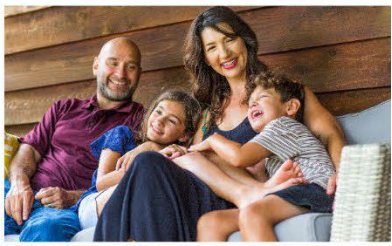
MODULE 2

Understanding Substance Use Disorders, Treatment & Recovery







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 both foundational and special topic modules:

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, Domestic Violence & Trauma

Module 4: Engagement & 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 & Adolescents Affected by Parental Substance Use & Co-Occurring Disorders

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

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

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

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

NCSACW will add special topic modules to the Child Welfare Training Toolkit to stay ahead of emerging trends. These new modules will cover the latest developments and innovations, ensuring that training resources remain relevant and impactful. Regularly check the NCSACW website for the latest modules and enhancements.

In addition, the Child Welfare Training Toolkit is designed to offer states and local jurisdictions flexibility with delivery methods—the 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.

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.

Language & Terminology

Discipline-specific language and terminology are used throughout this training 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

Frequently Asked Questions

Question: Who can deliver the training toolkit modules?

Answer: Child welfare professionals, including but not limited to frontline workers, supervisors, managers, and workforce development specialists; as well as opportunities for partnership with substance use disorder treatment professionals such as counselors, therapists, social workers, and peer recovery support specialists.

Question: Are there any costs associated with using the training toolkit modules?

Answer: No, the training toolkit modules were developed for the public domain and are available for use at no cost.

Question: Is there a specific way child welfare agencies should acknowledge or give credit when using the training toolkit modules?

Answer: Yes, each training toolkit module includes an acknowledgement slide with detailed talking points recognizing NCSASW and its federal funders

Question: Can the training toolkit modules be branded with local child welfare agency logos and other identifying information?

Answer: Yes, child welfare agencies can add logos and other identifying information to any existing or new slides at their discretion.

Question: Can the training toolkit modules be modified or enhanced?

Answer: Yes, child welfare agencies are encouraged to adjust based on their local needs. This includes adding, removing, or consolidating slides and adjusting talking points for state or local policies, practice-level experience, community service array, or preferred language and terminology. Please just be sure to honor all original source information in the form of slides, scripts, and full reference citations.

Question: If a child welfare agency has questions related to using or implementing the training toolkit modules, who should they contact?

Answer: All additional inquiries about the training toolkit modules can be addressed to NCSACW@cffutures.org or toll free at 1-866-493-2758.

Supplemental Online Training Resources

NCSACW Online Tutorial for Child Welfare Professionals

This self-paced course provides tailored information on substance use and co-occurring disorders, focusing on the effects on parents, children, and families. Learners will acquire knowledge and skills to improve access to treatment services and implement effective case planning. The course promotes a family-centered approach that supports recovery, enhances safety, and improves overall family well-being through cross-system collaboration. This course consists of five modules and is eligible for submission to the National Association of Social Workers (NASW) to earn five CE credits.

Satisfaction Survey

Please take a moment to complete a brief survey about your experience with the Child Welfare Training Toolkit. The survey should take no more than five minutes to complete. Participation is voluntary, and all responses are anonymous—no identifying information will be linked to your answers. Your feedback is incredibly important and will help us enhance the quality and effectiveness of the Toolkit.

Module 2 Description & Objectives

The goal of module 2 is to increase knowledge and understanding about substance use, treatment, and recovery. Child welfare workers will learn about substances and their effects; the relationship between the brain and substance use disorders; the substance use disorder continuum of care with knowledge of screening, referral, and assessment practices; knowledge of diagnostic criteria for substance use disorders and how this informs indicated levels of treatment; knowledge of evidence-based interventions for families affected by substance use disorders, including benefits of specialized treatment services for men and women; and awareness of the benefits of integrating peer recovery support services into child welfare service delivery models.

After completing this training, child welfare workers will:

- Identify the different types of drug classifications based on chemical components, effects, and legality
- Recognize different types of substances, including their effects and methods of use
- Understand the basic brain chemistry of substance use disorders including the role of dopamine and changes to brain circuitry
- Outline the substance use disorder continuum of care with knowledge of screening, referral, and assessment practices
- Understand diagnostic criteria for substance use disorders and how this informs indicated levels of treatment
- Acquire knowledge on evidence-based interventions for families affected by substance use disorders
- Discuss the benefits of specialized treatment services for men and women affected by substance use and co-occurring disorders
- Understand the benefits of integrating recovery support services into child welfare service delivery models

Presentation Slide Deck & 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.

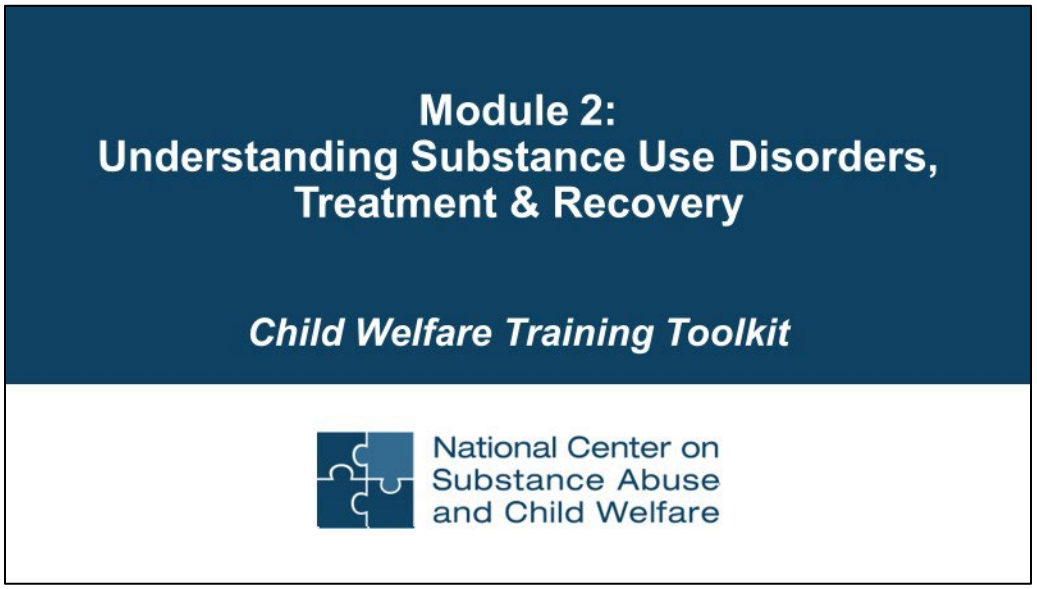
- Facilitative Prompts for Participants: content-specific inquiries developed to engage learners in further discussion and application of knowledge and skills (**bolded for easy reference**).

- 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 2: Understanding Substance Use Disorders, Treatment & Recovery

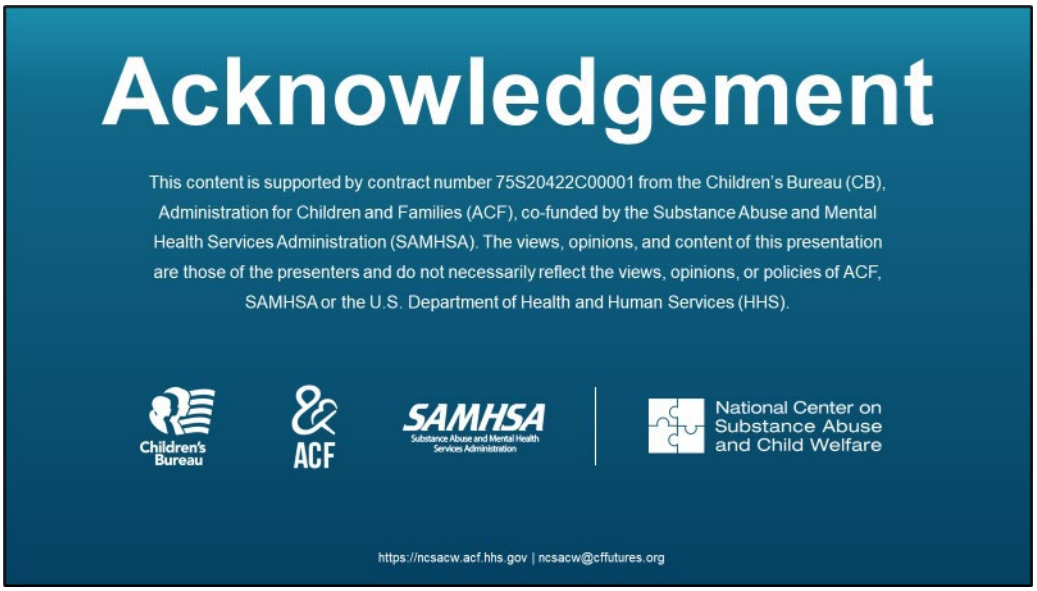


Facilitator Script:

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 substance use disorders, treatment, and recovery.

Slide 2

Acknowledgement

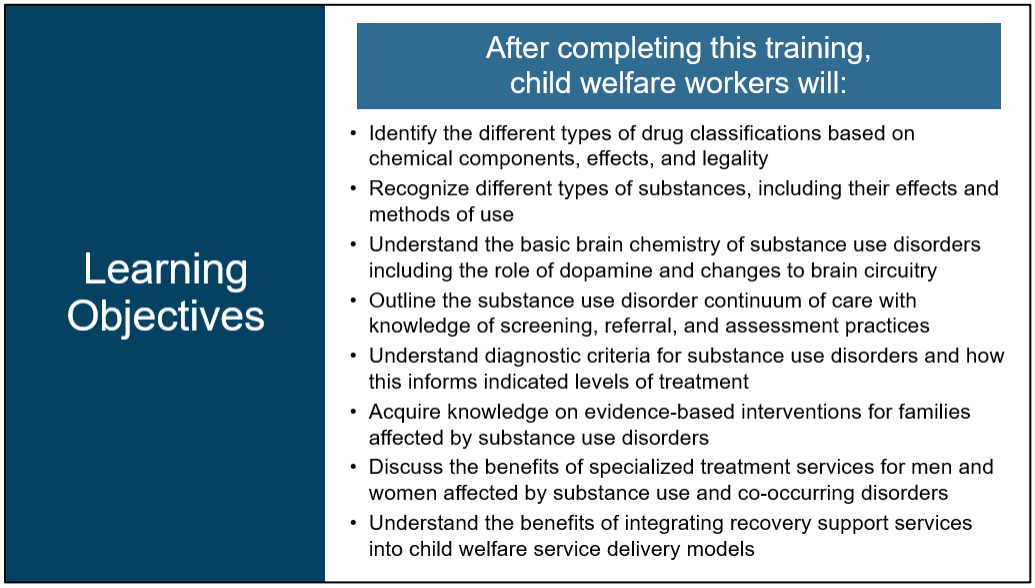


Facilitator Script:

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

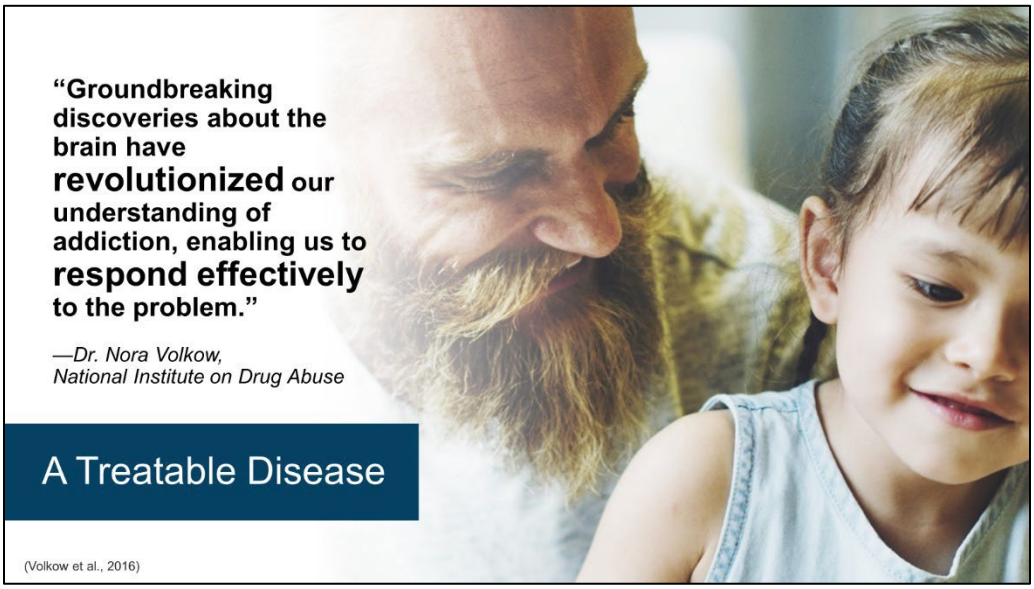


Facilitator Script:

The goal of module 2 is to increase knowledge and understanding about substance use, treatment, and recovery. Child welfare workers will learn about substances and their effects; the relationship between the brain and substance use disorders; the substance use disorder continuum of care with knowledge of screening, referral, and assessment practices; knowledge of diagnostic criteria for substance use disorders and how this informs indicated levels of treatment; knowledge of evidence-based interventions for families affected by substance use disorders, including benefits of specialized treatment services for men and women; and awareness of the benefits of integrating peer recovery support services into child welfare service delivery models.

