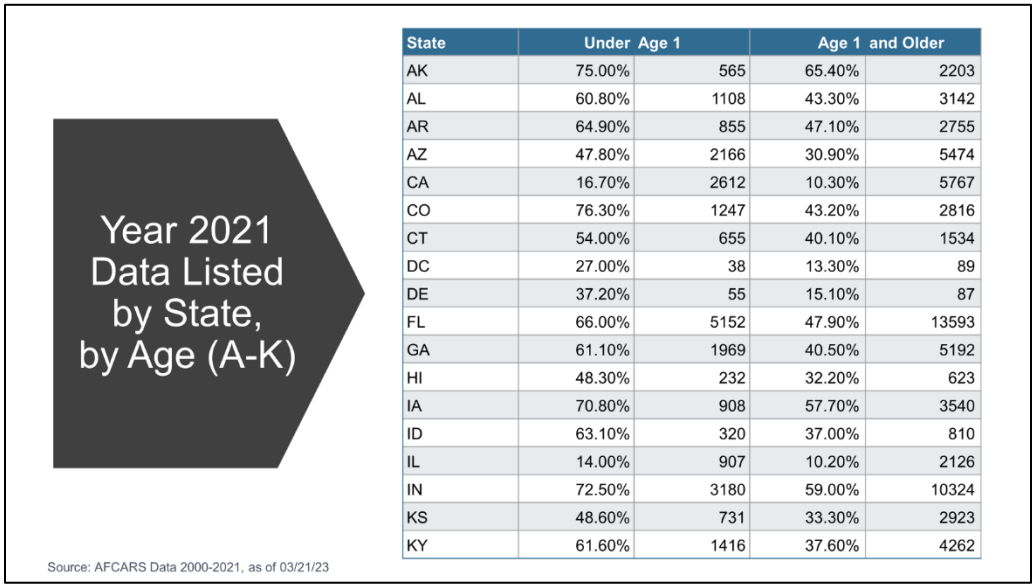
Prompts for Participants:

- **Any initial reactions to these comparison figures?**
- **What thoughts do you have regarding your specific state or region?**
- **Do these figures align with the breakdown of age demographics on your caseloads?**

Source: AFCARS Data 2000-2021, as of 03/21/23

Slide 10

Year 2021 Data Listed by State, by Age (A-K)



State	Under Age 1		Age 1 and Older	
AK	75.00%	565	65.40%	2203
AL	60.80%	1108	43.30%	3142
AR	64.90%	855	47.10%	2755
AZ	47.80%	2166	30.90%	5474
CA	16.70%	2612	10.30%	5767
CO	76.30%	1247	43.20%	2816
CT	54.00%	655	40.10%	1534
DC	27.00%	38	13.30%	89
DE	37.20%	55	15.10%	87
FL	66.00%	5152	47.90%	13593
GA	61.10%	1969	40.50%	5192
HI	48.30%	232	32.20%	623
IA	70.80%	908	57.70%	3540
ID	63.10%	320	37.00%	810
IL	14.00%	907	10.20%	2126
IN	72.50%	3180	59.00%	10324
KS	48.60%	731	33.30%	2923
KY	61.60%	1416	37.60%	4262

Source: AFCARS Data 2000-2021, as of 03/21/23

Facilitator Script:

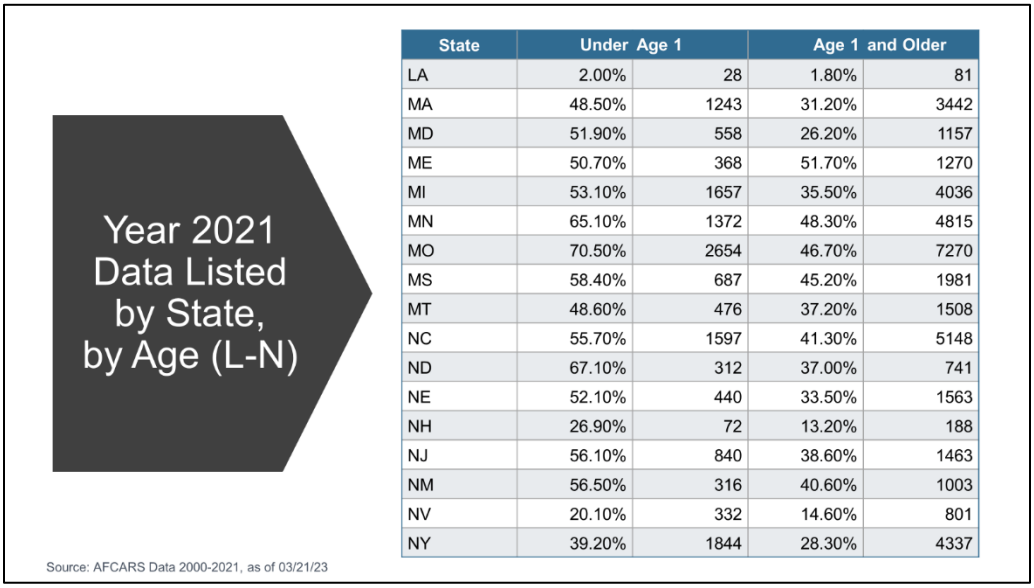
Facilitator Notes:

This slide details state-specific data organized alphabetically for the year 2021—broken out by age category. Based on where you are training, this presents an opportunity to take a closer review of the data to help provide additional context and increased awareness of state and/or regional data trends.

Source: AFCARS Data 2000-2021, as of 03/21/23

Slide 11

Year 2021 Data Listed by State, by Age (L-N)



State	Under Age 1		Age 1 and Older	
LA	2.00%	28	1.80%	81
MA	48.50%	1243	31.20%	3442
MD	51.90%	558	26.20%	1157
ME	50.70%	368	51.70%	1270
MI	53.10%	1657	35.50%	4036
MN	65.10%	1372	48.30%	4815
MO	70.50%	2654	46.70%	7270
MS	58.40%	687	45.20%	1981
MT	48.60%	476	37.20%	1508
NC	55.70%	1597	41.30%	5148
ND	67.10%	312	37.00%	741
NE	52.10%	440	33.50%	1563
NH	26.90%	72	13.20%	188
NJ	56.10%	840	38.60%	1463
NM	56.50%	316	40.60%	1003
NV	20.10%	332	14.60%	801
NY	39.20%	1844	28.30%	4337

Source: AFCARS Data 2000-2021, as of 03/21/23

Facilitator Script:

Facilitator Notes:

This slide details state-specific data organized alphabetically for the year 2021—broken out by age category. Based on where you are training, this presents an opportunity to take a closer review of the data to help provide additional context and increased awareness of state and/or regional data trends.

Source: AFCARS Data 2000-2021, as of 03/21/23

Slide 12

Year 2021 Data Listed by State, by Age (O-W, Puerto Rico)

State	Under Age 1		Age 1 and Older	
OH	47.20%	2256	27.20%	5718
OK	65.30%	2015	48.40%	4073
OR	67.70%	1118	54.70%	3629
PA	53.40%	2284	32.70%	5612
RI	51.60%	320	35.10%	793
SC	30.20%	300	15.10%	862
SD	71.80%	328	55.00%	1194
TN	70.00%	1521	34.90%	4322
TX	76.70%	7564	62.60%	21959
UT	79.40%	540	57.50%	1834
VA	55.30%	591	30.30%	1971
VT	46.90%	123	28.60%	389
WA	66.20%	2324	36.80%	3620
WI	49.10%	1066	35.40%	2983
WV	75.90%	1611	50.70%	4963
WY	70.50%	146	47.80%	667
Puerto Rico	31.10%	111	15.50%	360
Total US	**51.30%**	**63130**	**36.00%**	**173013**

Source: AFCARS Data 2000-2021, as of 03/21/23

Facilitator Script:

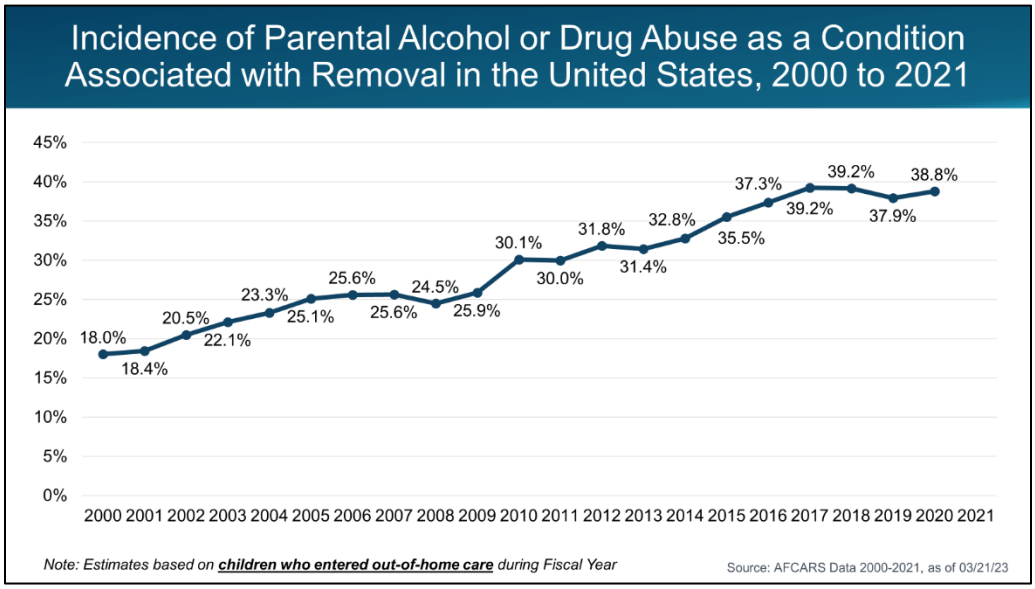
Facilitator Notes:

This slide details state-specific data organized alphabetically for the year 2021—broken out by age category. Based on where you are training, this presents an opportunity to take a closer review of the data to help provide additional context and increased awareness of state and/or regional data trends.

Source: AFCARS Data 2000-2021, as of 03/21/23

Slide 13

Incidence of Parental Alcohol or Drug Abuse as a Condition Associated with Removal in the United States, 2000 to 2021



Facilitator Script:

Here, it is important to note that this graph provides data related to incidence of parental alcohol or other drug (AOD) abuse as an identified condition associated with removal within a given amount of time (which is different than the previous data slide on prevalence); incidence data is more helpful in understanding changes in events occurring over time as incidence data only includes new cases and doesn't factor in length of out-of-home stays for children. With that important piece of clarification, we note here that there has been a steady increase of children entering out-of-home care due to conditions associated with parental AOD (with only slight decreases in 2008, 2011, and 2019).

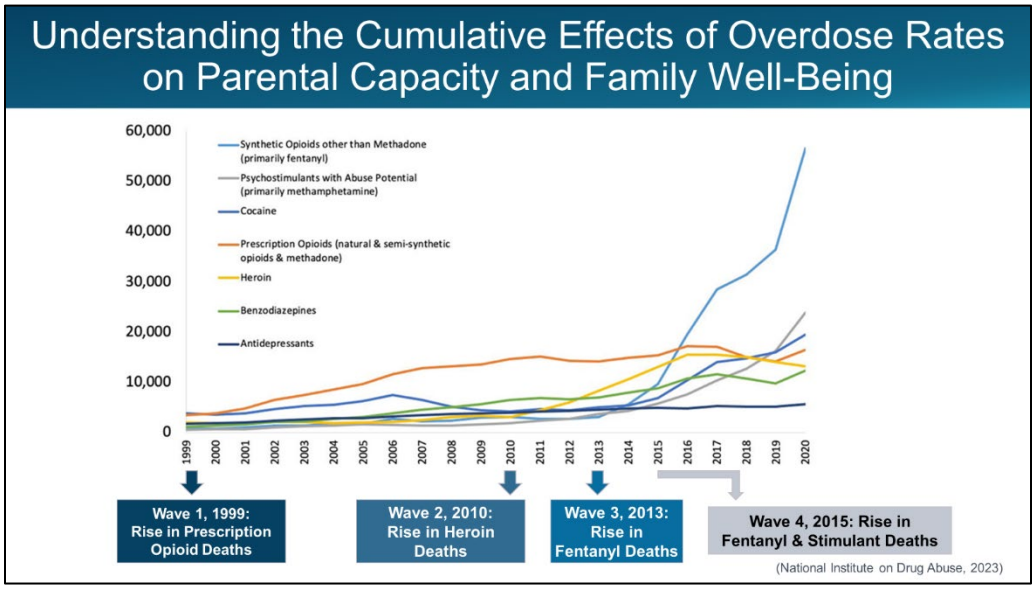
Prompts for Participants:

- **Any initial reactions to the upward trend in OOH data associated with parental AOD?**
- **In your opinion, what has contributed to the increase in removals over time?**
- **How does this data align with the advancements in the field of substance use disorder treatment and recovery?**

Source: AFCARS Data 2000-2021, as of 03/21/23

Slide 14

Understanding the Cumulative Effects of Overdose Rates on Parental Capacity and Family Well-Being



Facilitator Script:

[As we touched on with the previous slide's discussion], one of the most significant contributing factors to the upward trend in OOH data associated with parental AOD involves the cumulative effects of substance use including parental overdose death rates. Here we have a data overlay highlighting the waves of opioid-related deaths spanning two decades. In a separate study, parental AOD was found to have increased child removals by 147% when examining data from 2000-2017 alone. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) conducted a mixed-methods study to investigate this trend further. The study (released in early 2018) included rates of drug overdose deaths, rates of hospital stays, and emergency department visits related to substances to measure substance use prevalence. The study found a statistical relationship between the rates of drug overdose deaths and drug-related hospitalization to an increase in child welfare caseloads nationally—including a direct correlation to caseloads of families with more severe and complex needs.