Slide 4

A Treatable Disease



Facilitator Script:

As an important reminder to module one, substance use disorders are a treatable disease! With the advancements in addiction science, 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 family-centered treatment for sustained long-term recovery–often a combination of medication, behavioral interventions, and peer recovery support. Let's jump in by first gaining a foundational understanding of the different types of drug classifications.

Source: (Volkow et al., 2016)

Slide 5

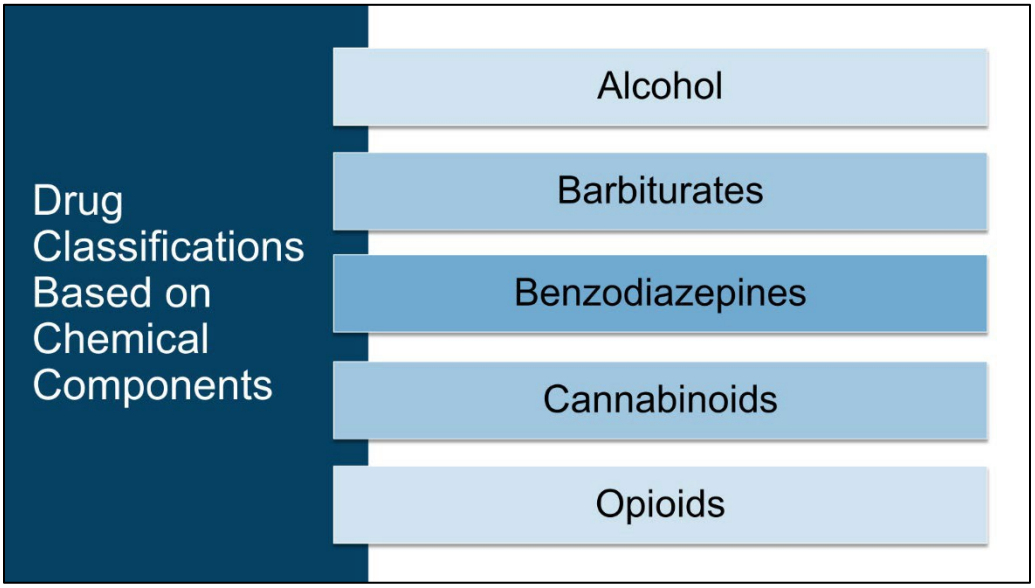
Drug Classifications 101

Facilitator Script:

Drug classifications are designed to help organize psychoactive substances into different categories. While there are no definitive lists, the three most common classifications are organized by chemical component, effects, and legal standing. Let's start by reviewing the classification of chemical components.

Slide 6

Drug Classifications Based on Chemical Components



Facilitator Script:

There are five main categories of drugs based on their chemical components—alcohol, barbiturates, benzodiazepines, cannabinoids, and opioids. While each individual substance within each classification has its own chemical makeup, they share similarities on a molecular level meaning they produce similar effects.

Alcohol works by altering the body's central nervous system, producing both short-term and long-term health effects. While it produces feelings of euphoria and relaxation it also diminishes an individual's sense of judgment, reduces inhibition, causes slurred speech, motor impairment, confusion, memory, and concentration problems. Other long-term effects include development of an alcohol use disorder and serious health problems including liver damage and certain types of cancer.

Barbiturates derive from the chemical substance barbituric acid. They also alter the body's central nervous system by slowing down an individual's ability for cognitive processing and functioning. Their effects include anxiety relief, mild euphoria, lack of restraint, and sedation. At higher dosages, barbiturates are known to cause paranoia and suicidal ideation. Individuals are also susceptible to quickly developing tolerance at higher dosage levels increasing the danger of overdose or death.

Benzodiazepines are substances that interact with the neurotransmitter gamma-aminobutyric acid-A or GABA-A. Like alcohol and barbiturates, benzodiazepines are also a central nervous depressant known for similar effects including sedation, anxiety relief, and relaxed mood. When combined with opioids, benzodiazepines can cause dangerous levels of sedation, respiratory depression, coma, and death.

Cannabinoids are a group of chemical structures that derive from the cannabis plant. There are two main cannabinoids–delta-tetrahydrocannabinol (THC) and cannabinol (CBD). THC is

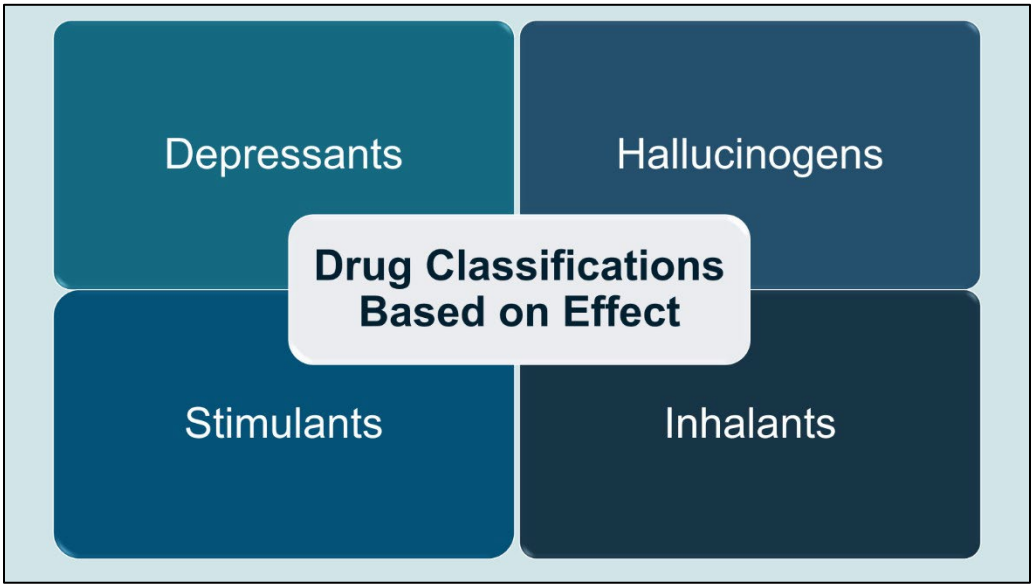
believed to be the main active ingredient responsible for cannabis' psychoactive effects including enhanced sensory perception and euphoria followed by relaxed mood, slowed reaction time, and problems with memory and coordination. Long-term use of cannabis is also associated with health problems such as bronchitis, emphysema, and suppressed immune systems.

Opioids are a group of drugs that contain either natural forms of opium derived from the poppy plant or those that are created chemically to produce the same effect. Opioids work by binding to and activating nerve cell receptors in the brain and central nervous system thereby blocking pain signals in the body. Like other central nervous system depressants, opioids (both prescribed and illicit) are known to produce high levels of euphoria placing individuals at high risk for misuse, overdose, and death. More detailed information on opioids and their effects is covered in module 9 of this toolkit.

Source: (U.S. Drug Enforcement Administration, 2022; Juergens, 2022)

Slide 7

Drug Classifications Based on Effect



Facilitator Script:

Another common way to classify drugs is based on how they affect the mind and body…

Depressants, also commonly referred to as 'downers', alter the mind and body by lowering mood and energy levels. As previously covered in the chemical component discussion, central nervous system depressants are known and commonly misused for their ability to produce feelings of calmness, relaxation, and euphoria. Alcohol, barbiturates, benzos, and opioids are all examples of central nervous system depressants.

Opposite of depressants are stimulants (or uppers) which alter the mind and body by increasing mood and energy levels. Stimulants are known and commonly misused for their ability to produce a rush leading to increased productivity, performance, and heightened euphoria. Adderall, cocaine, and methamphetamine are all examples of stimulants.

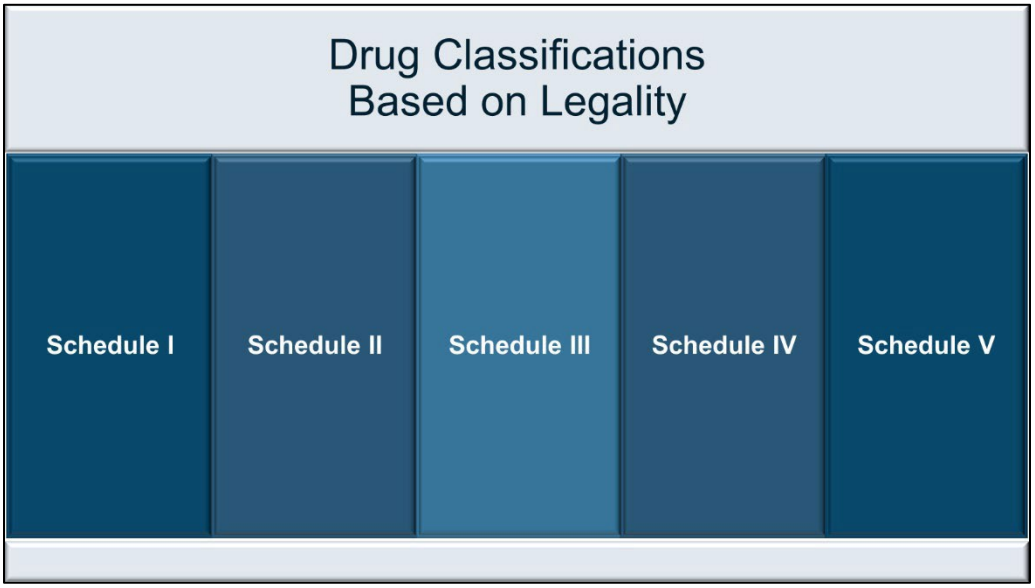
Hallucinogens are substances that work by altering perceptions of reality. These substances are often split into two subclassifications—classic and dissociative. Examples of classic hallucinogens include D-lysergic acid diethylamide (LSD), psilocybin, peyote, and ayahuasca; versus dissociative examples such as phencyclidine (PCP), ketamine, and salvia. While less addictive than other substances, hallucinogens propensity to induce auditory and visual hallucinations places individuals at high risk for adverse effects and dangers including paranoia and psychosis.

Inhalants are substances that are inhaled to achieve a euphoric high. While the euphoric effects of inhalants are brief in nature compared to other substances, they still present significant health risks due to the level of toxicity in the chemicals ingested. Nitrous oxide (or whippets), paint thinner, nail polish remover, aerosol sprays, and gasoline are all examples of inhalants.

Sources: (Juergens, 2022; National Institute on Drug Abuse, 2023)

Slide 8

Drug Classifications Based on Legality



Facilitator Script:

The final classification of drugs is based on their legality. In 1970, the federal government passed the Controlled Substances Act (CSA) which established five schedules of drugs. These five schedules are organized with consideration to legitimacy and value in medical use along with potential for misuse and abuse.

Schedule I drugs represent the classification with the most regulations and legal penalties. This schedule of drugs does not have legitimate medical use and have a high potential for abuse. Examples include heroin, LSD, and ecstasy. Also, important to note here is that marijuana (or cannabis) remains classified as a schedule I controlled substance despite decades of legal petitions and federal appeals to have the drug rescheduled by the Drug Enforcement Agency (DEA). The latest on this includes requests to the United States Attorney General to further review the classification schedule as part of larger federal marijuana reform efforts. We should also mention that state classifications may differ from federal classifications—wherein states can pass laws to legalize marijuana or cannabis. To date, this includes 38 states, 3 territories, and the District of Columbia who have legalized for medicinal use and 24 states, 2 territories, and the District of Columbia who have legalized for recreational use.

Schedule II drugs have the next highest level of regulations and legal penalties. This schedule includes substances with legitimate medical use—both licit and illicit with a high potential for abuse. Examples include cocaine, methamphetamine, and a large number of opioids including fentanyl, methadone, morphine, and oxycodone.

Schedule III drugs have more moderate regulations and legal penalties compared to the previous schedules and while they also have legitimate medical use, they tend to have a lower potential for abuse. Examples of schedule III drugs include buprenorphine, ketamine, and prescription medications that mix codeine or hydrocodone with aspirin or acetaminophen such Vicodin or Percocet.

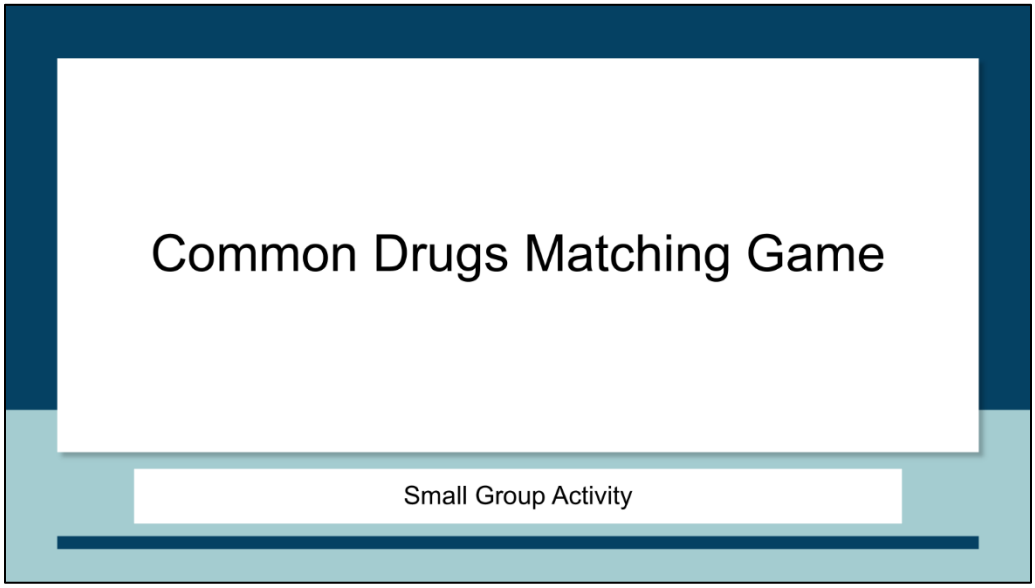
Schedule IV drugs have fewer regulations and legal penalties and are often prescription medications that have an even lower potential for misuse or abuse. Examples of schedule IV drugs include prescription brand names such as Ativan, Klonopin, Valium, and Xanax.

Lastly, schedule V drugs have the least number of regulations and penalties of all classifications combined with the lowest risk for potential misuse. Examples include cough medicines that contain codeine and prescription brand names like Lomotil (treatment of diarrhea) and Lyrica (treatment of nerve pain).

Sources: (U.S. Drug Enforcement Administration, 2022; The White House, 2022; National Conference of State Legislatures, 2023; Bryan, 2024)

Slide 9

Common Drugs Matching Game



Facilitator Script:

Facilitator Notes: Divide learners up for a small group activity titled Common Drugs Matching Game. Using pre-filled large easel paper that lists de-identified descriptions of short and long-term effects of drugs and pre-filled post-it notes with names of common drugs (six total–alcohol, cocaine, heroin, methamphetamine, marijuana, fentanyl). Ask learners to work with their team members to quickly and accurately match the descriptions. Set a timer for 3 minutes and track to notice which group completes the task first. Ask them to walk through their answers with the larger group and verify that all matches are correct; use this as an opportunity to redirect to another group should there be any incorrect matches identified. Let learners know we will circle back to these large easel papers for part II of the activity in this next section of the training.

Answer Key:

Alcohol:

Short-term effects: reduced inhibitions, slurred speech, motor impairment, confusion, memory problems, concentration problems

Long-term effects: high blood pressure, heart disease, stroke, liver and kidney disease, increased risk for certain types of cancers (head and neck, esophageal, liver, colorectal, and breast)

Cocaine:

Short-term effects: euphoria, narrowed blood vessels, enlarged pupils, increased body temperature, heart rate, and blood pressure, headache, abdominal pain and nausea

Long-term effects: loss of sense of smell, chronic nosebleeds, nasal damage and trouble swallowing, infection and death of bowel tissue from decreased blood flow

Heroin:

Short-term effects: euphoria, dry mouth, itching, nausea, vomiting, analgesia (loss of pain sensation), slowed breathing and heart rate

Long-term effect: collapsed veins, abscesses (swollen tissue with pus), infection of the lining and valves in the heart, constipation and bowel obstruction, liver or kidney disease, and pulmonary infections

Methamphetamine:

Short-term effects: increased energy including physical and sexual activity, decreased appetite and weight loss, increased heart rate, blood pressure, temperature

Long-term effects: anxiety, confusion, insomnia, mood problems, violent behavior, paranoia, hallucinations, delusions

Marijuana:

Short-term effects: enhanced sensory perception and euphoria followed by drowsiness and relaxation; slowed reaction time; memory impairment, problems with balance and coordination

Long-term effects: chronic bronchitis, higher risk for respiratory infections, psychosis including paranoia, hallucinations, and delusions

Fentanyl:

Short-term effects: extreme euphoria, drowsiness, confusion, nausea, vomiting, constipation, sedation, slowed breathing

Long-term effects: bowel obstruction, heart attack or heart failure, hypoxia (decrease in amount of oxygen that reaches the brain), overdose, and death

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**Alternative Instructions for Virtual Training*

Use your virtual platform's polling feature to create the following prompts:

Match the short- and long-term effects to its respective substance (Choose one answer)

Short-term effects: reduced inhibitions, slurred speech, motor impairment, confusion, memory problems, concentration problems

Long-term effects: high blood pressure, heart disease, stroke, liver and kidney disease, increased risk for certain types of cancers (head and neck, esophageal, liver, colorectal, and breast)

1. Alcohol
2. Cocaine
3. Heroin
4. Methamphetamine
5. Marijuana
6. Fentanyl

Answer Alcohol

Match the short- and long-term effects to its respective substance (Choose one answer)

Short-term effects: increased energy including physical and sexual activity, decreased appetite and weight loss, increased heart rate, blood pressure, temperature

Long-term effects: anxiety, confusion, insomnia, mood problems, violent behavior, paranoia, hallucinations, delusions

1. Alcohol
2. Cocaine
3. Heroin
4. Methamphetamine
5. Marijuana
6. Fentanyl

Answer: Methamphetamine

Match the short- and long-term effects to its respective substance (Choose one answer)

Short-term effects: extreme euphoria, drowsiness, confusion, nausea, vomiting, constipation, sedation, slowed breathing

Long-term effects: bowel obstruction, heart attack or heart failure, hypoxia (decrease in amount of oxygen that reaches the brain), overdose, and death

1. Alcohol
2. Cocaine
3. Heroin
4. Methamphetamine
5. Marijuana
6. 18. Fentanyl

Answer: Fentanyl

Match the short- and long-term effects to its respective substance (Choose one answer)

Short-term effects: euphoria, narrowed blood vessels, enlarged pupils, increased body temperature, heart rate, and blood pressure, headache, abdominal pain and nausea

Long-term effects: loss of sense of smell, chronic nosebleeds, nasal damage and trouble swallowing, infection and death of bowel tissue from decreased blood flow

1. Alcohol
2. Cocaine
3. Heroin
4. Methamphetamine
5. Marijuana
6. Fentanyl

Answer: Cocaine

Match the short- and long-term effects to its respective substance (Choose one answer)

Short-term effects: enhanced sensory perception and euphoria followed by drowsiness and relaxation; slowed reaction time; memory impairment, problems with balance and coordination

Long-term effects: chronic bronchitis, higher risk for respiratory infections, psychosis including paranoia, hallucinations, and delusions

1. Alcohol
2. Cocaine
3. Heroin
4. Methamphetamine
5. Marijuana
6. Fentanyl

Answer: Marijuana

Match the short- and long-term effects to its respective substance (Choose one answer)

Short-term effects: euphoria, dry mouth, itching, nausea, vomiting, analgesia (loss of pain sensation), slowed breathing and heart rate

Long-term effect: collapsed veins, abscesses (swollen tissue with pus), infection of the lining and valves in the heart, constipation and bowel obstruction, liver or kidney disease, and pulmonary infections

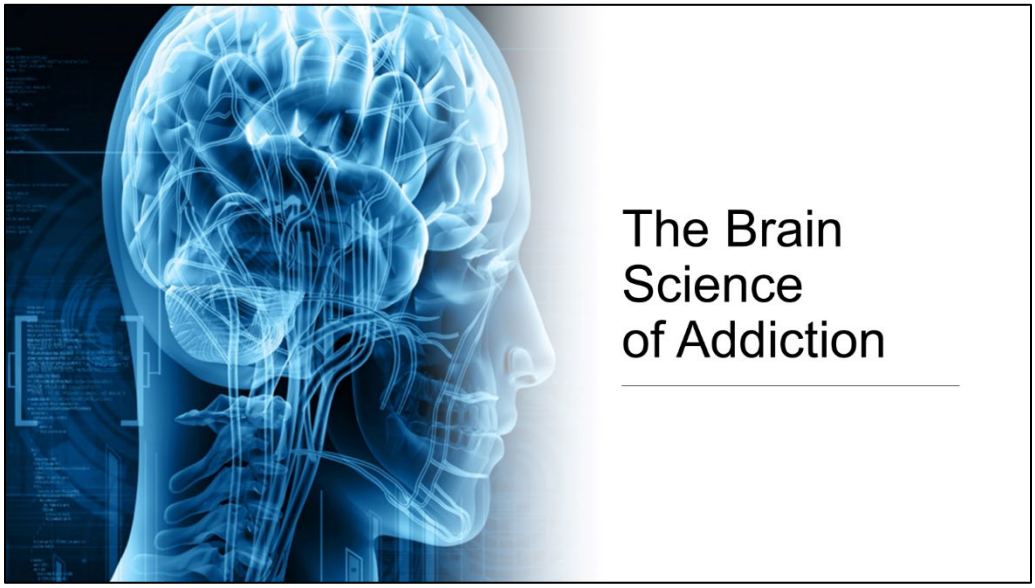
1. Alcohol
2. Cocaine
3. Heroin
4. Methamphetamine
5. Marijuana
6. Fentanyl

Answer: Heroin

Sources: (U.S. Drug Enforcement Administration, 2022; National Institute on Drug Abuse, 2019)

Slide 10

The Brain Science of Addiction



Facilitator Script:

The American Society of Addiction Medicine (ASAM) defines addiction as:

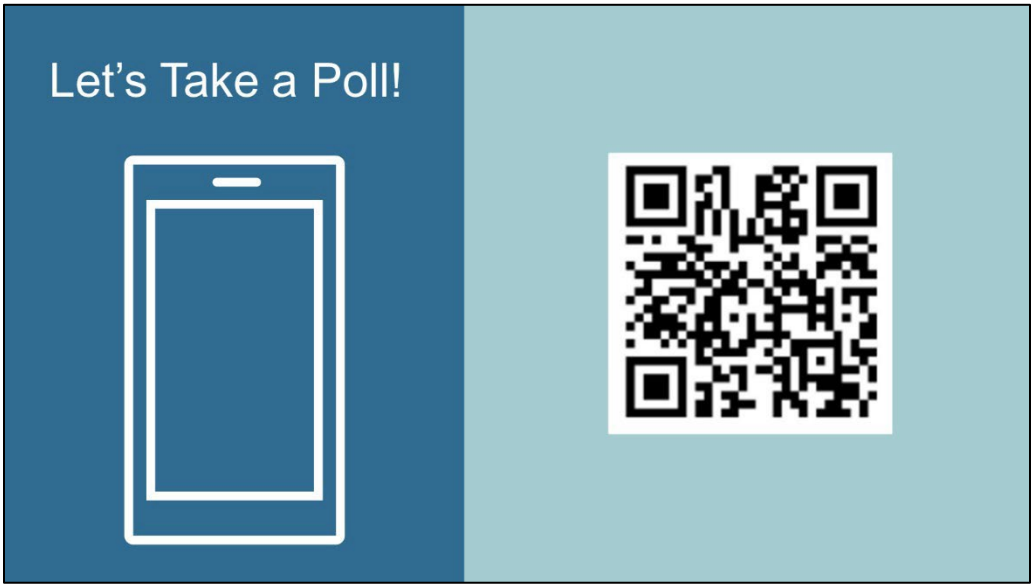
A primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

There's a lot to unpack with this one but before we move forward let's take a moment to acknowledge and discuss how our own values and beliefs about addiction can shape how we approach our work with children and families affected by substance use disorders.