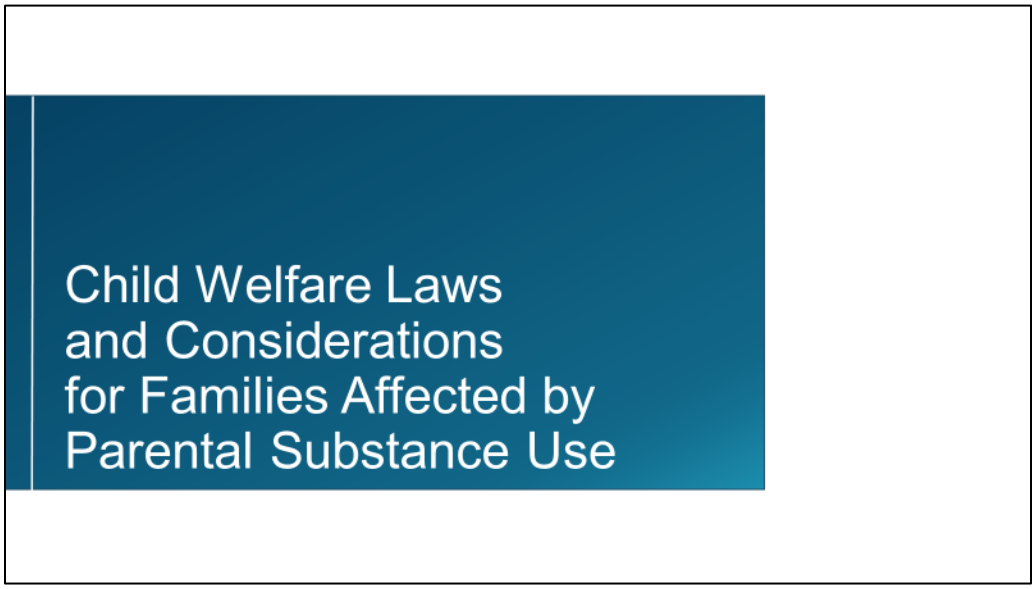
Prompt for Participants:

Does the data presented here (both on the slide and the supporting references) resonate with what you have been experiencing in your direct work with families affected by parental substance use?

Sources: (National Institute on Drug Abuse, 2023; Radel et al., 2018; Meinhofer & Angleró-Díaz, 2019)

Slide 15

Child Welfare Laws and Considerations for Families Affected by Parental Substance Use



Facilitator Script:

Now that we have familiarized ourselves with the data, let's also spend some time reviewing key child welfare laws and considerations for families affected by parental substance use…

Slide 16

Adoption and Safe Families Act (ASFA)

Facilitator Script:

The adoption and safe families act (commonly referred to as ASFA) was enacted into federal law in 1997; the goal of this law was to improve the lives of children in foster care by establishing three primary goals for child welfare intervention, these include:

Children are safely maintained in their homes whenever possible and appropriate—Safety.

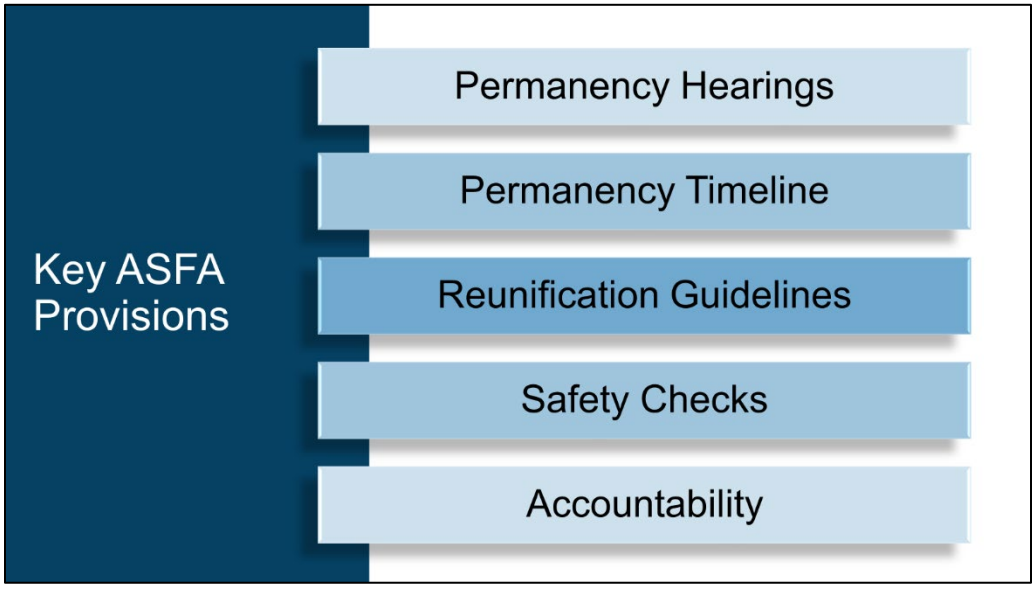
Children have permanency and stability in their living situations and continuity of family relationships and natural supports is preserved for children—Permanency.

Families develop enhanced capacities to safely provide for their children's needs (physical, mental, emotional, and educational)—Well-being.

Let's now review the key provisions of ASFA…

Slide 17

Key ASFA Provisions



Facilitator Script:

The passage of ASFA also established new guidelines for child welfare agencies and the courts to improve permanency outcomes for children and youth in foster care (an attempt to prevent long-term foster care where children remain in care without any form of legal permanency). These key provisions included…

Permanency Hearings—requires that each child must receive a permanency hearing within 12 months of entry into care with an identified permanency goal (returned home, placed for adoption, referred for legal guardianship, or an alternate permanent living arrangement).

Permanency Timeline—requires child welfare agencies to file a petition for termination of parental rights for all children who have been in foster care for 15 out of the most recent 22 months. This provision also requires child welfare agencies to make concerted efforts to find an adoptive family for the child or youth regardless of age. The only exceptions being:

- If the child or youth is being care for by a relative
- Demonstrates a compelling reason why filing for termination is not in the best interest of the child
- The child welfare agency has not provided the family the needed services within the required deadlines

Reunification Guidelines—identifies specific circumstances in which the child welfare agency is not required to make attempts to reunify children with their parent(s) due to high-risk safety concerns placing the priority on the safety of the child over family reunification. Examples of these circumstances include the parent inflicting significant harm or bodily injury on the child, parent has a conviction related to the death of the child's sibling or half-sibling or felony assault resulting in serious bodily injury to the child or sibling (again including half-siblings), or parental rights to the child's sibling have been involuntarily terminated.

Safety Checks—requires criminal background checks be completed on all prospective foster or adoptive parents before placement of a child in the home.

Accountability—established specific guidelines and measures related to the goals of safety, permanency, and well-being. Child welfare agencies are required to undergo service reviews every three years to monitor progress and improved service delivery on behalf of children and families.

Prompts for Participants:

- **How do ASFA provisions affect children and families in the child welfare system?**
- **And how might this be different for children and families affected by parental substance use?**

Slide 18

Conflicting Timetables: Time to Treatment Matters!

Facilitator Script:

As you just identified, child welfare cases move quickly. The ASFA timeline for reunification poses challenges for children and families affected by parental substance use because it may not provide parents with enough time to complete treatment or to demonstrate sufficient stability to care for their children. Another timetable for consideration is the child's development and the nature of the parent-child relationship. For our youngest children, we know this is critical due to the significance of formative years, specifically related to bonding and attachment. Balancing all these needs can be challenging and speaks to the importance of early identification through screening and referral for substance use disorder treatment.

Slide 19

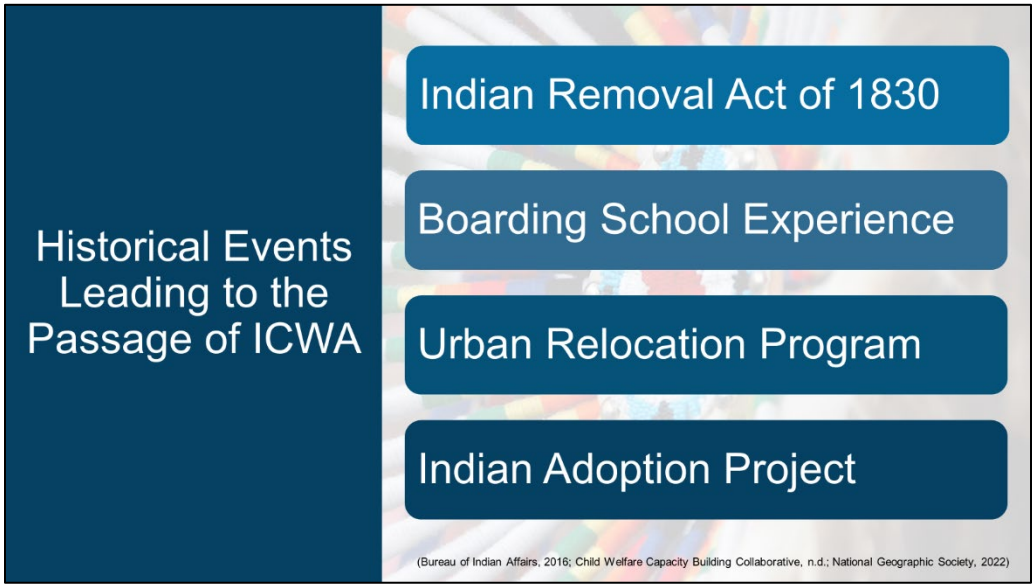
Indian Child Welfare Act…

Facilitator Script:

Now that we've covered the basics of ASFA, let's now shift our attention to another key federal law governing our practice—the Indian Child Welfare Act (or commonly known and referred to as ICWA).

Slide 20

Historical Events Leading to the Passage of ICWA



Facilitator Script:

Before we get into the Indian Child Welfare Act, it is important that we first take the time to recognize and understand the historical events leading to its passage in 1978.

Dating back to 1830, congress passed the Indian Removal Act allowing for the forcible removal of Native persons from their ancestral lands and relocating them to what was referred to as “Indian Territory” the area now known as Oklahoma. The act became known as the “Trail of Tears” due to more than 4,000 Native American’s dying.

In 1891, a federal law was passed that made boarding school attendance mandatory for all Native children and allowed for withholding key provisions like food for tribal communities who refused to comply with this mandate. By the 19th and 20th centuries, the US and Canada were both using federal funds to operate boarding schools specifically designed for Native children's forced assimilation into white society. Children were forcibly removed from their families and were not permitted to keep their given birth name, speak in their native language, or engage in native cultural practices. Many children endured abuse, neglect, and death while under the care of these federally-funded boarding schools.

In 1953 congress established a policy that ended the protected status of Indian-owned lands and support by the government. The Bureau of Indian Affairs created the urban relocation program. The program was voluntary and was designed to ease the transition. Native children and families could move from tribal lands to metropolitan areas (e.g., Chicago, Denver, Los Angeles, Cleveland, and Seattle). Understandably, acclimating to urban life was not easy; many struggled finding adequate housing and employment, and faced high rates of discrimination and social inequities.

The Indian Adoption Project was established contractually between the Child Welfare League of America (CWLA) and the Bureau of Indian Affairs (BIA) from 1958-1967. The project aimed to

promote the adoption of Native children by predominantly Caucasian and religious-based families. **The federally recognized project allowed child welfare agencies to forcibly remove Native children from their homes often with no formal paperwork or acknowledgement of parental rights–purposefully severing all ties to their parents, families, and culture.**

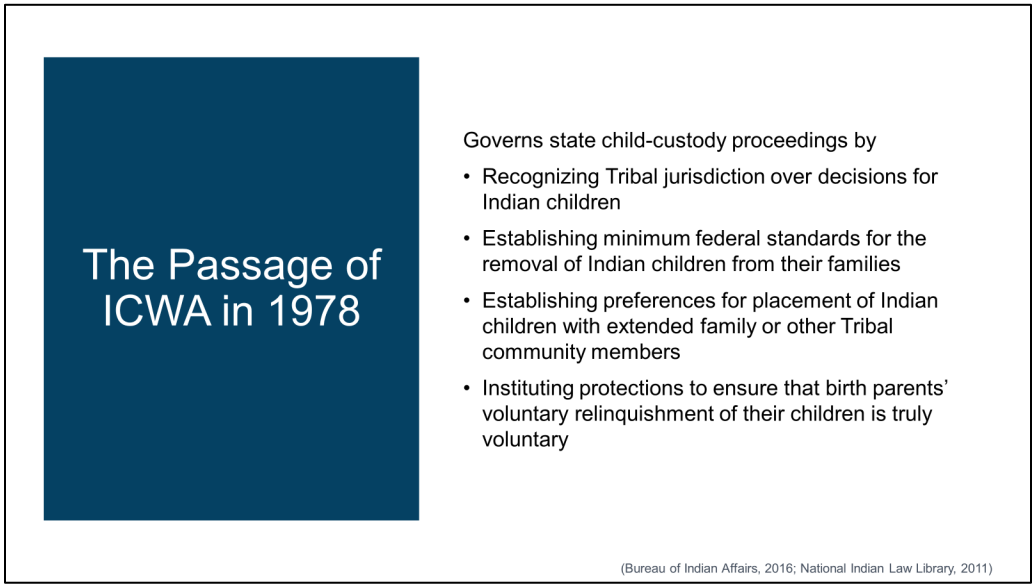
According to the Association of American Indian Affairs, 85% of Native children were forcibly removed and placed into non-Native homes or institutions between the years 1941-1967 alone. As we piece together these historical events, we only begin to understand the deeply rooted historical trauma caused by our federal policies and the subsequent efforts to amend and repair these wrongdoings—to allow for individual, familial, and cultural healing. Let's now take a closer review of the passage of ICWA.

Facilitator Note: For more information about ICWA historical events or current best practices please visit the Center for Tribes Website. We have added the link to the resource slide at the end of this presentation.

Sources: (Bureau of Indian Affairs, 2016; Child Welfare Capacity Building Collaborative, n.d.; National Geographic Society, 2022)

Slide 21

The Passage of ICWA in 1978



Facilitator Script:

The passage of ICWA in 1978 signified formal acknowledgment and the beginning of restorative justice (or a remedial act) for tribal communities nationwide. Its purpose and intent was to restore and maintain connections between Indian children, their families, as well as their culture. Children and youth ages 0-18 who are a member of a federally recognized tribe, or the biological child of a member (thereby eligible for tribal membership) are protected under ICWA.

In addition, the passage of ICWA protected tribes by granting them jurisdiction over their enrolled tribal members in place of federal, state, or contracted government agencies; this included federal assistance to tribal communities for oversight of their own child and family agencies and courts with full discretion on how they choose to exercise their tribal sovereignty.