Source: (American Society of Addiction Medicine, 2023)

Slide 11

Let's Take a Poll!

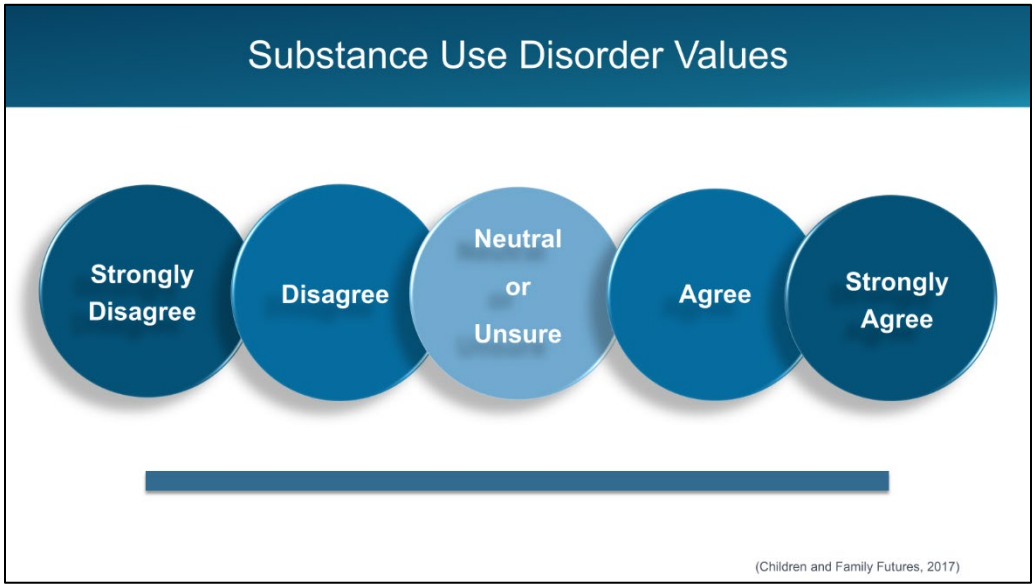


Facilitator Script:

Alright, who's ready for a quick poll?! Let's have everyone scan the QR code on the slide which will take you to a brief poll.

Slide 12

Substance Use Disorder Values



Facilitator Script:

So, for this polling exercise we'll be asking for your thoughts on a variety of statements. Please respond to each by indicating the level to which you agree or disagree using the scaled responses on your smartphone…

- **Substance use is a sign of moral failing or lack of willpower**
- **If parents truly loved their children, they would stop using alcohol and other drugs altogether**
- **Parents with substance use disorders can be effective parents**
- **For families, it is just as important for fathers with a substance use disorder to receive treatment as it is for mothers**
- **The stigma associated with addiction prevents parents from seeking treatment**
- **Medication for opioid use disorder is just replacing one drug for another**

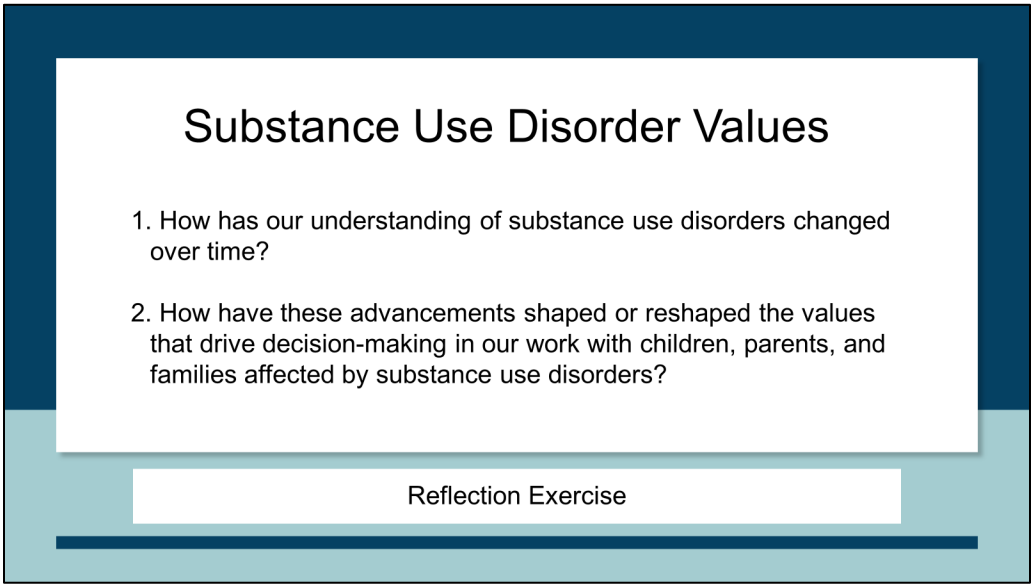
I'll give you all a minute to respond before moving on to a large group reflection exercise…and don't worry, polls are set to be anonymous, and the results will not be broadcasted.

Facilitator Note: Additional resources are available for more information on this topic: Building Collaborative Capacity Series—Module 2: Setting the Collaborative Foundation: Addressing Values and Developing Shared Principles and Trust in Collaborative Teams and the *Collaborative Values Inventory*.

Source: (Children and Family Futures, 2017)

Slide 13

Reflection Exercise



Facilitator Script:

Great, thank you all for participating in the polling exercise! Let's now spend some time together reflecting as a large group on these two facilitative prompts listed here…

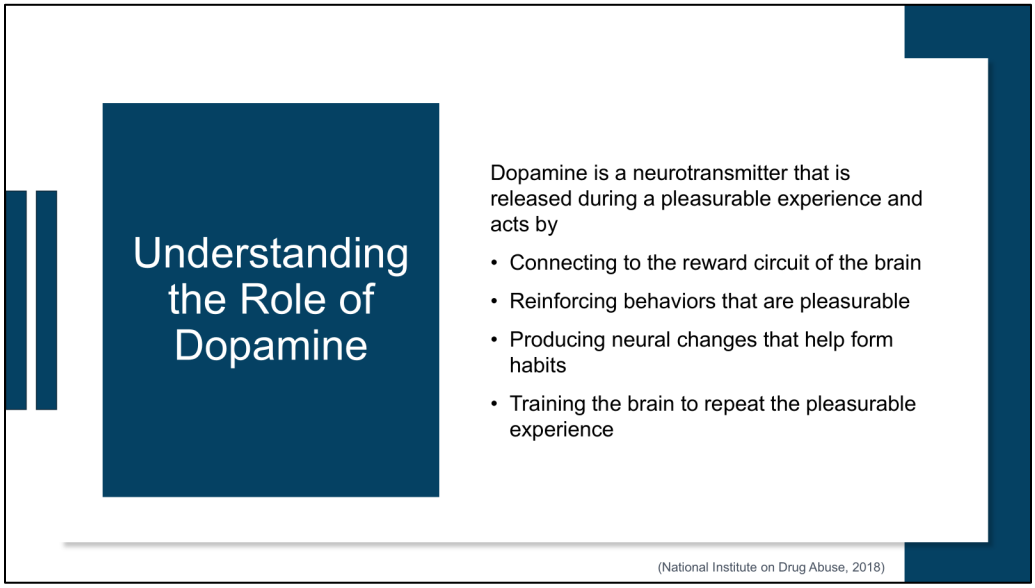
1. **How has our understanding of substance use disorders changed over time?**
2. **How have these advancements shaped or reshaped the values that drive decision- making in our work with children, parents, and families affected by substance use disorders?**

[Possible examples include viewing substance use disorders as a medical disease; and understanding that length of treatment matters and this will vary greatly for each individual and/or substance which has implications for treatment and case plan goals and objectives]

This was great, thank you all for participating! Let's keep all this information in mind as we now move into the more technical discussion about substance use and the brain…

Slide 14

Understanding the Role of Dopamine



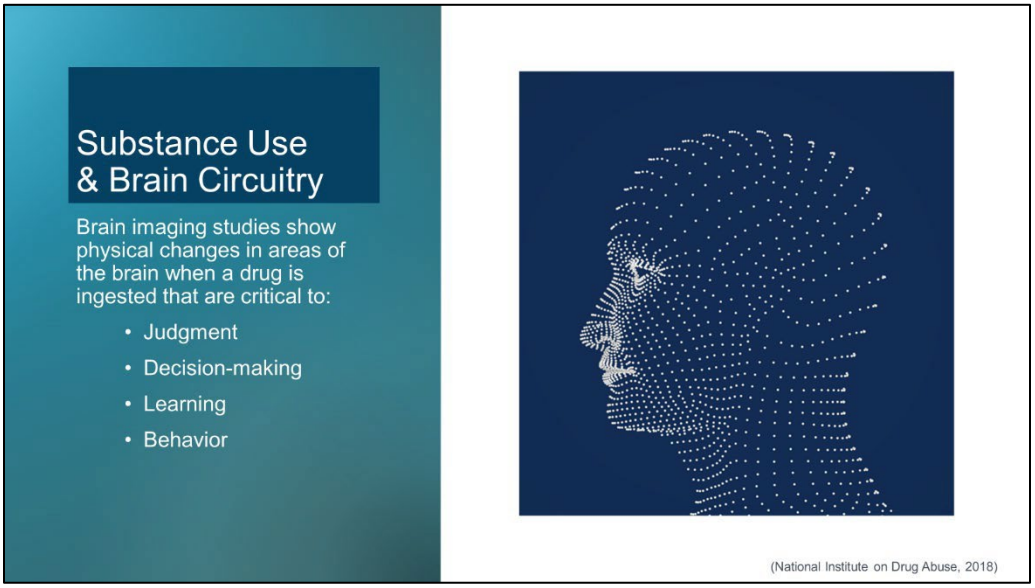
Facilitator Script:

So, let's jump in. Dopamine is a neurotransmitter that is released during a pleasurable experience– this can be from literally anything pleasurable from foods, different types of activities, social interactions, etc. Dopamine acts by connecting to our body's natural reward circuit of the brain associating the experience and related cues as pleasurable thereby reinforcing that the experience will be repeated. Over time, the release of dopamine in the brain starts to produce changes to our neural circuitry responsible for forming the habits that lead us to continue seeking out these same pleasurable experiences.

Source: (National Institute on Drug Abuse, 2018)

Slide 15

Substance Use & Brain Circuitry



Facilitator Script:

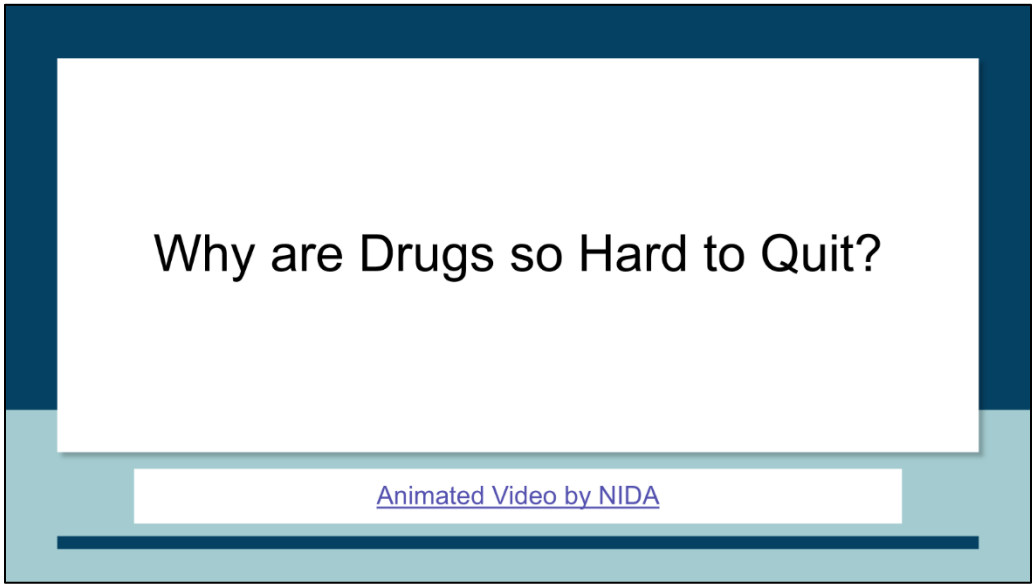
Now let's take that same understanding and apply it to repeated use of alcohol or drugs. All substances regardless of type, produce a pleasurable experience or as we now know, a surge of the neurotransmitter, dopamine. Think of these neurotransmitters as chemical messengers between nerve cells in the area of the brain responsible for our judgment, decision-making, learning, and behavior. As substance use increases, so do changes in our neural circuitry. We've already touched on how dopamine affects our brain's natural reward system through positive reinforcement, creation of habits, and seeking out the same pleasurable experience—in this case the euphoric high from the substance.