ICWA also established minimum federal standards for the removal of Indian children from their families, requiring placement into foster or adoptive homes that reflect and preserve the values of Indian culture—establishing preferences for placement with extended family or other tribal community members.

As we know, American Indian and Alaskan Native children have and continue to be disproportionately removed from their homes and families at a higher rate compared to other non-Native children. We just reviewed the historical events predating ICWA's passage that highlighted the forcible and involuntary removal of children which speaks to the need to ensure that birth parents' voluntary relinquishment of their children is truly voluntary and in no way reflective of past coercive practices. To ensure a birth parent's voluntary consent to a foster placement, it must be executed in writing and recorded before a judge, after the parent has a full understanding of the consequences of the consent.

Let's now watch a poignant digital story detailing the heart of ICWA…

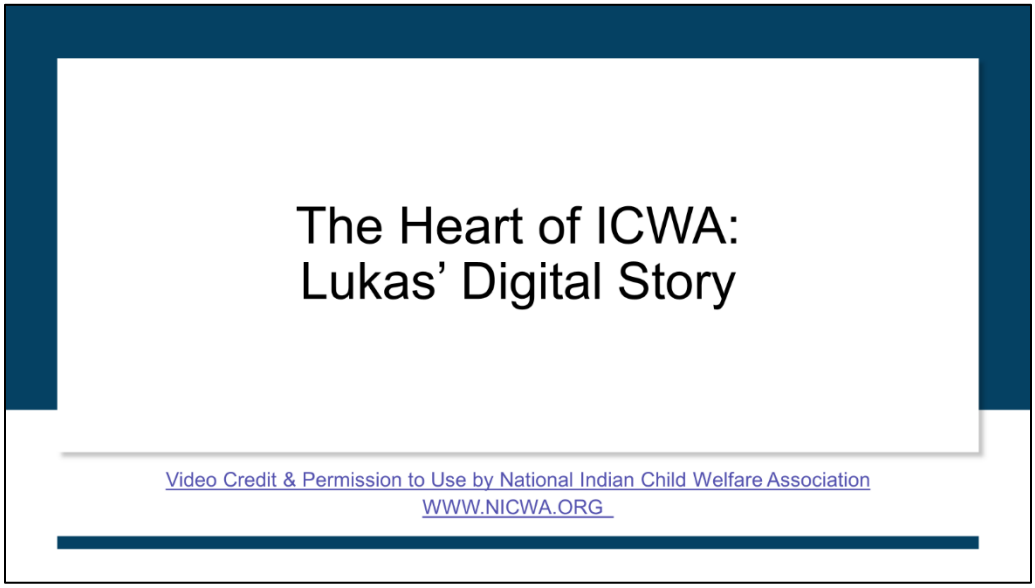
Facilitator Notes: If the families you serve include members of Native American tribes, you can learn more by visiting the National Indian Child Welfare Association.

Please refer to the resource slide on the Center for Tribes Website at the end of the presentation for more resources on ICWA.

Sources: (Bureau of Indian Affairs, 2016; National Indian Law Library, 2011)

Slide 22

The Heart of ICWA: Lukas' Digital Story



Facilitator Script:

Facilitator Notes: Internet or Wi-Fi permitting, open the hyperlink for a 5-minute digital story about a family's ICWA adoption protections. Proceed with facilitating a large group discussion using the following prompts:

Prompts for Participants:

- **Any initial reactions to the digital story?**
- **Which parts of Lukas' story resonated with you the most?**
- **Lukas' mother's birthing experience was a painful reminder of coercive practices despite the passage of ICWA—what other challenges are Native families enduring present day?**
- **Any key takeaways about the importance and value of preserving native culture as perceived through Lukas' experience?**

Video Source: National Indian Child Welfare Association

Slide 23

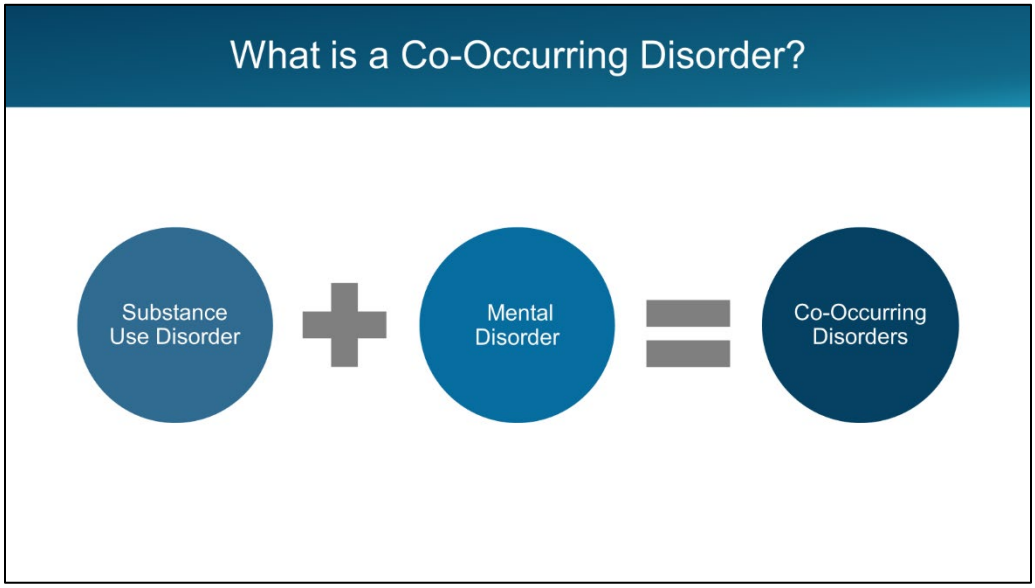
Understanding Substance Use and Co-Occurring Disorders

Facilitator Script:

Let's now shift our attention to the topic of co-occurring substance use and mental disorders...

Slide 24

What is a Co-Occurring Disorder?

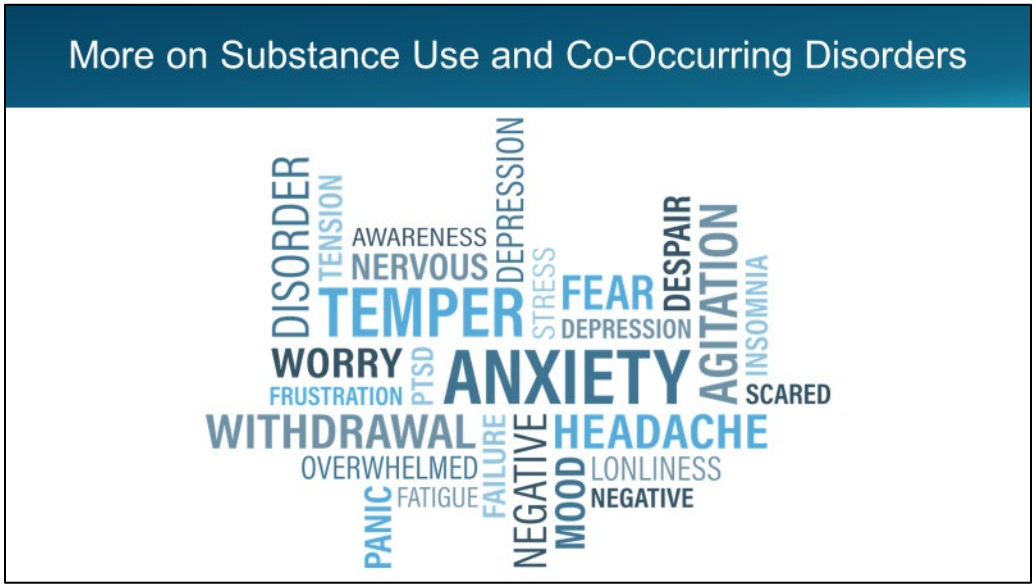


Facilitator Script:

In this context, a co-occurring disorder is a diagnostic term used to describe when a person meets criterion for a concurrent substance use and mental disorder (of any type and/or severity). In other contexts, a co-occurring disorder may also represent meeting criterion for two substance use disorders or two mental disorders, respectively.

Slide 25

More on Substance Use and Co-Occurring Disorders

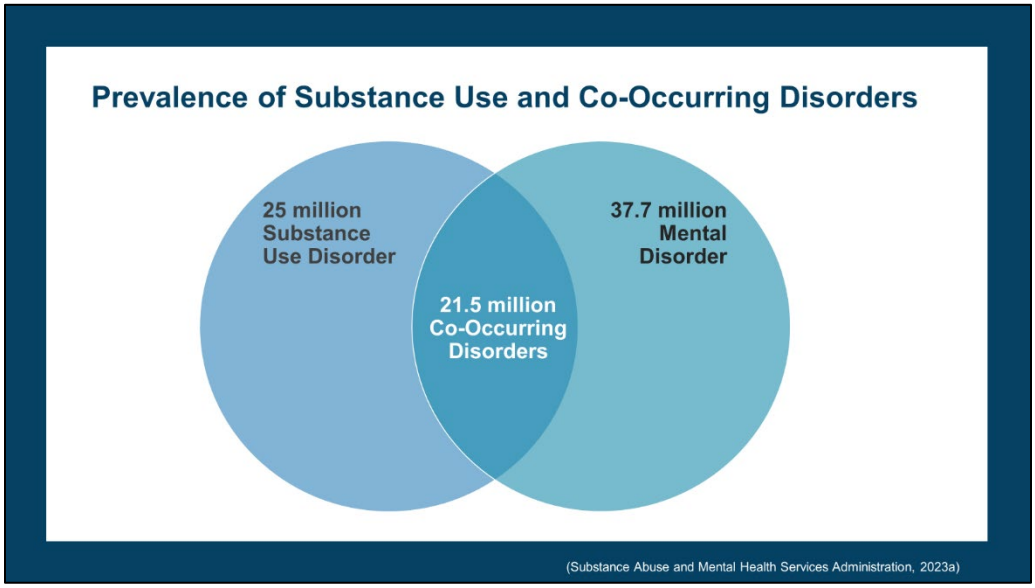


Facilitator Script:

Co-occurring disorders present in many ways. This can include a substance use disorder in combination with a mood disorder such as depression or bipolar disorder; or an anxiety disorder such as post-traumatic stress disorder (PTSD); or for some individuals a psychotic disorder like schizophrenia (among many other different types). Regardless of the specific type, it's important to remember that the severity of the co-occurring disorder can vary from mild, moderate, or severe. And in some instances, one disorder can mask or complicate the symptoms of the other, making it difficult to differentiate for diagnostic purposes.

Slide 26

Prevalence of Substance Use and Co-Occurring Disorders



Facilitator Script:

So, just how common are co-occurring disorders? According to the 2022 National Survey on Drug Use and Health, 9.7% of adults aged 18 or older (or 25 million people) met criteria for a substance use disorder (not in combination with a mental disorder) while 14.7% (or 37.7 million people) met criteria for a mental disorder (not in combination with a substance use disorder), with another 8.4% (or 21.5 million people) meeting criterion for co-occurring disorders (or as we've learned, a substance use disorder in combination with a mental disorder of any type or severity).

Source: (Substance Abuse and Mental Health Services Administration, 2023a)

Slide 27

Understanding the Cumulative Effects of Trauma

Facilitator Script:

Let's now spend some more time on the concept of trauma. Trauma can affect all aspects of a person—from their own behavior and responses to the relationships they have with others. This is especially important for parents affected by substance use disorders as they often have a history of co-occurring trauma.

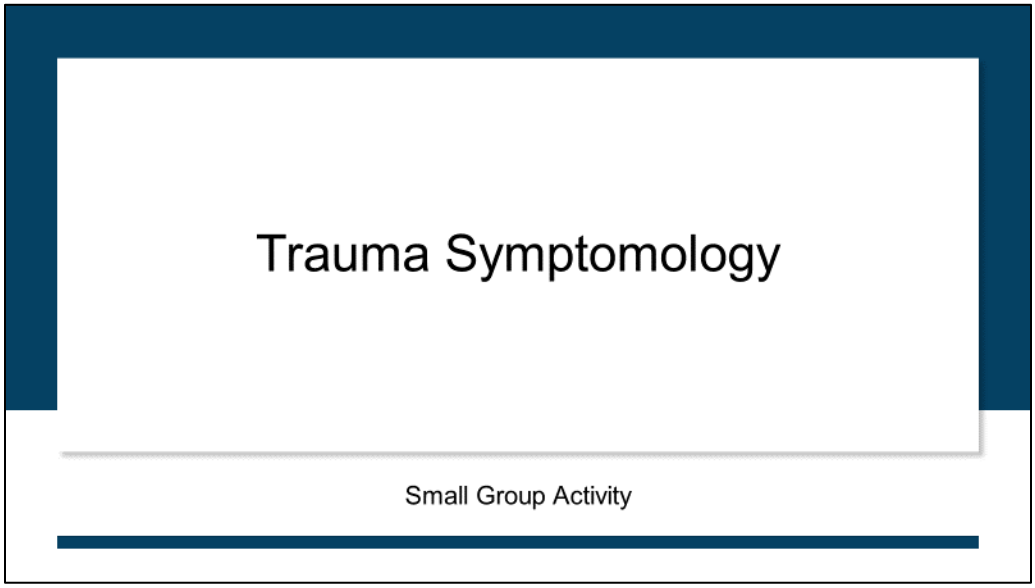
SAMHSA's concept of trauma: "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, and thinking; regulating behavior; or controlling the expression of their emotions. These are just a few examples of how trauma symptoms manifest but let's now shift to an activity to gain a more in-depth understanding of the cumulative effects of trauma.

Source: (Substance Abuse and Mental Health Services Administration, 2014).

Slide 28

Trauma Symptomology



Facilitator Script:

Facilitator Notes: Assign participants to small groups and assign one category to each group (depending on size of training you may have groups overlap on categories which is fine). Task the groups with generating a list of signs and symptoms (e.g., fatigue, anxiety, or nightmares). Each group will then add their list to one large post-it note in the front of the training room creating a visual representation of the cumulative effects of trauma.

Small Group Assignments:

- Physical Signs and Symptoms of Trauma
- Emotional/Behavioral Signs and Symptoms of Trauma
- Cognitive Signs and Symptoms of Trauma
- Interpersonal/Relational Signs and Symptoms of Trauma

Materials Needed:

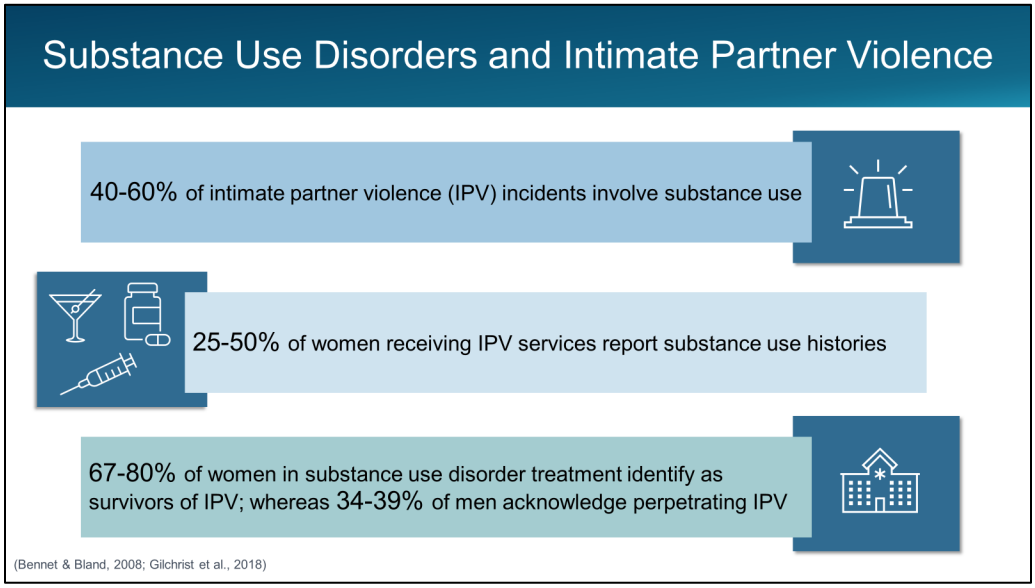
- *One large easel paper in the front of the training room*
- *Markers for each small group*

**Alternative Virtual Instruction:*

Prepare a link for a word cloud generator through www.mentimeter.com. Ask participants to identify physical, emotional, cognitive, or interpersonal/relational signs or symptoms of trauma. Then display the completed word cloud for the learners in real-time to create the same effect as the in-person exercise.

Slide 29

Substance Use Disorders and Intimate Partner Violence



Facilitator Script:

When substance use and intimate partner violence co-occur, substance use may play a facilitative role in intimate partner violence by precipitating or exacerbating the violent encounter. Here we have some key data points to highlight…

Substance use is involved in 40-60% of intimate partner violence incidents.

25-50% of women receiving intimate partner violence services report substance use histories.

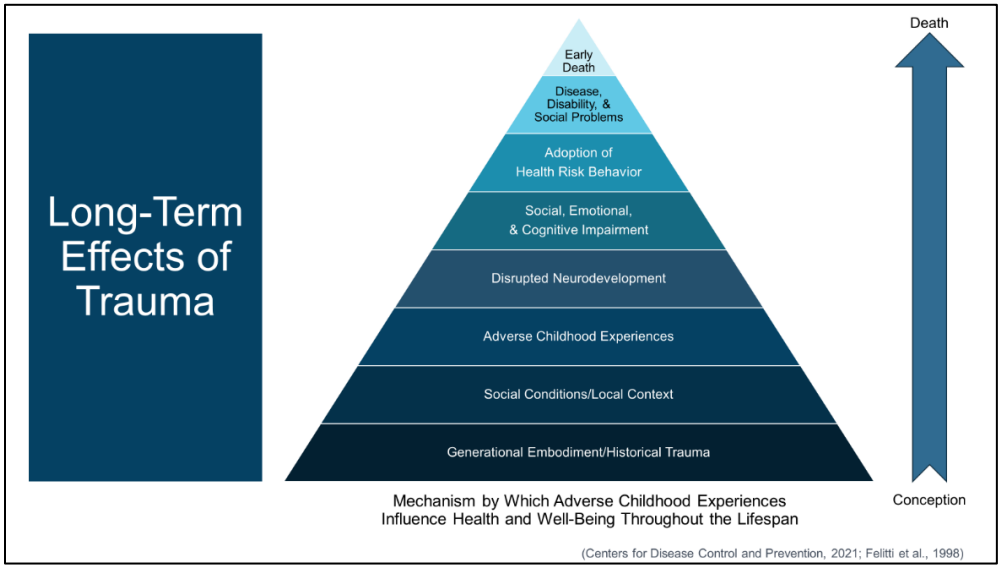
67-80% of women in substance use disorder treatment identify as survivors of intimate partner violence; whereas 34-39% of men acknowledge perpetrating (or as we'll reference to now moving forward within this toolkit as using violence or coercion) in the 12 months preceding substance use disorder treatment.

We'll take a deeper dive into the intersection of substance use disorders and intimate partner violence in module 4 of this toolkit.

Sources: (Bennet & Bland, 2008; Gilchrist et al., 2018)

Slide 30

Long-Term Effects of Trauma



Facilitator Script:

Parents affected by substance use and co-occurring disorders need a system of care that recognizes the cumulative effects of trauma and understands how this may impact their daily functioning and sustained recovery. Who here is familiar with the Adverse Childhood Experiences (or ACEs) Study? Would anyone like to summarize for your peers what this study found in relation to ACEs and long-term health and well-being?

That was great, thank you for jumping in and sharing your knowledge with your peers.

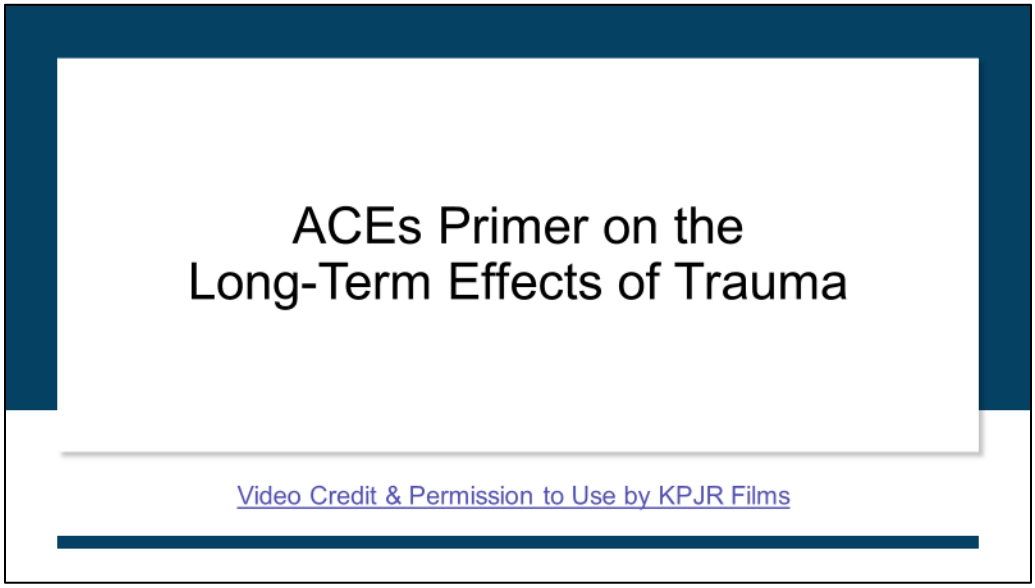
We now have a better understanding of the cumulative effects of trauma. ACEs may include childhood exposure to various forms of abuse: emotional, psychological, physical, or sexual; household dysfunction including exposure to substance abuse, mental illness, familial violence, and/or criminal behavior. We also know that ACEs are linked to chronic health problems such as heart disease, diabetes, obesity, among many others that may result in early death. In addition, ACEs are known to increase the propensity for substance use and mental disorders in adolescence and adulthood; and can negatively impact social and well-being conditions such as educational and employment opportunities, as well as earning potential. As ACEs add up, so does the risk for these long-term health and well-being outcomes. We also now have a better understanding about the prevalence of ACEs—according to the CDC 61% of individuals surveyed across 25 states reported experiencing at least one type of ACE before age 18 with nearly 1 in 6 reporting 4 or more ACEs. Additional evidence points to greater risk for women and children of minority racial and ethnic groups with reports of 4 or more ACEs. We'll have a much deeper discussion about ACEs and trauma in upcoming modules, but let's now transition to watching a video describing the long-term effects of trauma.

Facilitator Note: The CDC's About the CDC-Kaiser ACE Study webpage has detailed information on the ACE study, including free access to ACE questionnaires.

Sources: (Centers for Disease Control and Prevention, 2021; Felitti et al., 1998)

Slide 31

ACEs Primer on the Long-Term Effects of Trauma



Facilitator Script:

Facilitator Notes: Show the 5-minute video summarizing the relationship between adverse childhood experiences and long-term effects of trauma. Proceed with facilitating a large group discussion using the following prompts:

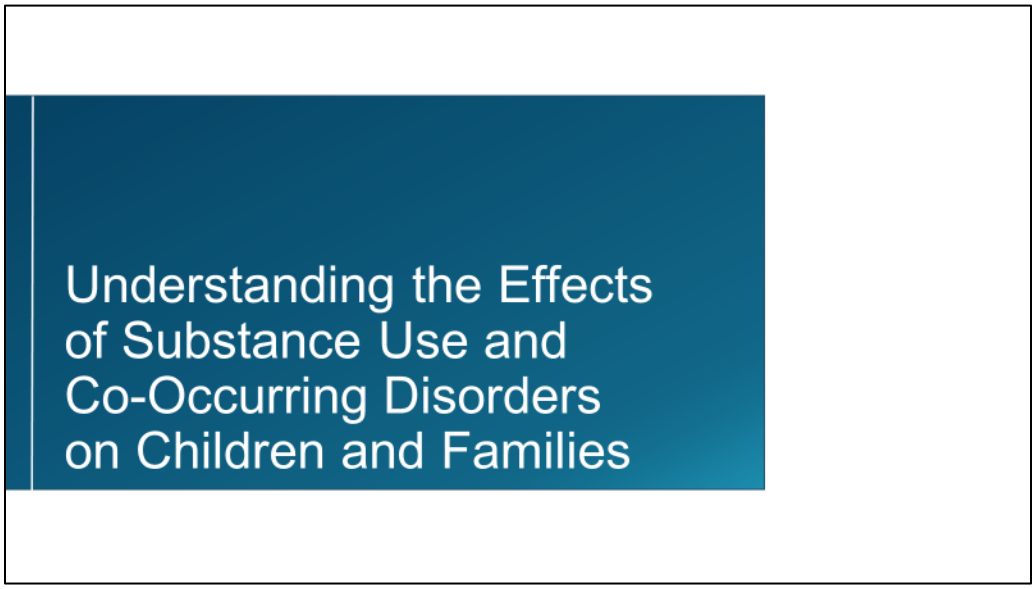
Prompts for Participants:

- **Any initial reactions to the video?**
- **What specifically stood out to you from the video's content?**
- **Was anybody surprised to hear the statistics on substance use—5 ACEs increases the risk for an alcohol use disorder by 8x's? What about the statistic about 6 or more ACEs leading to 20 years less in life expectancy?**
- **How can this information about ACEs and long-term health and well-being outcomes help improve how we go about serving children and families affected by substance use and co-occurring disorders?**

Video Source: KPJR Films

Slide 32

Understanding the Effects of Substance Use and Co-Occurring Disorders on Children and Families

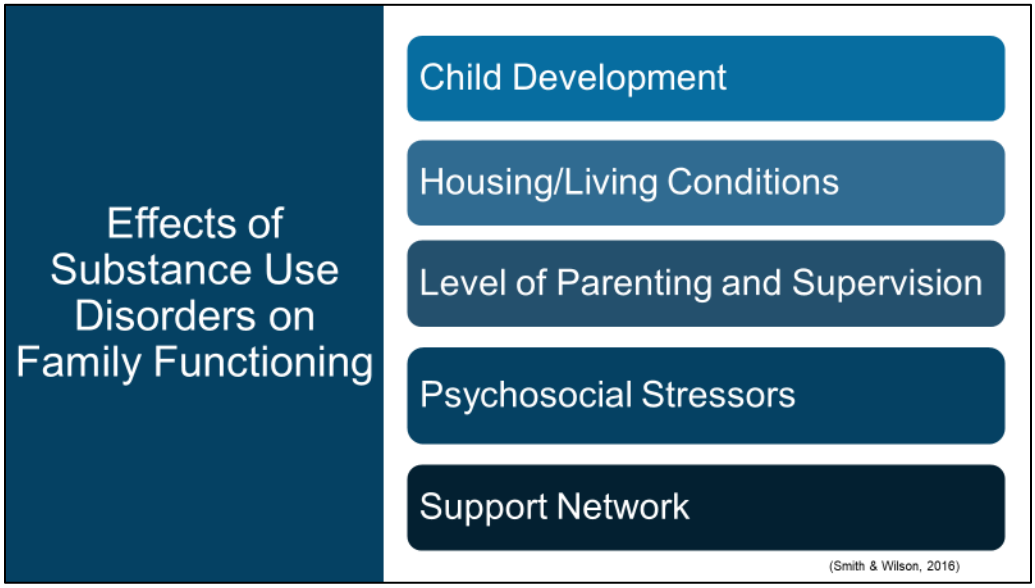


Facilitator Script:

Let's now take what we've just learned and begin applying it to how it might affect child and family well-being…

Slide 33

Effects of Substance Use Disorders on Family Functioning



Facilitator Script:

The life of a person with a substance use disorder is often out of balance, and the negative effects of misuse or abuse can have an enormous impact on those around them. Let's review how substance use disorders can negatively affect a family's functioning across various life domains.

Child Development:

- Children may present with fetal alcohol syndrome or have a history of neonatal abstinence syndrome. Infants exposed to substances may experience a range of social, emotional, and behavioral effects. In the absence of universal screening practices, many children's prenatal exposure goes undetected until later stages of development when other needs present which greatly limits the opportunity for early screening and intervention known to be associated with more optimal outcomes.