What we haven't talked about is that changes in neural circuitry from substance use also simultaneously alter sensitivity to dopamine levels causing a reduced or less euphoric high—a process recognized as tolerance. This, as we know, can often lead to individuals using more of the same substance or introducing other substances to achieve or re-experience that initial state of euphoria. Other changes to neural circuitry include the area of the brain responsible for our stress response—the amygdala. Separate from tolerance, repeated use of substances can result in heightened emotional and physical distress when not actively using the substance—a process recognized as withdrawal. As the level of severity of substance use increases so does the severity of withdrawal symptoms which can further exacerbate patterns of use as the motivation has evolved beyond just the euphoric high and becomes also about escaping the physical and psychological effects of withdrawal. We'll cover all this more in detail in additional modules within this toolkit, but for now let's turn our attention to a brief animated video explaining why drugs are so hard to quit.

Source: (National Institute on Drug Abuse, 2018)

Slide 16

Why are Drugs so Hard to Quit?



Facilitator Script:

Facilitator Note: Internet or Wi-Fi permitting, open the hyperlink for a 4-minute animated video by NIDA. Proceed with facilitating a large group discussion using the following prompts:

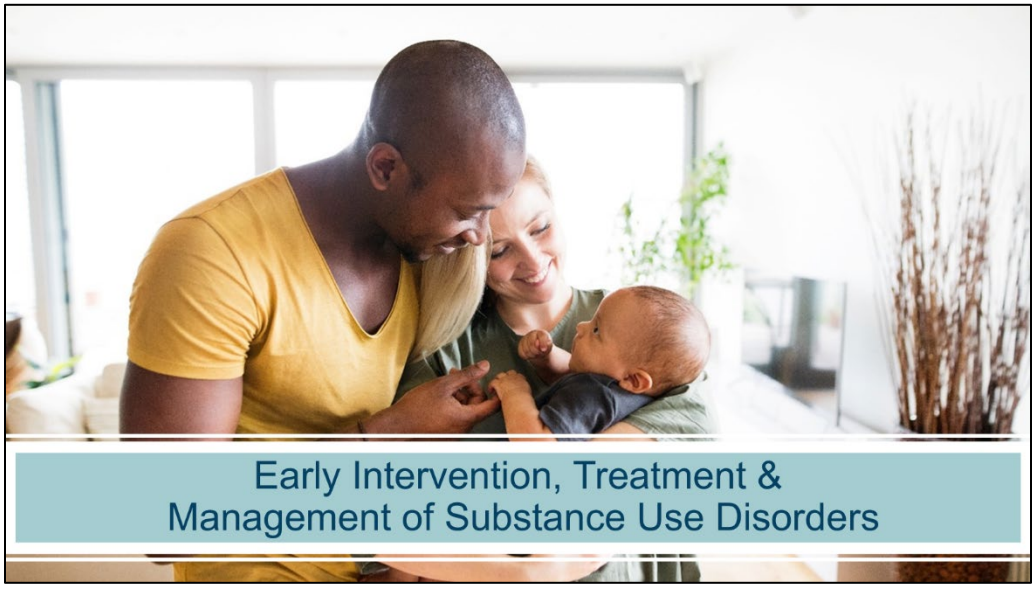
Prompts for Participants:

- **Any initial reactions to the animated video?**
- **Did it help improve your understanding of substance use disorders? If so, in what ways exactly?**
- **How can these advancements about the brain, including changes to neural circuitry, and psychological and physical effects, begin to challenge or reshape common views and beliefs about substance use disorders?**
- **What about the part that states return to use is not uncommon– is our current child welfare service delivery model designed to acknowledge and support this common reality of long-term recovery?**

Video Source: National Institute on Drug Abuse (NIDA)

Slide 17

Early Intervention, Treatment & Management of Substance Use Disorders

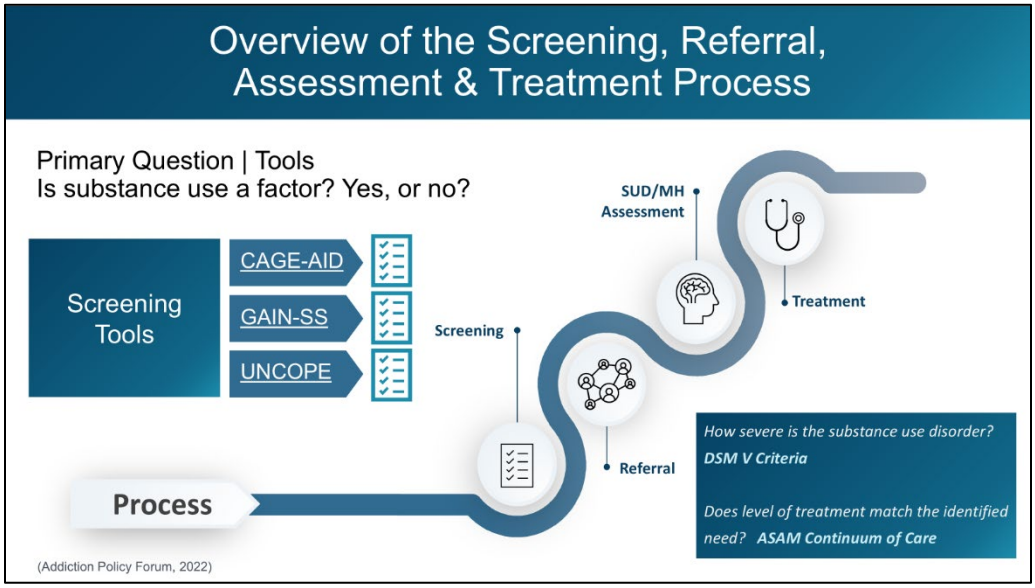


Facilitator Script:

That was a great discussion. Let's now segue into a broad-level overview of early intervention, treatment, and management of substance use disorders.

Slide 18

Overview of the Screening, Referral, Assessment & Treatment Process



Facilitator Script:

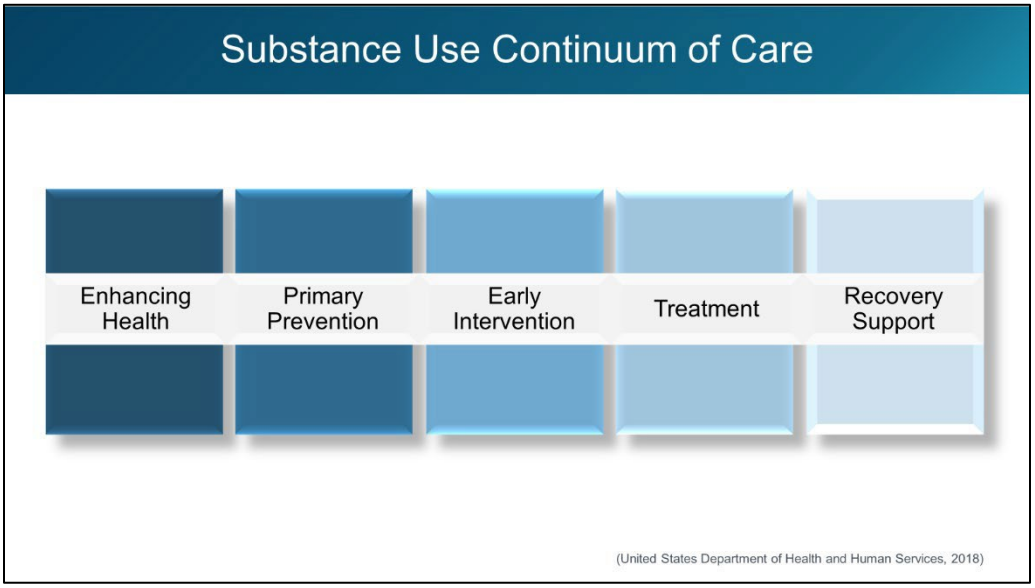
On the slide, we have a helpful visual outlining the critical points of intervention that lead to access and utilization of substance use disorder treatment services. It's a process—so let's break it down together!

Facilitator Note: Additional resources are available for more information on this topic: Building Collaborative Capacity Series—Module 5: Frontline Collaborative Efforts: Developing Screening Protocols to Identify Parental Substance Use Disorders and Related Child and Family Needs.

Source: (Addiction Policy Forum, 2022)

Slide 19

Substance Use Continuum of Care



Facilitator Script:

Let's first start by learning about the substance use continuum of care—a comprehensive array of health services to support an individual's wellness needs. For substance use, this often includes any combination of prevention, early intervention, treatment, and recovery support strategies. This specific continuum referenced here is adapted from the surgeon general's report on alcohol, drugs, and health.

Enhancing Health captures efforts at raising awareness through health communications and promoting availability of healthcare services.

Primary Prevention includes efforts to mitigate risk factors for substance use through various evidence-based programs, resources, or strategies.

Early Intervention includes services designed for screening and assessment for substance use disorders including brief intervention strategies when indicated.

Treatment includes interventions through use of pharmacotherapy, counseling, and other adjunct services to support an individual's health, mental health, and recovery goals.

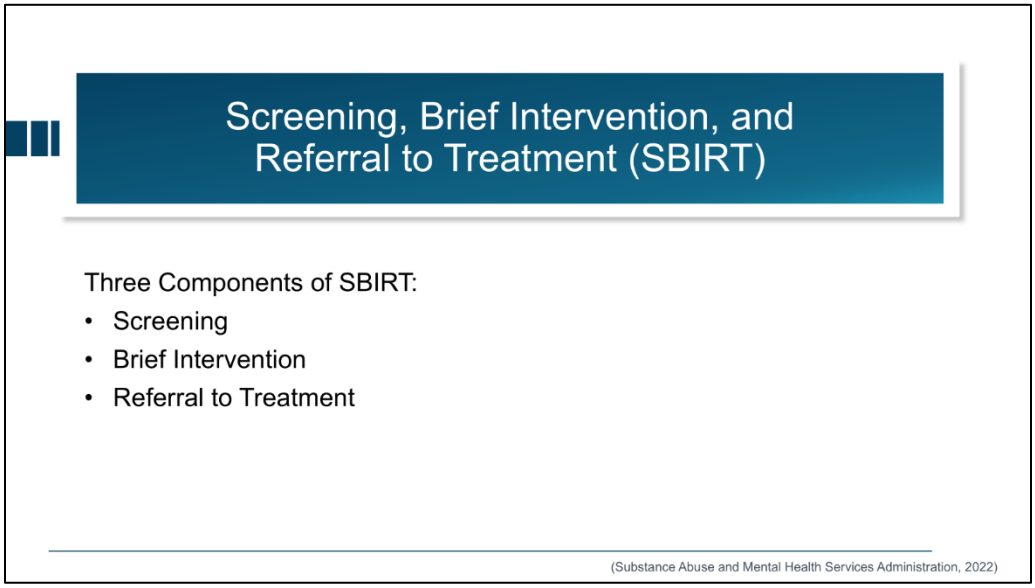
And lastly, recovery support aims to reduce barriers and increase access to a full range of services that help facilitate an individual's long-term recovery.

Now that we have a better understanding of the full substance use continuum of care, let's circle back and dive a little deeper into some notable early intervention strategies.

Source: (U.S. Department of Health and Human Services, 2018)

Slide 20

Screening, Brief Intervention, and Referral to Treatment (SBIRT)



Facilitator Script:

Screening, Brief Intervention, and Referral to Treatment (or SBIRT) is a recognized evidence-based practice designed to support early identification and treatment for individuals with substance use disorders including those only at risk for misuse. The SBIRT model is made up of three main components—screening, brief intervention, and referral to treatment.

- The screening process is designed to quickly assess for severity of use while simultaneously identifying the most appropriate level of care;
- Brief intervention is then tailored to awareness of substance use and readiness for change; and
- Concludes with a referral to treatment for those individuals necessitating ongoing care for the management of their substance use disorder.

The SBIRT model is one of the leading public health approaches to screening, early identification, and treatment of substance use disorders—often found adopted by primary care settings, hospital emergency rooms, trauma centers, and other community-based agencies.