Housing and Living Conditions:

- It is not uncommon for families affected by substance use disorders to experience homelessness, housing insecurity and/or unsafe living conditions. We'll learn more in the next module about the science of addiction and how misuse or abuse of substances alters our brain chemistry where the need for the substance can supersede all other basic needs. This could look like parents mismanaging their finances to support their use or not being able to plan and manage their finances (e.g., timely payment of rent or utilities), resulting in possible eviction. Alternatively, this could also look like unkept housing conditions, or exposure to safety hazards due to open use of substances, in-home manufacturing and/or selling of illicit substances.

Level of Parenting and Supervision:

- Substance use disorders may also interfere with consistent levels of parenting and supervision. This may look like inconsistencies in meeting a child's physical and emotional needs; an absence of daily structure and family routines; inappropriate or inadequate levels of supervision during or immediately after active substance use; and exposure to high levels of toxic stress secondary to the parent's own adverse childhood experiences and long-term health and well-being outcomes.

Psychosocial Stressors:

- Parental substance use can also be associated with a host of psychosocial stressors —we've already touched on some, but others include financial instability, food insecurity, limited educational and employment opportunities, exposure to violence both at the intimate partner and community levels, and incarceration. All contribute significantly to the level of undue toxic stress for children and families with direct impact on their stability and well-being.

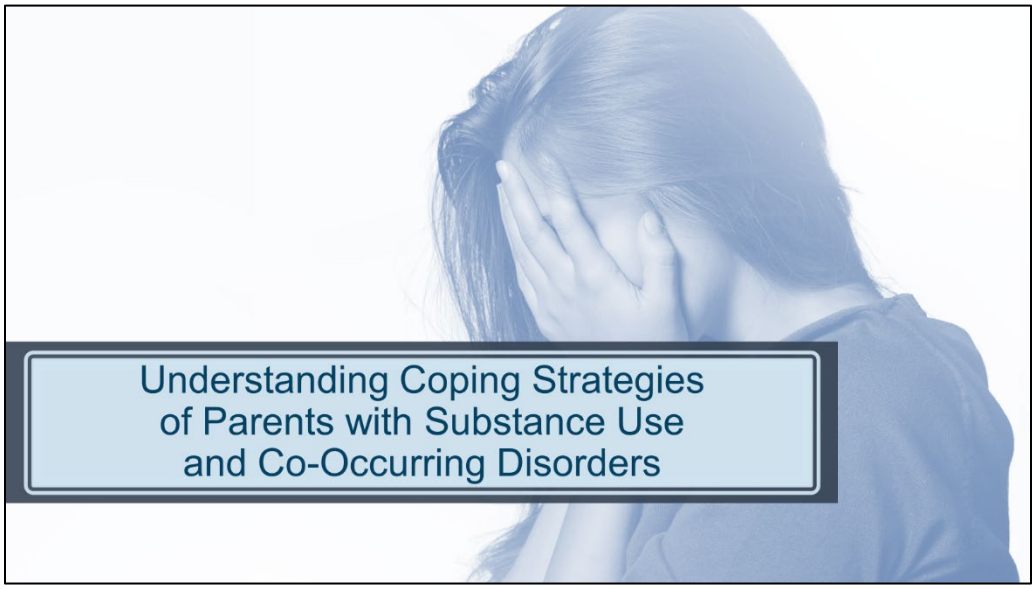
Support Network:

- Substance use disorders affect all levels of family functioning and relationships which can greatly alter a parent's access to a healthy support network. Remember, the brain is rewired to prioritize the drug over all other basic needs—relationships with family members and friends are not immune to this change. Parents in active use may begin surrounding themselves with other individuals who use substances and similarly, friends and family members may begin to distance themselves to exercise healthy boundaries. Parental substance use is often associated with increased social isolation and this in part is directly linked to the level of public and personal stigma– we'll touch more on this in just a few minutes as well as cover different components throughout the remaining modules of this toolkit.

Source: (Smith & Wilson, 2016)

Slide 34

Understanding Coping Strategies of Parents with Substance Use and Co-Occurring Disorders



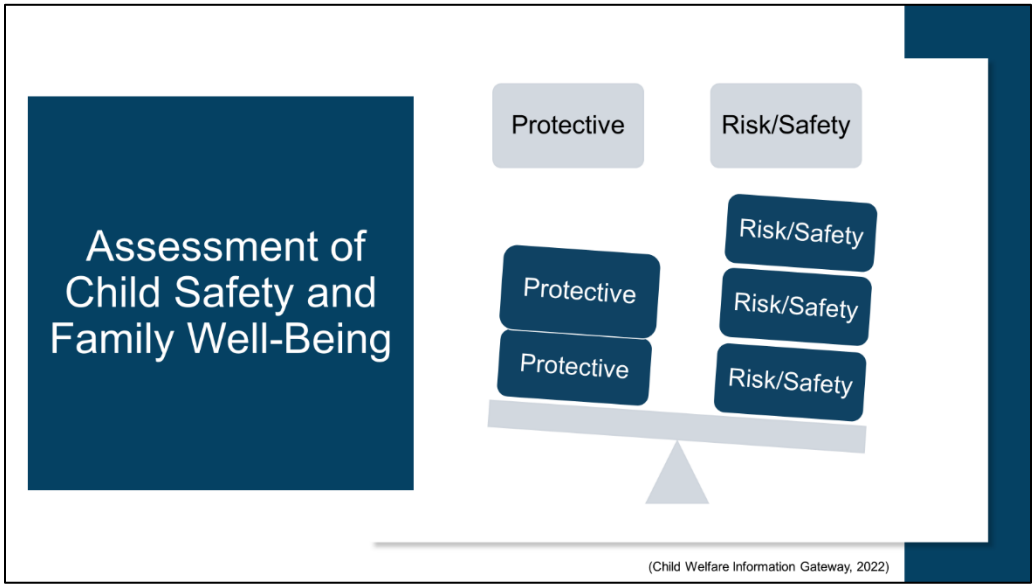
Facilitator Script:

Part of understanding the effects of substance use disorders on children and families is also understanding the various levels of coping strategies that may be at play at the point of child welfare intervention. Many persons including parents may have gone all their life without a formal diagnosis or treatment for any combination of trauma, substance use or mental disorders. It is also not uncommon for these same parents to be engaging in self-medicating behaviors with alcohol and other drugs to manage symptoms from undiagnosed or untreated trauma or mental disorders. This speaks volumes for the need for screening and assessment at point of child welfare intervention for early identification and referral to treatment as indicated. Some parents may indeed meet diagnostic criterion for a co-occurring substance use and mental disorder—but this doesn't mean they will be ready for behavioral change which might come off as denial or minimization of use. We'll spend much more time digging into readiness for change and stages of change theory in module 4 of this toolkit including the use of solution-focused and motivational interviewing techniques to use in your casework practice.

Source: (Child Welfare Information Gateway, 2022)

Slide 35

Assessment of Child Safety and Family Well-Being



Facilitator Script:

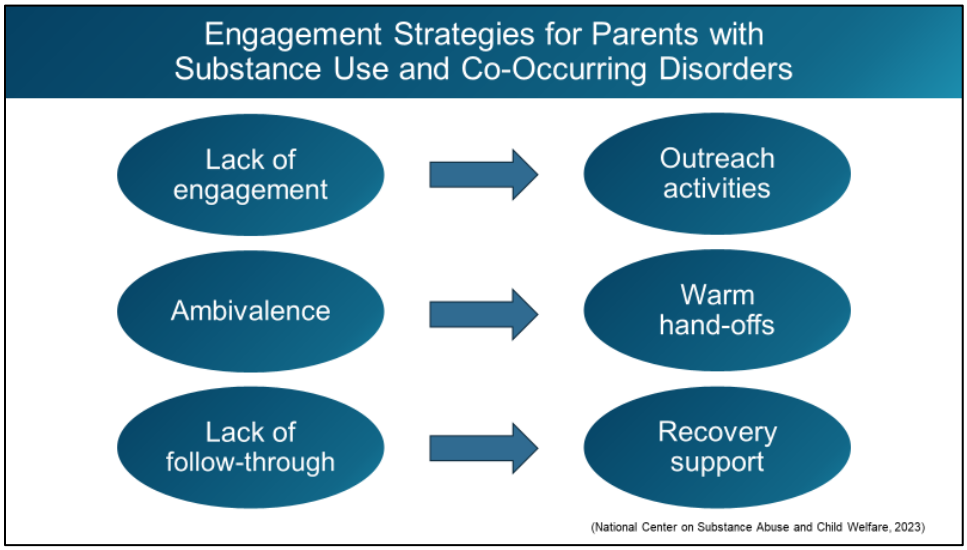
As we know, substance use, mental disorders, and/or trauma do not in and of itself make a child unsafe or warrant child welfare intervention. As child welfare workers we must assess the situation that brought the family to the attention of the department as well as the family's circumstances to determine if the child is in immediate or impending danger and if the child's safety and well-being is or likely to be threatened. We do this by using standardized assessment tools for the identification of safety, risk, strengths (also commonly referred to as protective capacities or factors) and needs. While no standardized assessment tool can provide comprehensive insight into each family's individual dynamics and circumstances, it can inform and generate discussions with the child and family team and support collaborative case planning and decision-making. Assessment of child safety and well-being are not one-time events—rather, ongoing practice throughout the life of a family's child welfare involvement. We will go into greater detail on assessment and safety planning for families affected by substance use disorders in module 6 of this toolkit. But for now, let's hear from you about current standardized tools used in your agency practice.

Facilitator Note: Available resource Identifying Safety and Protective Capacities for Families with Parental Substance Use Disorders and Child Welfare Involvement

Source: (Child Welfare Information Gateway, 2022)

Slide 36

Engagement Strategies for Parents with Substance Use and Co-Occurring Disorders



Facilitator Script:

The cumulative effects of substance use and co-occurring disorders may lead to a myriad of actions, decisions, or behaviors that can make a parent appear uninterested, inconsistent, or evasive. Individuals who appear this way may not recognize a need for change or may feel ambivalent toward making any changes (e.g., doesn't recognize the effects of substance use on themselves or their children/family), perhaps parents do not know how to go about taking steps toward their recovery (e.g., not sure how to access treatment or recovery supports), or may have negative experiences from past efforts at initiating change (e.g., stigma or bias; severe withdrawal symptoms or negative reactions to medications).

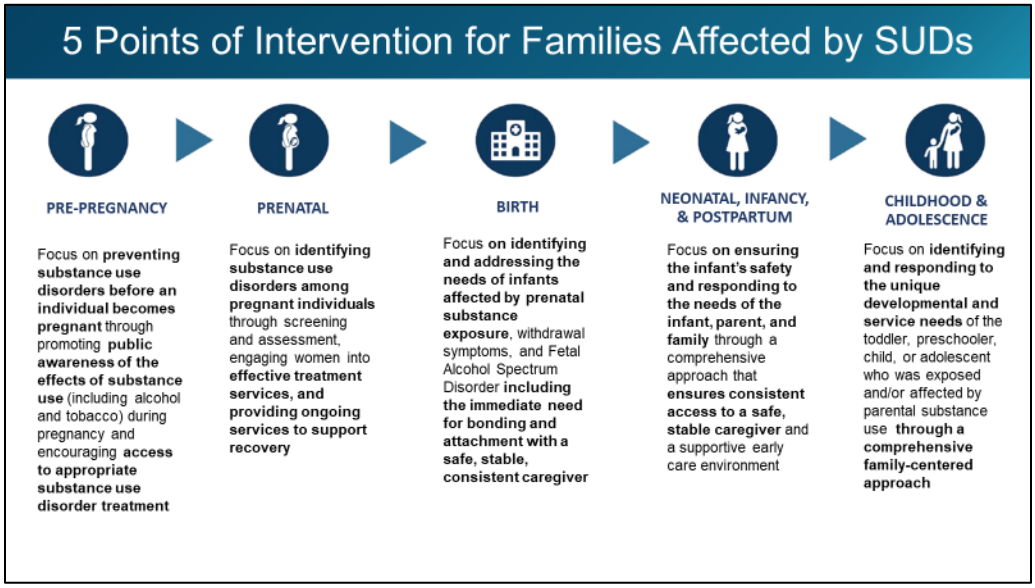
Our role as child welfare workers is to actively engage parents for screening, assessment, and treatment—this means going beyond just providing a referral. We do this by integrating engagement strategies to ensure access and utilization. For parents not willing to engage or who become unresponsive to your attempts to engage—don't give up. Ambivalence is a normal part of the change process. Instead, use a strength-based approach and other engagement techniques to understand their reasons or concerns. Other strategies for engagement might be in the form of a warm hand-off with the parent and new provider or assisting parents with scheduling appointments, completing intake and enrollment paperwork, or problem-solving barriers such as lack of childcare or transportation. In addition, access to peer recovery supports (e.g., a person with lived experience and in recovery from a substance use or mental disorder) allows parents to receive help navigating the treatment system, reinforcing treatment plans and recovery behaviors, and serve as a source of hope and inspiration to the parent on their road to long-term recovery.

Facilitator Note: Available resources: Understanding Screening and Assessment Of Substance Use Disorders: Child Welfare Practice Tips

Source: (National Center on Substance Abuse and Child Welfare, 2023)

Slide 37

5 Points of Intervention for Families Affected by SUDs



Facilitator Script:

Here we'll wrap up this section with a visual reminder of the 5-points of intervention for families affected by substance use disorders…

- Beginning with the pre-pregnancy stage—the focus is on prevention. Promoting awareness of the effects of substance use during pregnancy and encouraging access to appropriate substance use disorder treatment services.
- With the prenatal stage—the focus is on early identification through screening, assessment, and referral for effective treatment services including recovery-oriented supports for pregnant persons.
- During the birth stage—the focus is on screening and identification of prenatal substance exposure, access to non-pharmacological and pharmacological treatment to promote the health and well-being of both infant and parent.
- With the neonatal, infancy, and postpartum stage—the focus should remain on meeting the comprehensive needs of the infant, parent, and family to ensure a stable and supportive early care environment.
- And lastly, the childhood and adolescence stage—the focus is on early screening and identification of developmental needs and referral to indicated services and supports.