Source: (Substance Abuse and Mental Health Services Administration, 2022)

Slide 21

Screening & Referrals in Child Welfare Settings

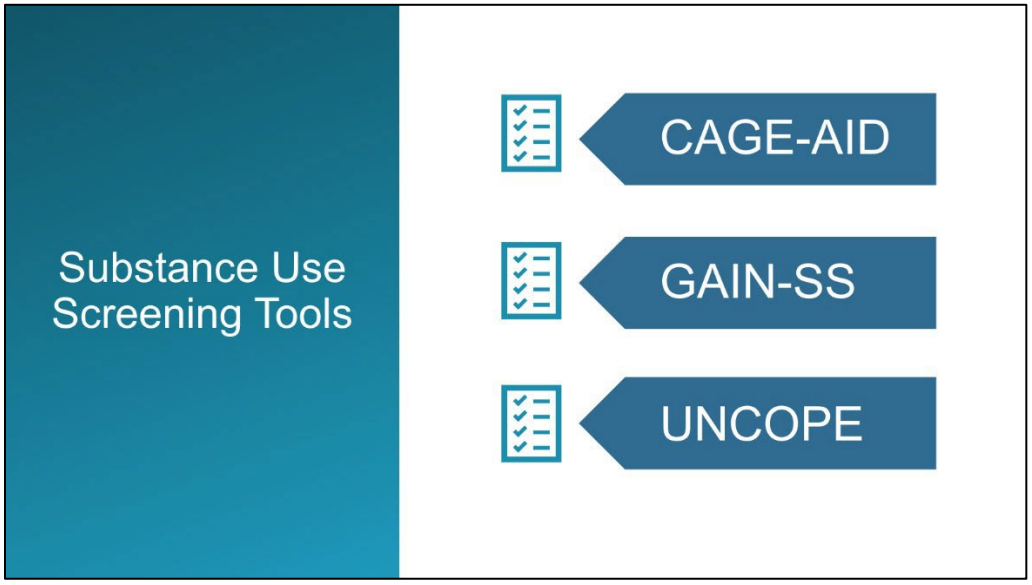
Facilitator Script:

Child welfare agencies also play a key role in the screening and early identification of substance use disorders. An integral part of your safety and risk assessment will be determining whether parental substance use is a factor at play. With the help of validated tools, child welfare workers can screen parents and, when indicated, make a referral for a substance use disorder clinical assessment. Let's quickly review some commonly used tools to support your screening efforts.

Facilitator Note: An additional resource is available for more information on this topic: Referral and Engagement of Families in Services.

Slide 22

Substance Use Screening Tools



Facilitator Script:

Displayed are three options for validated screening tools.

The CAGE-AID is an adaptation of the original tool designed to screen for alcohol use–AID stands for adapted to include drug use. The tool comprises of four standardized questions scored by a point system for yes or no responses. A score of 2 or more indicates a need for clinical assessment (though a score of 1 or more is encouraged to cast a wider net allowing for prevention and early intervention services).

The GAIN-SS stands for the Global Appraisal of Individual Needs– Short Screener. This version of the tool is designed to take only 5 minutes and can identify the need for further assessment of substance use or mental disorders.

The UNCOPE screening tool consists of six standardized questions scored by a positive response system (yes equaling positive) with two or more positive responses indicating a need for clinical assessment.

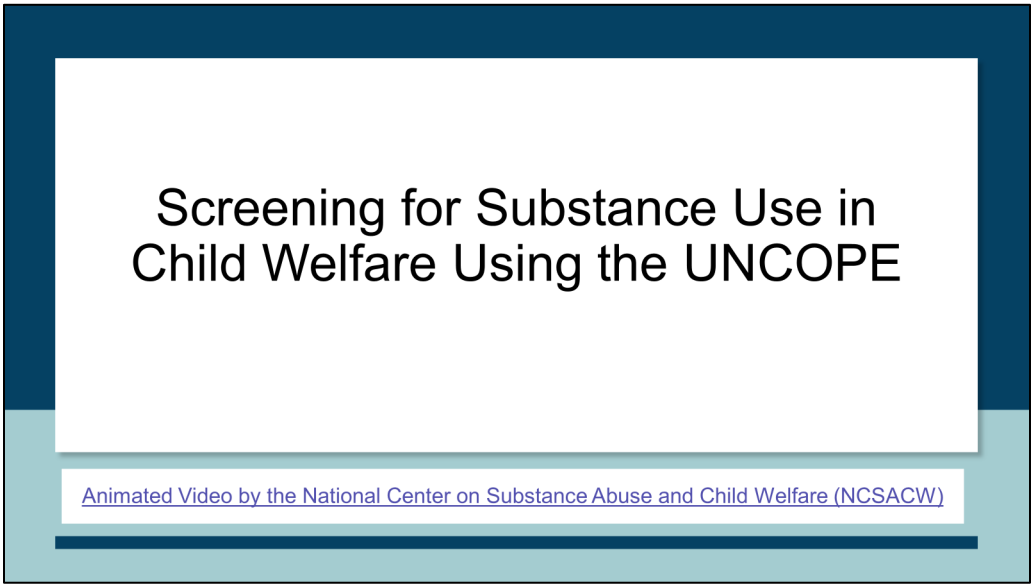
These are just three commonly used tools, but there are many to choose from. Let's now turn our attention to a 14-minute animated video modeling use of the UNCOPE with child welfare-involved families.

Facilitator Note: An additional resource is available for more information on this topic: Screening for Substance Use in Child Welfare Using the UNCOPE Video.

Source: (American Society of Addiction Medicine, 2023)

Slide 23

Screening for Substance Use in Child Welfare Using the UNCOPE



Facilitator Script:

Facilitator Note: Internet or Wi-Fi permitting, open the hyperlink for a 14-minute animated video by the National Center on Substance Abuse and Child Welfare. Proceed with facilitating a large group discussion using the following prompts:

Prompts for Participants:

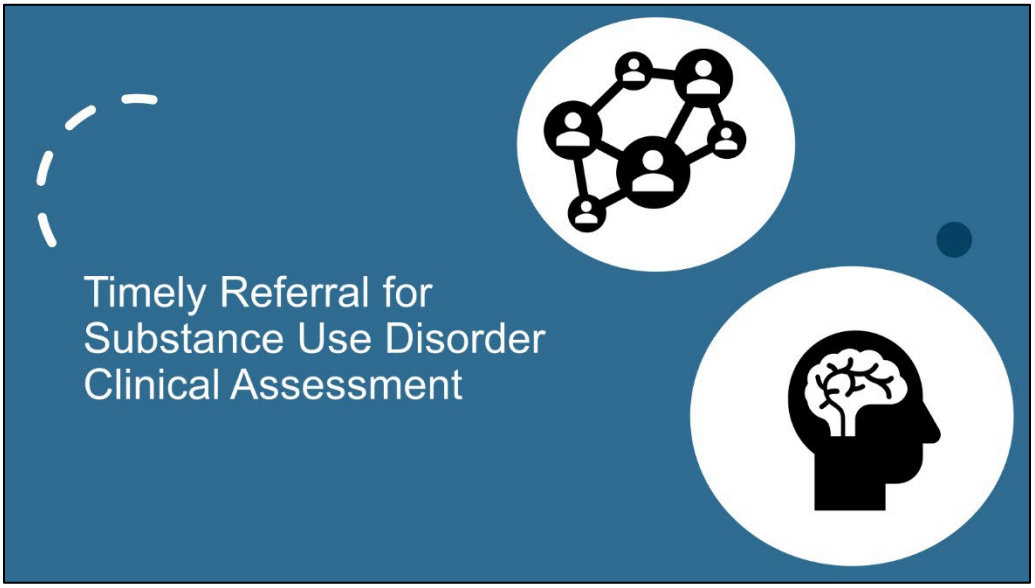
- **Any initial reactions to the animated video?**
- **Did it help improve your understanding or practical use of the UNCOPE screening tool? If so, in what ways exactly?**
- **Now that we have covered a few options for validated screening tools, let's hear from you about which tools your agency is using to screen for substance use.**

Thank you all for sharing…this is the perfect segue to our next topic on referral and assessment.

Video Source: National Center on Substance Abuse and Child Welfare (NCSACW)

Slide 24

Timely Referral for Substance Use Disorder Clinical Assessment

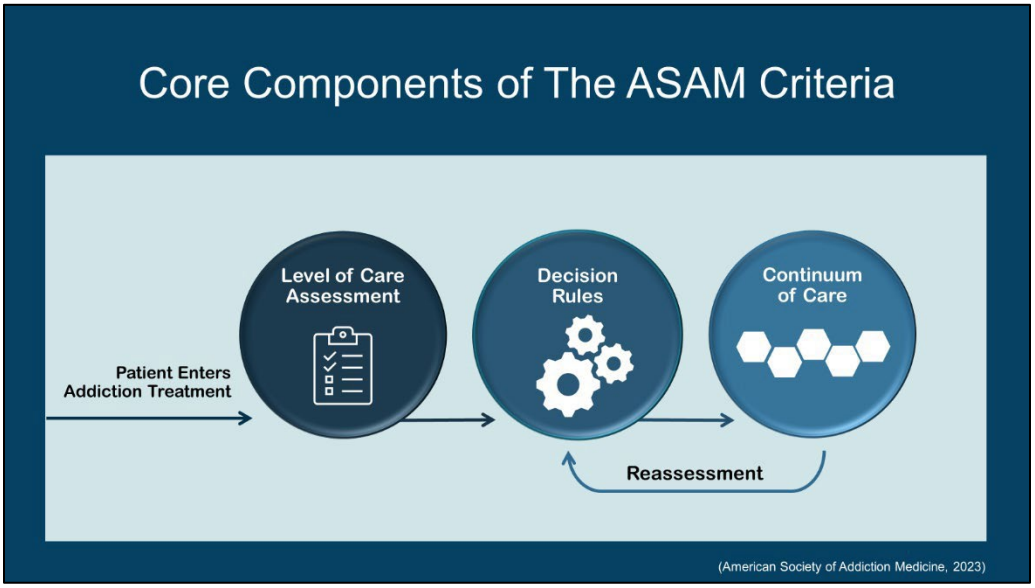


Facilitator Script:

So, after screening your next point of intervention will be ensuring timely referral for substance use disorder clinical assessments for all indicated screens. Your knowledge of community providers who are trained and qualified to conduct these specialized assessments will also help ensure that parents will receive appropriate and high-quality substance use disorder treatment services. Let's examine more closely what this next point of intervention entails…

Slide 25

Core Components of The ASAM Criteria



Facilitator Script:

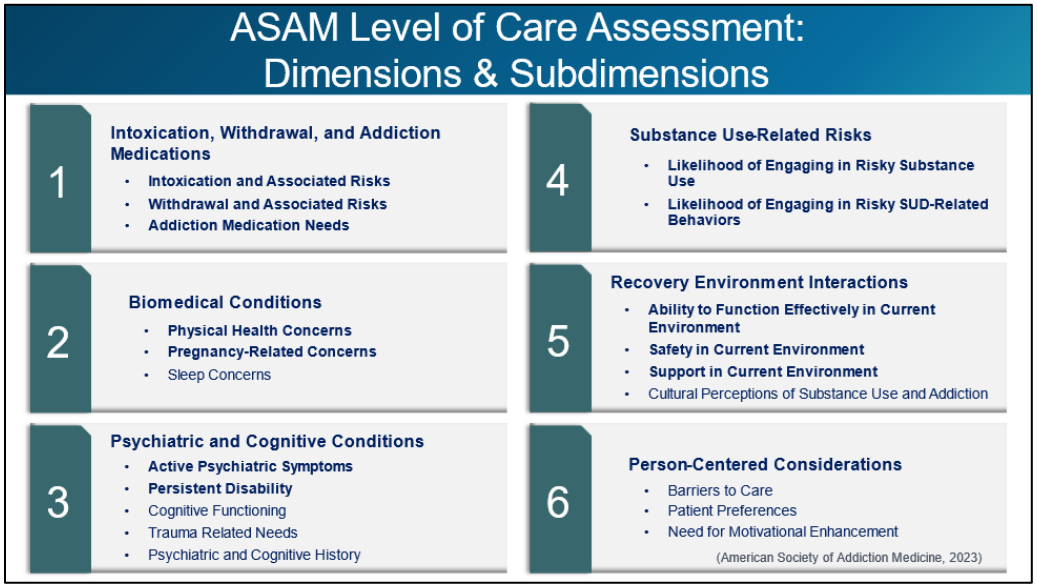
Use of The ASAM Criteria reinforces a future where there is no wrong door for accessing substance use and co-occurring disorder treatment—the idea being that no matter where consumers reach out for support, they will have access to the same standardized multidimensional assessment allowing for a determination of the most appropriate—with emphasis on the least intensive yet safe and effective—level of care tailored to their individual needs.