We'll go into a much more in-depth level on these points on intervention throughout the remaining modules of this toolkit, but for now let's segue into a discussion about stigma.

Facilitator Note: The Prenatal module has additional information on the prenatal stage and Plans of Safe Care.

Slide 38

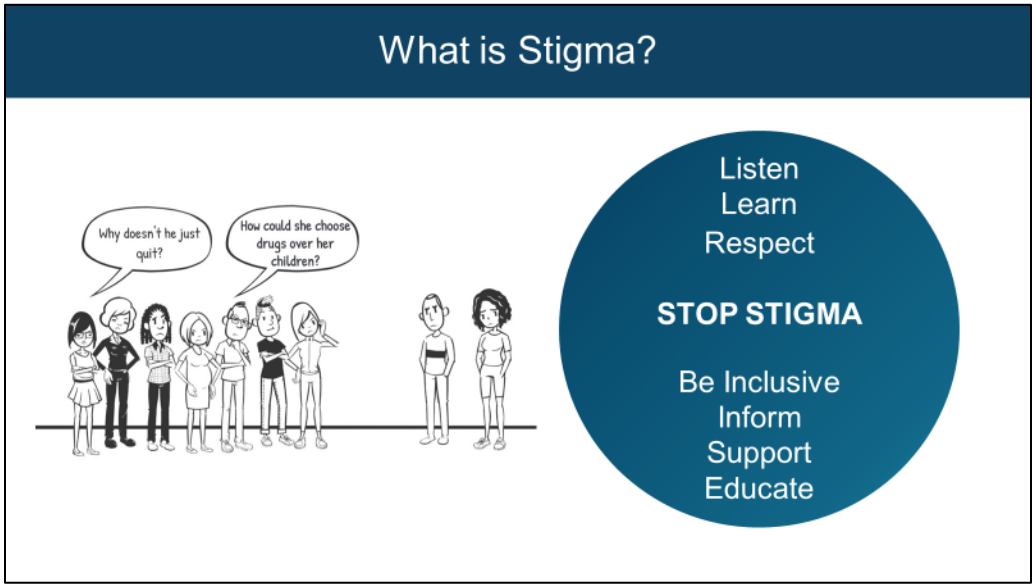
Understanding How Stigma Affects the Families We Serve

Facilitator Script:

Understanding how stigma affects the families we serve is critical to their well-being and recovery outcomes. Let's start off this discussion with a little exercise…

Slide 39

What is Stigma?



Facilitator Script:

With a show of hands, who here has heard any one of these two comments made in relation to your work with children and families affected by substance use disorders? These are just two examples, but what others come to mind? [allow time for responses]

Other examples include:

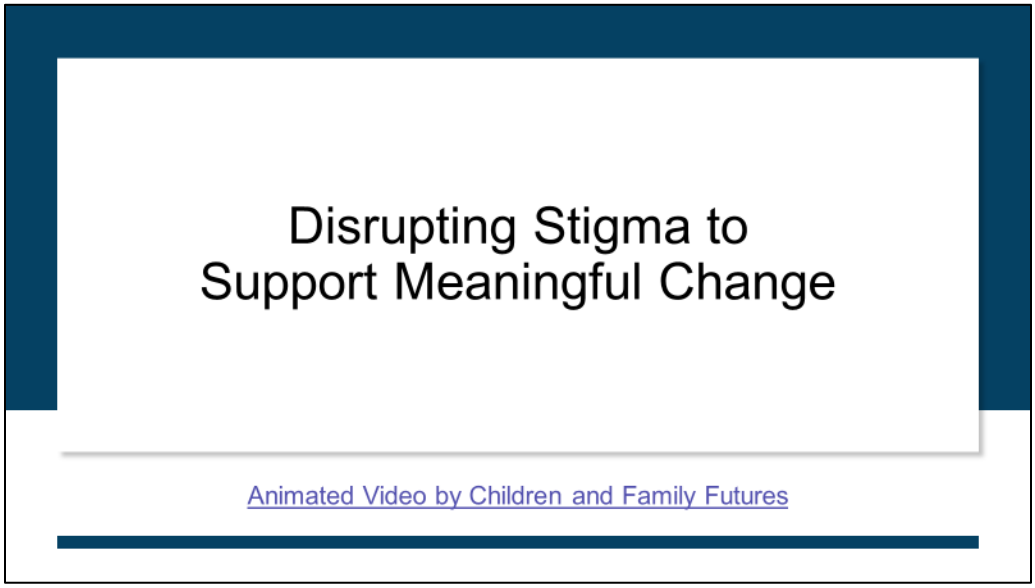
- Once an addict, always an addict.
- She/He/They must really not love their children or else they would just stop using drugs.
- Children should be removed from parents who abuse alcohol or drugs.

Thank you for your additions. Now let's turn our attention to how common statements like these shape and perpetuate substance use disorder stigma.

Facilitator Note: The video is embedded on the next slide; the full video is available on Children and Family Futures website.

Slide 40

Disrupting Stigma to Support Meaningful Change



Facilitator Script:

Facilitator Notes: Internet or Wi-Fi permitting, open the hyperlink for a 5-minute animated video about disrupting stigma to support meaningful change. Proceed with facilitating a large group discussion using the following prompts:

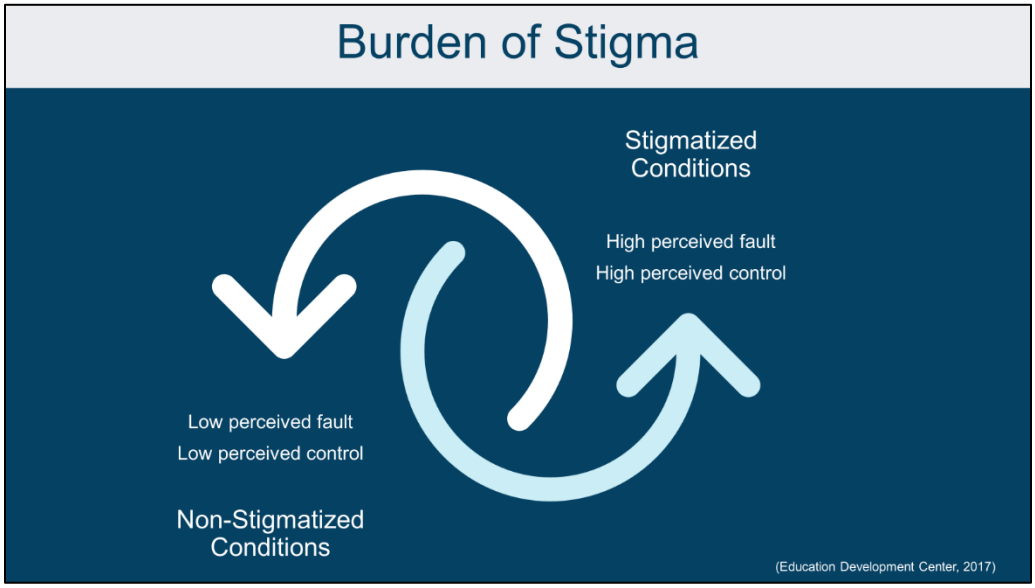
Prompts for Participants:

- **Any initial reactions to the animated video?**
- **We heard some examples of institutional stigma specific to Family Treatment Court (or FTC) program requirements—what are some other examples of institutional stigma contributing to discriminatory outcomes across the child welfare continuum?**
- **What about the relationship between the media and public stigma—in what ways has the media perpetuated negative stereotypes (or attitudes, beliefs, values) about individuals affected by substance use disorders, and specifically in relation to parenting?**
- **From your experience, how has self-stigma (or shame) affected parent's engagement and retention in child welfare and substance use disorder treatment services?**

Video Source: Children and Family Futures

Slide 41

Burden of Stigma



Facilitator Script:

For people with a substance use disorder, stigma disproportionately influences health outcomes and mental well-being. Fear of being judged or discriminated against can prevent people with substance use disorders, or those who are at risk of having substance use disorders, from getting the help they need.

What is represented here is that when individuals perceive a low level of fault and a low level of control over their substance use disorder, they feel less stigmatized. If an individual feels that others blame them for their substance use—that their condition is a choice (and a bad one at that) and that they can change if they really want to—perceived stigma increases.

Another form of stigma that we can work to prevent is attribution error. Let's put this into perspective for a moment. If a parent is late dropping off their children to school or making it to a pediatrician's appointment it is easy to place blame on the morning commute and subsequent traffic, or the reality of having kids—misplaced shoes or backpacks, last minute diaper change, etc. Now let's think of a parent who may miss or is late to their treatment, therapy, or child and family team meeting– are we in this scenario quick to equate their actions (or inactions) as lack of engagement or accountability? This is a good reminder for all of us in our work with parents to remain mindful of our own perceptions and how these may potentially place blame even when we don't intend to. Let's review more concrete examples of this…

Facilitator Note: Available resource Disrupting Stigma: How Understanding, Empathy, and Connection Can Improve Outcomes for Families Affected by Substance Use Disorders

Source: (Education Development Center, 2017)

Slide 42

Your Choice of Language Reflects Your Understanding of Substance Use Disorders as a Disease

Your Choice of Language Reflects Your Understanding of Substance Use Disorders as a Disease

Instead of…	Try…
Addict/Drug Abuser	Person/parent with a substance use disorder
Former Addict	Person in recovery
Drug Addicted Baby	Infant with prenatal substance exposure
Drug of Choice	Drug of use
Clean/Dirty Drug Screen	Screen tested negative or positive for substances
Opioid Replacement	Medication for opioid use disorder

Facilitator Script:

Reframing our use of language is the first step to reduce stigma and helps raise awareness about substance use disorders as a chronic disease, not a personal failing.

With a show of hands, who still hears the terms in the first column being used in our field present day? *[allow time for a response]*

Let's examine a few of these more closely…

- Clean/Dirty Drug Test—What does that say about the person who tested positive for a substance? That they are dirty? Does that language increase or decrease stigma?
- Drug Addicted Baby—Are babies really addicted? No. Addiction is characterized by tolerance and cravings. Babies don't have cravings. They may be exposed prenatally and may have a physical dependency—but they are not addicted.
- Drug Abuse—What does this really mean? Think back to the idea of perceived fault and perceived control. The word "abuse" implies the person is at fault and has control over their behavior.

When we talk with parents, we want to use person-first language, which is a strength-based approach that suggests that the person has a problem that can be addressed and does not use the problem to define the person (e.g., "a person with a substance use disorder" versus "an addict").

Slide 43

Proportional Access, Equitable Treatment, Equitable Outcomes

Facilitator Script:

Studies show that individuals with substance use and mental health disorders who are members of racial, ethnic, and other minority groups, such as the lesbian, gay, bisexual, transgender, questioning, intersex, asexual, and two-spirit (LGBTQIA2S+) community, are less likely than their white-majority, heteronormative counterparts to receive appropriate diagnoses, enter, remain in, and complete treatment, and receive adequate care. They also report lower satisfaction with treatment. There are many reasons these groups are less likely to engage and complete treatment but biases within the healthcare, substance use and mental health treatment community, and a failure to provide culturally- and linguistically-competent treatment are several of the primary reasons.

Substance use, mental health disorders, and child neglect or abuse are three of the most highly stigmatized conditions in our society. And since we know people of color are disproportionately involved with the child welfare system, these families experience compounded stigma that reinforce negative stereotypes.

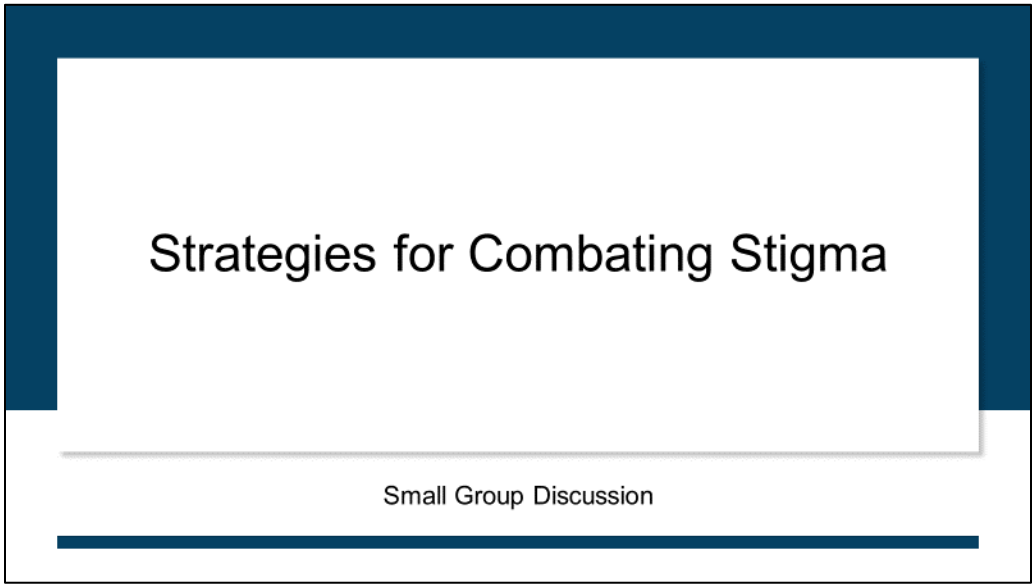
It is also important to remember how our implicit biases (i.e., unconscious biases) may influence our understanding of who is affected by co-occurring disorders. According to the 2022 National Survey on Drug Use and Health, multiracial adults aged 18 or older experienced the highest rates for co-occurring disorders at 46.4% (as compared to white adults at 34%, Hispanic adults at 31.7%, Black adults at 31.3%, or Asian adults at 22.5%).

Facilitator Note: Available resource 2022 National Survey of Drug Use and Health (NSDUH)

Sources: (Kennedy et al., 2020; Substance Abuse and Mental Health Services Administration, 2023a; Wogen & Restrepo, 2020)

Slide 44

Strategies for Combating Stigma



Facilitator Script:

Let's convene in our small groups for the next [x] minutes to discuss strategies for combating stigma. Use the following list of questions to help facilitate your small group discussions…

Prompts for Participants:

- **Is the language we use strength-based and person-first?**
- **Do families affected by substance use and co-occurring disorders have an equal opportunity to succeed?**
- **Are staff reflective of the groups you seek to serve—race, ethnicity, gender, age, lived experience?**
- **Are staff trauma-informed and aware how physical spaces and processes can be traumatic experiences for parents and families?**
- **Does your agency solicit feedback from parents and families including those who don't remain engaged in services?**

Facilitator Note: Reconvene learners for a large group debrief highlighting key takeaways or lessons from the small group discussions.

**Alternative Virtual Instruction:*

Engage learners for the list of facilitative prompts in a large group virtual format.

Slide 45

Treatment of Substance Use and Co-Occurring Disorders

Facilitator Script:

Let's now segue into a broad-level overview regarding treatment of substance use and co-occurring disorders…

Slide 46

A Treatable Disease

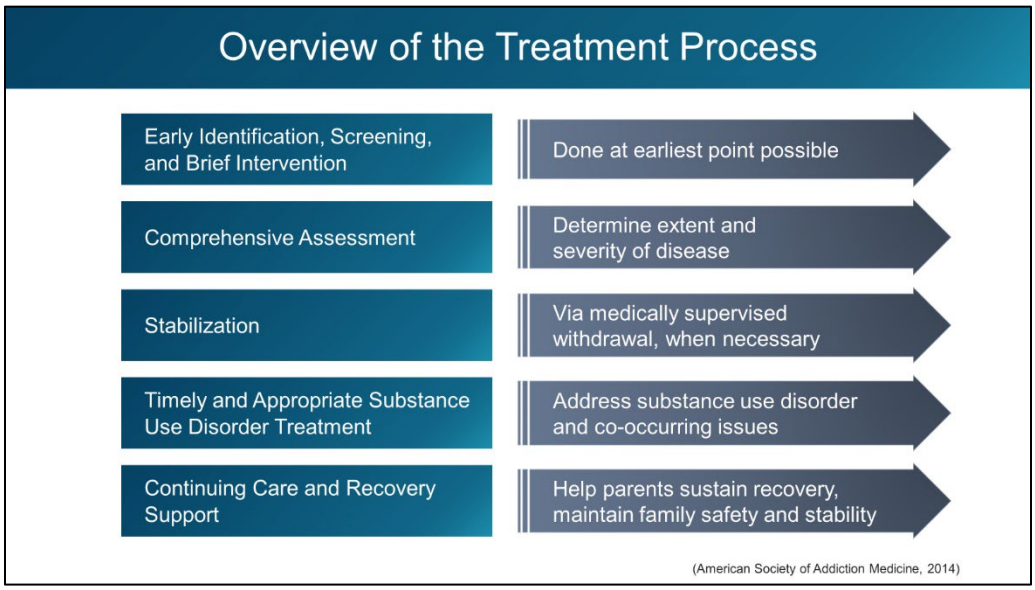
Facilitator Script:

Substance use disorders are a treatable disease! Through scientific advances, we now have a better understanding about the short- and long-term effects of substance use, namely the powerful influence on brain circuitry and subsequent physical and psychological effects. These groundbreaking discoveries have led to improvements in how we approach substance use disorder treatment for sustained long-term recovery—often a combination of medication, behavioral interventions, and peer recovery support.

Source: (Volkow et al., 2016)

Slide 47

Overview of the Treatment Process



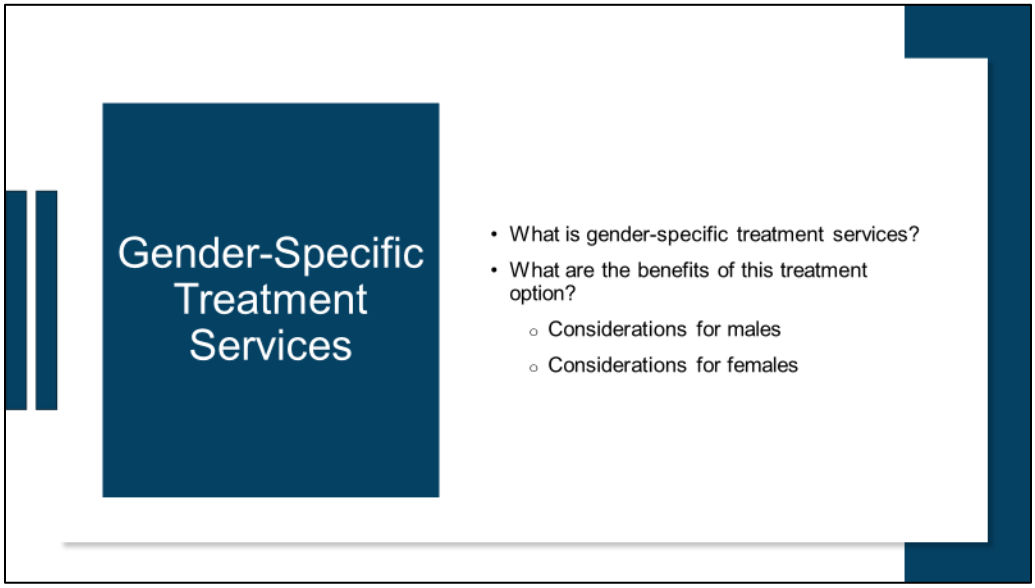
Facilitator Script:

As child welfare workers, when we have concerns that a parent may have a substance use disorder, we should ensure timely screening and refer the parent for a substance use disorder assessment when indicated. This slide provides a general overview of the treatment process from assessment through ongoing support or after care. We'll have a more in-depth discussion of the assessment and treatment process in Module 2 of this toolkit, but for now let's spend more time reviewing treatment services and approaches.

Source: (American Society of Addiction Medicine, 2014)

Slide 48

Gender-Specific Treatment Services



Facilitator Script:

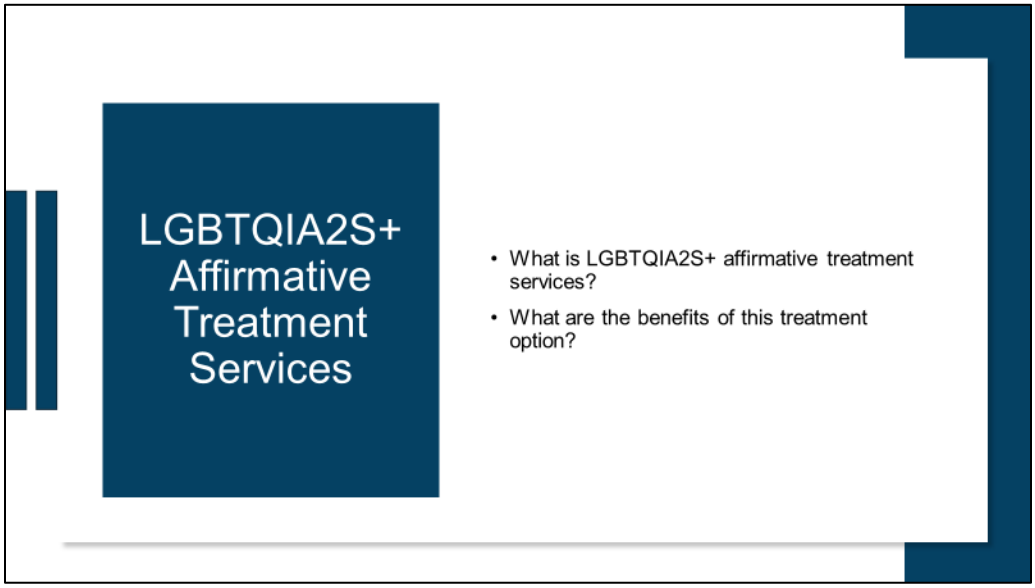
Gender-specific treatment services are designed to meet the unique needs of men and women, respectively. While both genders are affected by substance use disorders, how each gender is affected is different. Gender-specific treatment allows practitioners to tailor programming to these very specific differences which often include information on preferred substances, rates of dependence, neurobiological responses, and careful attention to psychosocial stressors that may increase risk of return to use.

In addition to addressing these inherent biopsychosocial differences, gender-specific programming also allows for an environment that is tailored to the emotional and interpersonal needs of men and women alike. For men, this may mean a greater emphasis on their physiological needs as a strategy to build trust and a willingness to speak openly about their emotional and psychological needs. Whereas women who are more generally open and willing to speak freely may need the safety of a gender-specific treatment group especially when addressing areas of intimate partner violence and trauma. Lastly, gender-specific programming allows men and women to prioritize their health and well-being away from the opposite sex thereby reducing the risk of co-dependent relationships during treatment.

Sources: (Substance Abuse and Mental Health Services Administration, 2021a; Substance Abuse and Mental Health Services Administration, 2013)

Slide 49

LGBTQIA2S+ Affirmative Treatment Services



Facilitator Script:

LGBTQIA2S+ affirmative treatment services are committed to creating a welcoming and safe environment for individuals seeking support for a substance use disorder regardless of their sexual orientation, gender identity, or expressions. Health disparities for the LGBTQIA2S+ community are well documented. According to SAMHSA the prevalence of substance use disorders in the LGBTQIA2S+ community is 20-30% compared to 9% of the general population. In addition, 86.8% who meet criteria for co-occurring disorders (substance use and mental disorder) do not receive substance use treatment services.

LGBTQIA2S+ affirmative treatment services can look like many things—from the acknowledgment and use of chosen names and preferred pronouns; changing language on intake forms to be more gender inclusive or gender neutral; providing safe and supportive treatment environments; presence of LGBTQ or affirming staff; offering LGBTQ specialized treatment modalities, among other strategies and efforts. Affirmative care promotes inclusivity and when people feel welcomed and safe, they are more likely to seek support for their substance use disorder, engage in treatment, and remain committed to their long-term recovery.

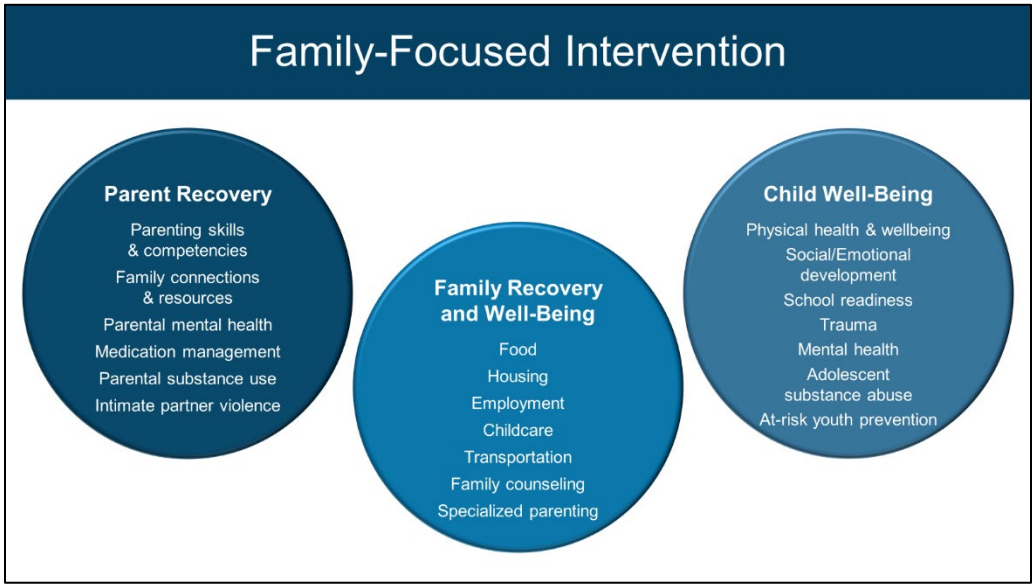
We'll have more in-depth discussions of gender-specific and LGBTQIA2S+ affirmative treatment services in module 2, so let's shift our focus to family-focused interventions.

Facilitator Note: Additional resource SAMHSA's LGBTQ+ Behavioral Health Equity Center of Excellence

Source: (Substance Abuse and Mental Health Services Administration, 2023b)

Slide 50

Family-Focused Intervention



Facilitator Script:

When serving a family holistically, intervention efforts are designed to meet the needs of every member of the family. This includes identifying the family's strengths and using these as a catalyst for achieving increased safety and stability.

Services to support the parent's recovery should include:

- Parenting skills and competencies
- Family connections and resources
- Parental mental health
- Medication management
- Parental substance use
- Intimate partner violence

Providing services that support child's well-being must include:

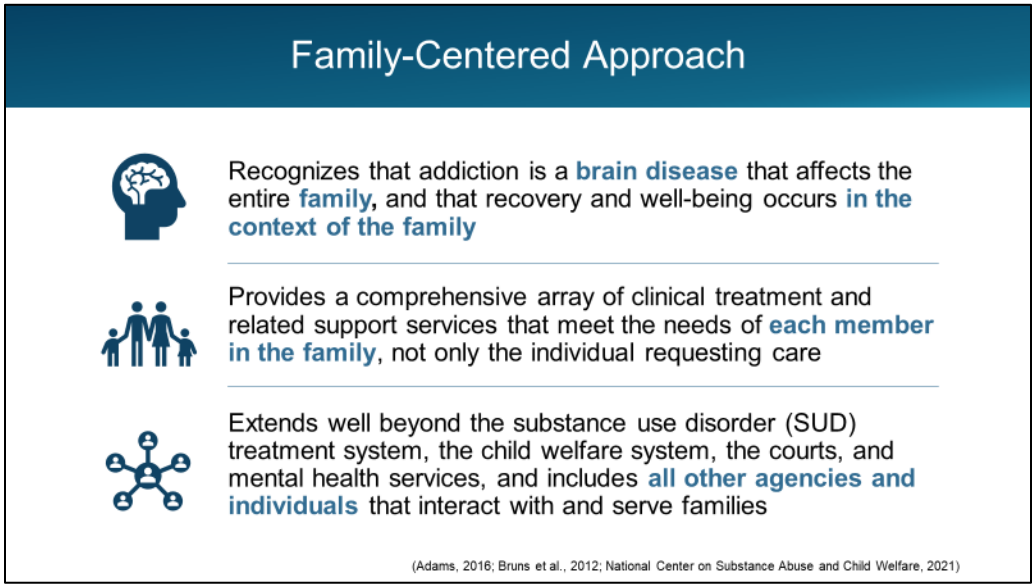
- Physical health and well-being
- Social/emotional development
- School readiness
- Trauma
- Mental health
- Adolescent substance use
- At-risk youth prevention

Supporting the entire family's recovery and well-being means providing:

- Food
- Housing
- Employment
- Childcare
- Transportation
- Family counseling
- Specialized parenting

Slide 51

Family-Centered Approach



Facilitator Script:

A family centered approach recognizes and accepts the individual person's definition of family and recognizes that every person defines "family" differently.