The first of the core components of The ASAM Criteria is the level of care assessment—a standardized assessment tool guiding practitioners through a series of dimensions and subdimensions aimed at identifying individualized treatment and service planning needs. Practitioners then apply the assessment findings to the dimensional admission criteria—a series of decision rules designed to help inform a recommended level of care along the continuum of substance use and co-occurring disorder treatment. This process is relied upon throughout the entirety of the treatment process—as emphasized in this graphic—prompting ongoing assessment of needs allowing for adjustments to treatment plans including changes to placement along the level of care continuum.

Source: (American Society of Addiction Medicine, 2023)

Slide 26

ASAM Level of Care Assessment: Dimensions & Subdimensions



Facilitator Script:

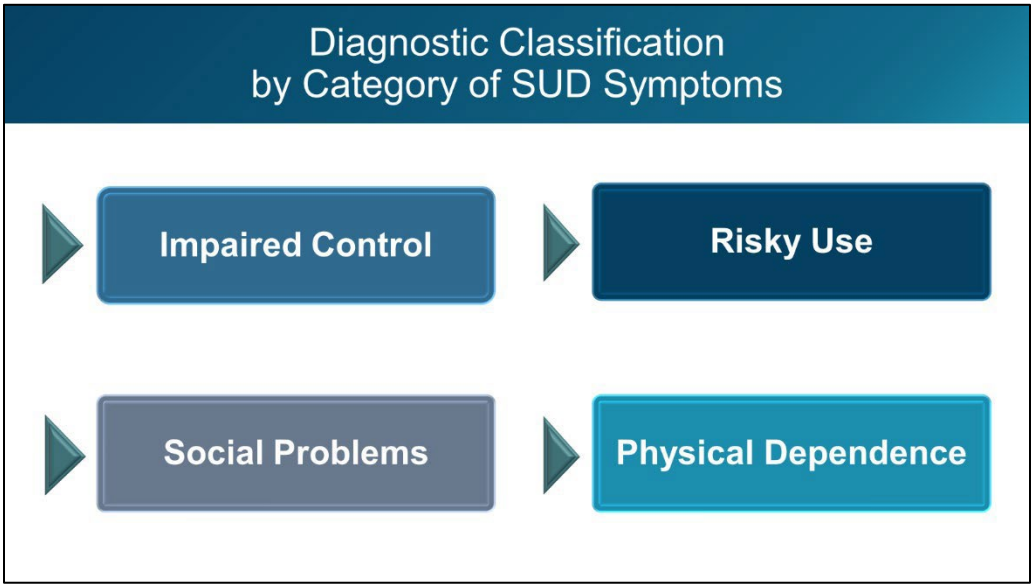
As we just briefly touched on, The ASAM Criteria assessment and reassessment process consists of six dimensions each with clearly defined subdimensions that are used to help inform a level of care recommendation and individualized treatment planning. More specifically, subdimensions listed in bold inform level of care recommendations and initial treatment for immediate needs, whereas all subdimensions—bold and non-bold—are considered for treatment planning purposes.

If you are familiar with previous editions of The ASAM Criteria, you'll notice some changes to the six dimensions—both in titling and ordering. In addition, readiness to change is now integrated into each dimension versus being its own standalone which bumped up Substance Use-Related Risks and Recovery Environment Interactions to dimensions 4 and 5—previously 5 and 6—and now concludes with Person-Centered Considerations. This new dimension is designed for considerations related to barriers to care—including assessment of financial, geographic, social, or environmental conditions that may be limiting access to quality substance use disorder treatment and recovery services—along with considerations to individual patient preferences, as well as any need for motivational enhancements.

Source: (American Society of Addiction Medicine, 2023)

Slide 27

Diagnostic Classification by Category of SUD Symptoms



Facilitator Script:

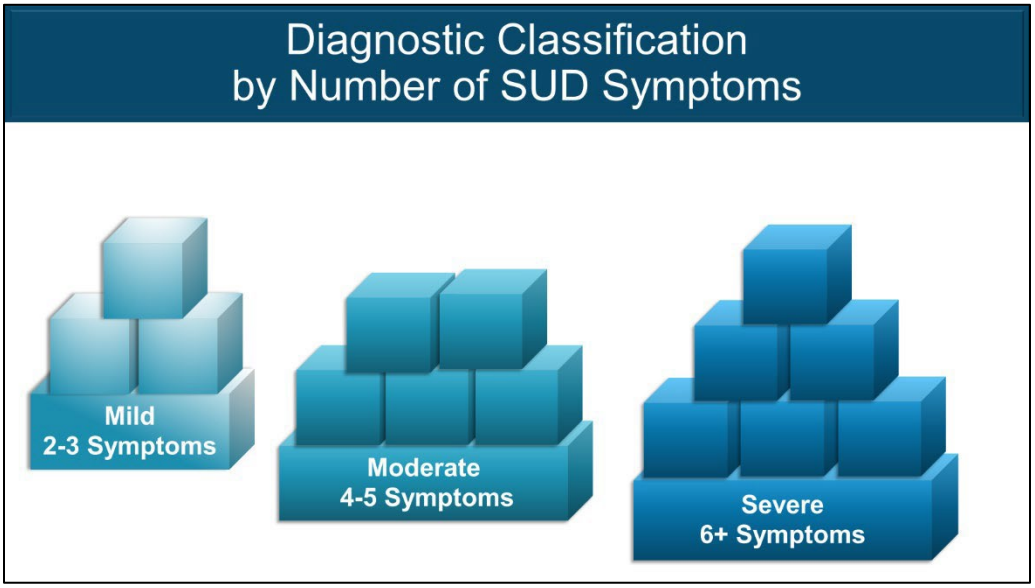
Another major part of the clinical assessment process is determining the degree to which an individual is presenting with substance use disorder symptoms. The Diagnostic and Statistical Manual of Mental Disorders, fifth edition text revision commonly referred to as the DSM-V-TR, organizes symptoms of substance use disorders into four general categories to help aid in the assessment and diagnostic process. These four categories include:

1. Impaired Control which defines substance use as both using more or more often than intended; it also acknowledges an individual's desire to cut back or stop use altogether but without success.
2. Social Problems defines substance use as interfering with daily responsibilities and/or relationships such as school, home, and work. This category also includes when individuals give up on previously enjoyable activities or hobbies in preference for their substance use.
3. Risky Use represents an individual engaging in behaviors to support their ongoing use despite awareness of known problems, consequences, or increased danger.
4. Physical Dependence is the need for increased use to achieve the same effect due to the body developing tolerance for the substance. This category also includes the development of withdrawal symptoms that may result in continued patterns of use to relieve the physical and psychological effects of the withdrawal process.

Source: (American Psychiatric Association, 2023)

Slide 28

Diagnostic Classification by Number of SUD Symptoms



Facilitator Script:

The DSM-V-TR also outlines guidance for determining the severity of substance use disorders which is dependent on the number of identified SUD symptoms:

The diagnostic specifier of a mild SUD is equivalent to two to three identified symptoms.

The diagnostic specifier of a moderate SUD is equivalent to four to five identified symptoms.

Whereas the diagnostic specifier of a severe SUD is equivalent to six or more identified symptoms.

Facilitator Note: The diagnostic criteria for substance use disorders is defined as a problematic pattern of use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring at any time in the same 12-month period:

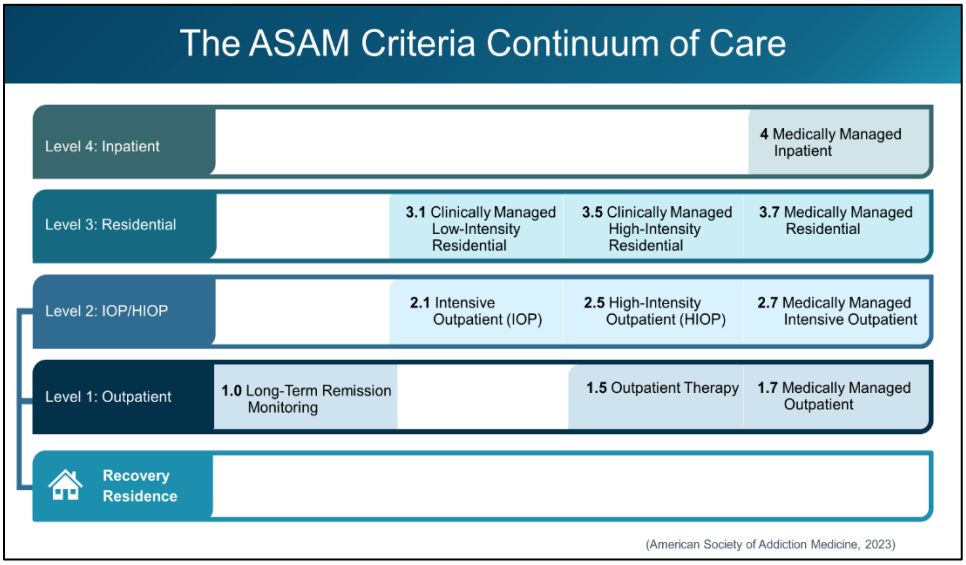
1. *Substance is often taken in larger amounts or over a longer period than was intended.*
2. *There is a persistent desire or unsuccessful efforts to cut down or control substance use.*
3. *A great deal of time is spent in activities necessary to obtain substance, use substance, or recover from its effects.*
4. *Craving, or a strong desire or urge to use the substance.*
5. *Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.*
6. *Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.*
7. *Important social, occupational, or recreational activities are given up or reduced because of substance use.*

8. *Recurrent substance use in situations in which it is physically hazardous.*
9. *Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated the substance.*
10. *Tolerance, as defined by either of the following:*
    - *A need for markedly increased amounts of the substance to achieve intoxication or desired effect.*
    - *A markedly diminished effect with continued use of the same amount of the substance.*
11. *Withdrawal, as manifested by either of the following:*
    - *The characteristic withdrawal syndrome for the substance*
    - *Substance, or a closely related substance, is taken to relieve or avoid withdrawal symptoms.*

Sources: (Addiction Policy Forum, 2022; American Psychiatric Association, 2023)

Slide 29

The ASAM Criteria Continuum of Care



Facilitator Script:

After completion of the ASAM Criteria level of care assessment, including establishing diagnostic criteria, practitioners then use the information obtained to indicate the most appropriate level of care across the full continuum of substance use and co-occurring disorder treatment services.

In this latest edition, The ASAM Criteria continuum of care consists of four broad levels of treatment—Level 1 Outpatient, Level 2 Intensive Outpatient also commonly referred to as IOP, including High Intensity Outpatient or HIOP, Level 3 Residential, and Level 4 Inpatient. This version of the continuum of care also draws our attention to the possible need for a recovery residence—also commonly referred to as sober living experience or SLE—which would be in addition to level 1 and level 2 outpatient treatment services.

Within each of the four treatment levels, decimal numbers are used to notate gradations of intensity—think more intensive and less intensive rather than higher and lower—and include information about the type of care provided. For example, levels with decimals .1 and .5 indicate that treatment is managed by clinical staff and consists of a range of hours dedicated to psychotherapy, counseling and psychoeducational services and supports; whereas levels with decimals .7 indicate that treatment is managed by medical staff where there's a greater focus on withdrawal management, biomedical, and psychiatric services for stabilization prior to engaging in psychosocial services and supports.

Lastly, in this latest edition it is important to remember that the continuum of care is not intended to be linear nor always a stepwise progression. For instance, levels 1.5 and 1.7 may represent the point of entry into substance use or co-occurring disorder treatment for persons with a mild SUD, whereas for other persons, it may represent a step-down from a more intensive level of care or represent patient preference due to any combination of readiness for change or change barriers such as employment, childcare, transportation, or finances.

Source: (American Society of Addiction Medicine, 2023)

Slide 30

Addressing Gaps in SUD Treatment Service Array

Facilitator Script:

*Facilitator Note: Ask learners to return to their small groups for a discussion on addressing gaps in SUD treatment service array. *Or proceed with a large group discussion for virtual training.*

As we know in child welfare, there is no one size fits all approach to supporting families especially those affected by substance use disorders. Substance use disorders are complex, life-long conditions which may mean for some individuals accessing multiple levels of care on their path to early recovery and/or intermittently along their path of long-term recovery. We also know that access to quality SUD treatment services along the full continuum of care is needed across our communities but is not always available.