A family-centered approach extends well beyond the substance use disorder treatment system, the child welfare system, the courts, and mental health services. It includes all other agencies and individuals that interact with and serve families. It was important to us to be very intentional about our language. We used the phrase "family-centered treatment" when we were talking about treatment specifically but whenever possible we used "family-centered approach" to be more encompassing of all systems.

- Not all this work is clinical.
- A family-centered approach is important with schools, doctors, early education providers, anyone that is providing services to people.

A family-centered approach recognizes that parents and children live within the context of a larger family system and that families exist within the context of their community and culture and the cultural influences of race, ethnicity, religion, geography, and customs are considerations that must be prioritized when implementing a family-centered approach.

A family-centered approach is often a paradigm shift from business as usual. Identifying the family as a system requires a shift in thinking for service providers who have traditionally focused on their identified client. What we know is that child safety and parental recovery are critically linked to one another and must be addressed holistically to ensure the best outcomes for the entire family.

Sources: (Adams, 2016; Bruns et al., 2012; National Center on Substance Abuse and Child Welfare, 2021)

Slide 52

Principles of Family-Centered Treatment

Facilitator Script:

Currently, there is no universally accepted definition of "family-centered treatment." Provider approaches may differ along a continuum, from family involvement (a minimum standard of service) to family-centered services (in which children or other family members may receive their own services) to full comprehensive family-based treatment (in which all members of the family have individualized case plans and share an integrated family plan).

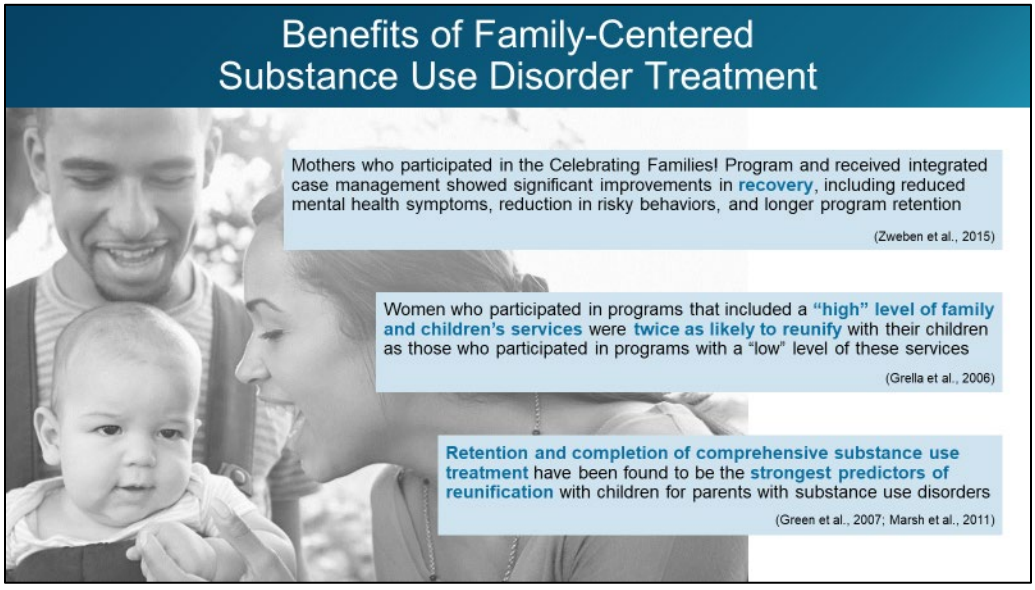
Despite this variation, some common principles underlie family-centered treatment, including:

- It is comprehensive and includes clinical treatment for substance use disorders, clinical support services, and community supports for parents and their families. Services often include recovery coaches or mentors, case management, aftercare services, access to co-occurring services, or other identified needs for the parent and the family.
- It focuses on the entire family unit as opposed to the individual parent with a substance use disorder. Women/parents define their families and treatment identifies and responds to the impact of substance use disorders on every family member.
- Treatment is based on the unique needs and resources of individual families.
- Families are dynamic, and thus treatment must be dynamic.
- Conflict within families is inevitable, but resolvable. Treatment offers whole-family services that build on family members' strengths to improve family management, well-being, and functioning.
- Meeting complex family needs requires coordination across systems.
- Services must be gender-responsive and specific and culturally competent.
- Family-centered treatment requires an array of professionals and an environment of mutual respect and shared training.
- Safety of all family members comes first.
- Treatment must support creation of healthy family systems.

Facilitator Note: Available resource Implementing a Family-Centered Approach Modules

Slide 53

Benefits of Family-Centered Substance Use Disorder Treatment



Facilitator Script:

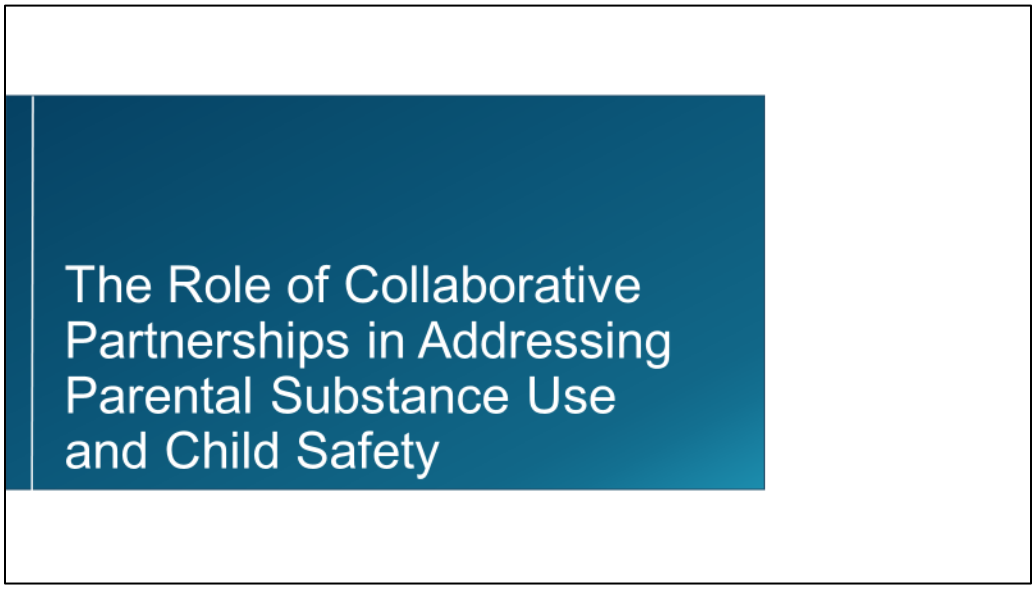
Here we have a summary of proven outcomes from family-centered substance use disorder treatment…

- Mothers who participated in the Celebrating Families! Program and received integrated case management showed significant improvements in recovery, including reduced mental health symptoms, reduction in risky behaviors, and longer program retention
- Women who participated in programs that included a "high" level of family and children's services were twice as likely to reunify with their children as those who participated in programs with a "low" level of these services
- Retention and completion of comprehensive substance use treatment have been found to be the strongest predictors of reunification with children for parents with substance use disorders

Sources: (Zweben et al., 2015; Grella et al., 2006; Green et al., 2007; Marsh et al., 2011)

Slide 54

The Role of Collaborative Partnerships in Addressing Parental Substance Use and Child Safety

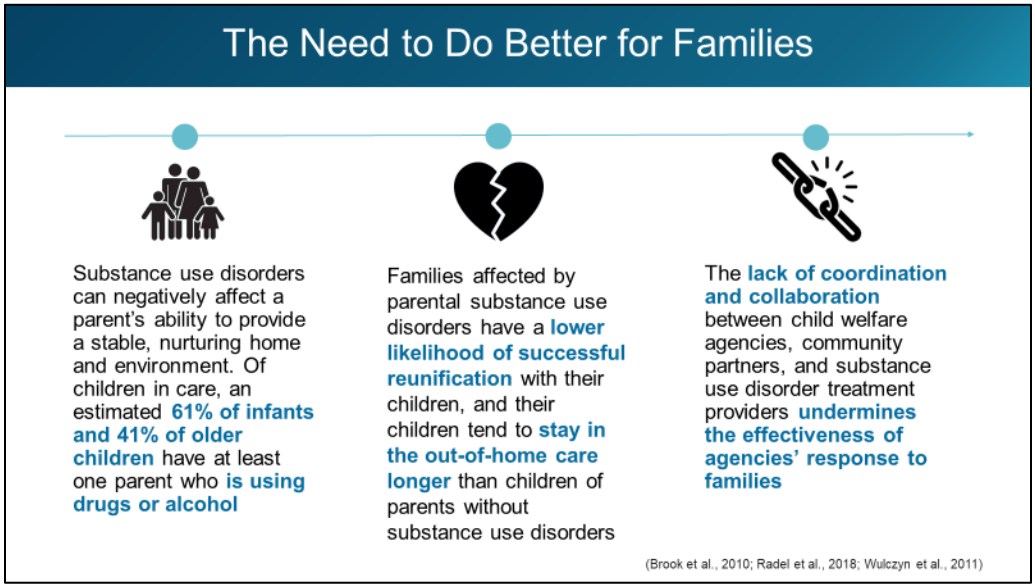


Facilitator Script:

Let's now close out today's training discussion with acknowledging the important role collaborative partnerships play in addressing parental substance use and child safety…

Slide 55

The Need to Do Better for Families



Facilitator Script:

The process of engaging and retaining parents with substance use disorders for screening, assessment, treatment, and in moving from treatment to lifelong recovery is multifaceted and complex.

We know families affected by substance use disorders and involved with child welfare often face a host of challenges and barriers to family well-being. While recovery is possible, substance use disorders can negatively affect a parent's ability to safely parent their children in the absence of services and supports to promote recovery and family stability. At the point of removal, we also know these same families have a lower likelihood of successful reunification and children tend to stay in out-of-home care longer.

Sources: (Brook et al., 2010; Radel et al., 2018; Wulczyn et al., 2011)

Slide 56

Improving Partnerships: No Single Agency Can Do This Alone

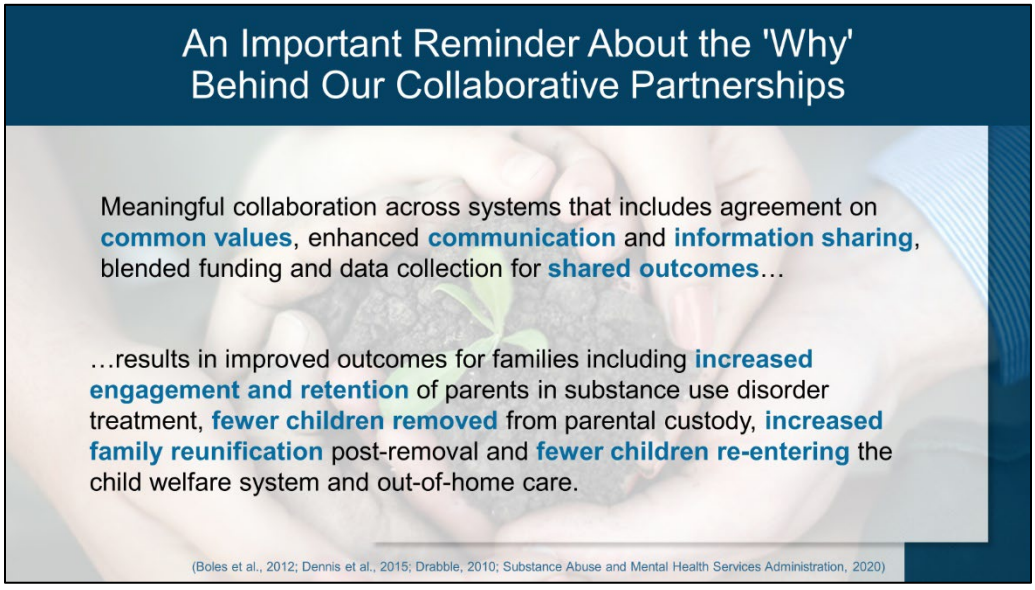
Facilitator Script:

We also know that no single agency can tackle this issue on its own—it requires a coordinated multi-system approach that draws on the talents and resources of many agencies and providers to promote the safety, permanency, well-being, and recovery outcomes of parents, children, and families. This new way of doing business will rely heavily on relationships across systems and within our communities that extends far beyond that of child welfare, substance use disorder treatment providers, and the courts—reaching agencies and providers in healthcare, early childhood, education, and family support —to just name a few.

Facilitator Note: Available resource Building Collaborative Capacity Series

Slide 57

An Important Reminder About the 'Why' Behind Our Collaborative Partnerships



Facilitator Script:

And finally, we also know that cultivating collaborative partnerships takes time and an ongoing commitment from all involved—we'll have a more in-depth discussion on this topic in module 7 but wanted to close out today's training with an important reminder about the 'why' behind our work…

Optimal family outcomes rely on a coordinated and collaborative approach across systems. When partner agencies share common values, understand each other's roles and responsibilities, and streamline procedures and protocols this leads to improved efficiencies in case planning and more effective monitoring of progress toward identified goals and objectives; these cross-system improvements in turn, result in an improved experiences for parents, children, and families—translating to better treatment engagement and retention, fewer child removals, improved reunification rates including lowered rates of re-entry.

Sources: (Boles et al., 2012; Dennis et al., 2015; Drabble, 2010; Substance Abuse and Mental Health Services Administration, 2020)

Slide 58

Contact the NCSACW Training and Technical Assistance (TTA) Program

Facilitator Script:

Alright everyone, this concludes the instructional content for module one. If you have any follow up questions from today's training, feel free to reach out to the National Center on Substance Abuse and Child Welfare at ncsacw@cffutures.org or toll free at 1-866-493-2758. Thank you all for our rich training discussion today and for your continued work on behalf of children, parents, and families affected by substance use and co-occurring disorders.

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