Let's now have you reconvene in your small groups for table discussions on addressing gaps in SUD treatment service array in your local communities.

Prompts for Participants:

- **Does your local community offer the full-service array for SUD treatment services? If no, what are the current service gaps in your community?**
- **When a parent's indicated level of care is not available (no provider or waitlisted), what services are offered as an interim?**
- **How have these gaps in SUD treatment service array impacted your work with families (e.g., engagement, retention)?**
- **Do any of your local treatment provider agencies partner with neighboring jurisdictions to expand access in your region?**
- **What are steps you can take in your role as a child welfare worker to support parents affected by substance use disorders as they wait for treatment (e.g., recovery supports, safety planning)?**

Slide 31

Small Group Discussion Questions

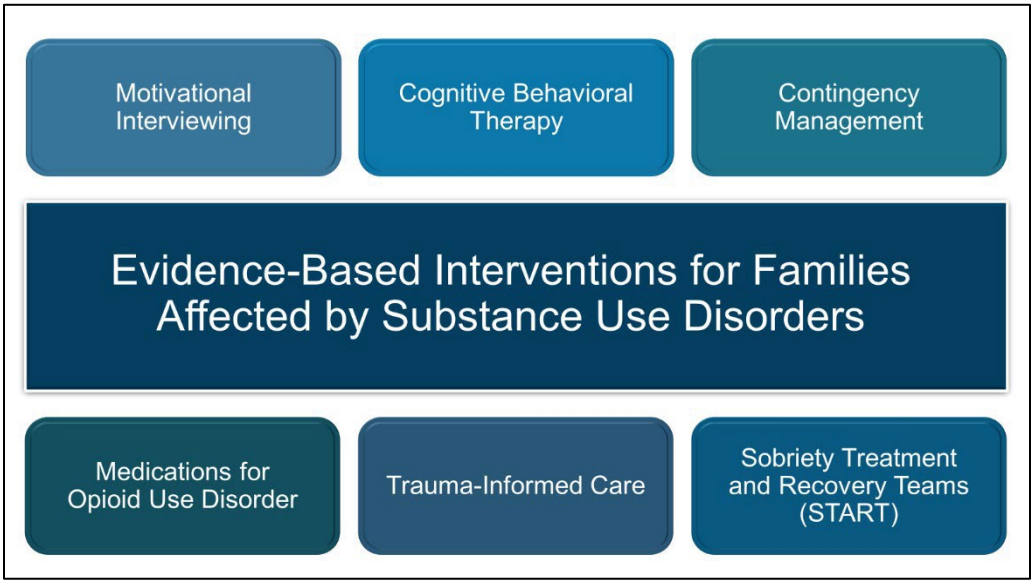
Facilitator Script:

Facilitator Notes: In-person training: ask learners to identify a scriber for their small group discussion to support readiness for large group debrief. After [x] minutes, bring the learners back for a large group debrief asking for volunteers to share highlights or key takeaways from their table discussions.

Virtual training: proceed with facilitating a large group discussion.

Slide 32

Evidence-Based Interventions for Families Affected by Substance Use Disorders

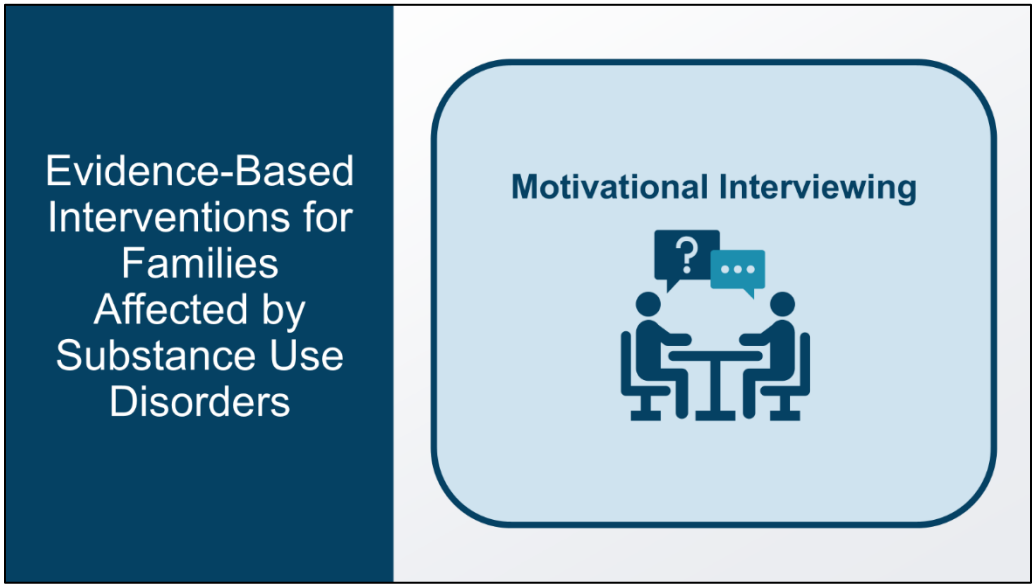


Facilitator Script:

Treatment and recovery from a substance use disorder is possible with the right type of treatment interventions. This often requires a combination of therapies and services that adequately address a parent's substance use and/or co-occurring needs. Interventions are considered evidence-based when there is a body of scientific evidence demonstrating their level of effectiveness. With the passage of the Family First Prevention Services Act, also known as FFPSA, child welfare agencies are now prioritizing funding of evidence-based programs or models as part of their 5-year prevention plans. Let's now examine some of these further…

Slide 33

Motivational Interviewing



Facilitator Script:

One of the most common and long-standing evidence-based treatment intervention for substance use disorders is motivational interviewing or more commonly referred to as MI. MI is currently rated as well-supported on the Title IV-E Prevention Services Clearinghouse. In summary, MI is an effective therapeutic method aimed at promoting an individual's behavioral change. Practitioners use MI strategies to help identify any potential ambivalence toward change while guiding clients through the 5-step readiness for change process. While MI can be used with many different focal populations, it has been tested rigorously within the substance use disorder demographic and shown to be highly effective in promoting favorable outcomes.

Slide 34

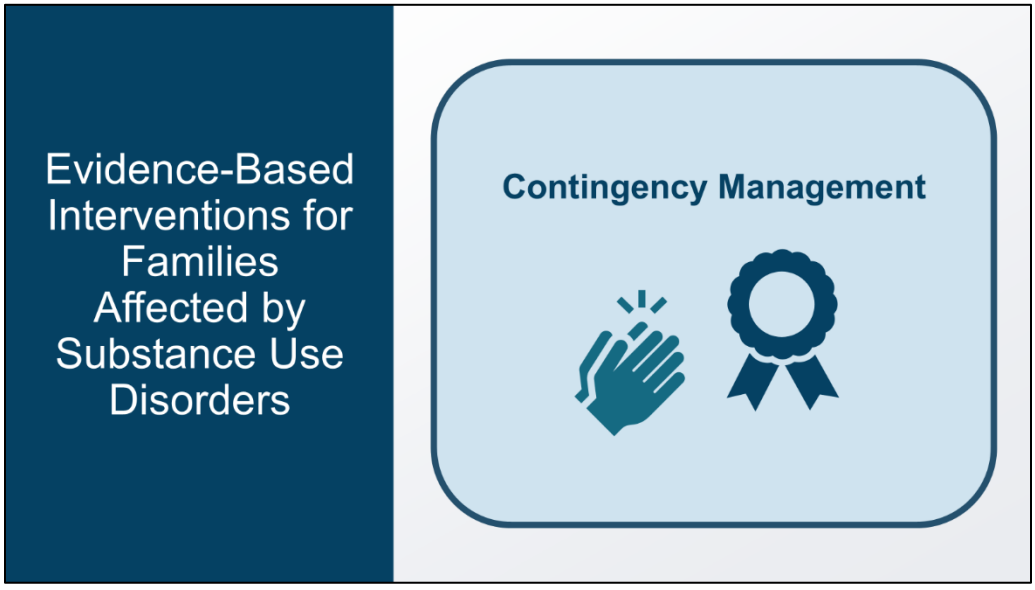
Cognitive Behavioral Therapy

Facilitator Script:

Cognitive Behavioral Therapy, commonly known as CBT, is also a widely used evidence-based treatment intervention for substance use disorders. CBT combines modalities that are grounded in the theory that feelings affect our thoughts, which in turn affect our behaviors—therefore asserting the belief that desired behavioral change can be achieved through reflection on our thoughts and feelings. Specific to substance use disorders there may be an emphasis on the relationship between our thoughts, feelings, behaviors—including cravings, triggers or activators, and the potential for return to use.

Slide 35

Contingency Management



Facilitator Script:

Contingency Management is another widely used and highly effective treatment intervention for substance use disorders. This intervention strategy is rooted in behavioral theory whereby individuals are rewarded for demonstrated progress or behavioral change. When applied to substance use disorder treatment settings, this often looks like providers reinforcing abstinence, as evidenced by negative drug tests, through monetary-based incentives such as vouchers or cash prize drawings that ideally increase with sustained periods of abstinence to continue serving as a motivator for behavioral change. While there is a large body of evidence supporting the use of contingency management with all types of substance use disorders, it is particularly effective in the treatment of methamphetamine.

Facilitator Note: An additional resource is available for more information on this topic: How Using Contingency Management Can Support Families Affected by Substance Use Disorders Webinar.

Slide 36

Medications for Opioid Use Disorder

Facilitator Script:

The language we use to discuss opioid use disorders, or OUDs, including our beliefs about individuals on medication matters greatly. SAMHSA issued guidance ***recommending*** replacing the term medication-assisted treatment (MAT) with medications for opioid use disorder (MOUD)—the reason being the term MAT implies that medication plays a secondary supportive role to other forms of treatment.

MOUD offers individuals a safe and effective way to support their long-term recovery goals. There are currently three U.S. Food and Drug Administration, or FDA, -approved medications for treatment of OUDs; these include methadone, buprenorphine, and naltrexone.

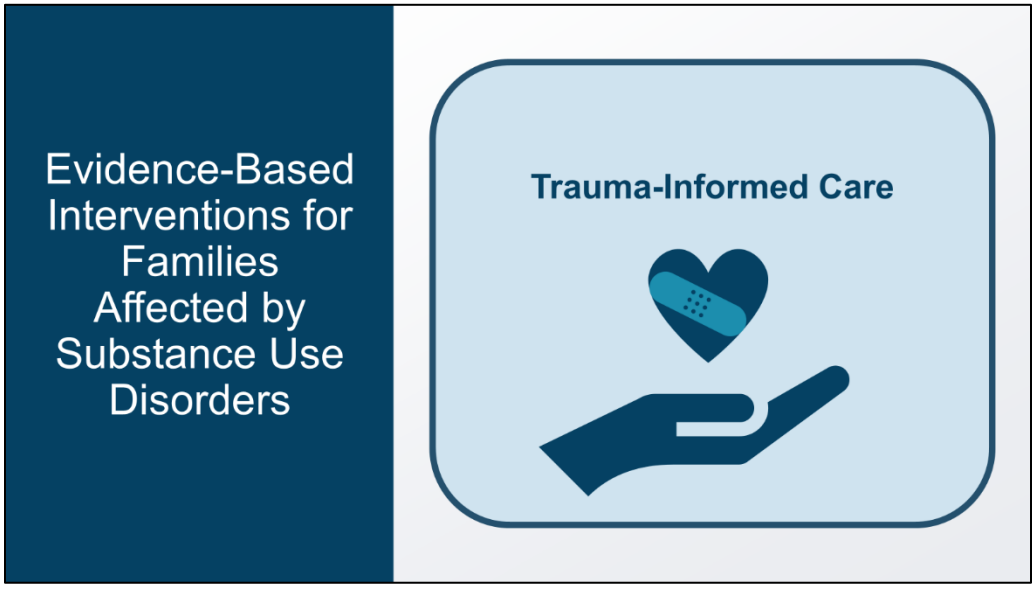
The evidence base for all three medications is strong—methadone and buprenorphine have been proven to reduce or eliminate opioid withdrawal symptoms while also reducing risk of opioid overdose or death; whereas all three have also shown evidence of blunting or blocking the effects of illicit opioids, in addition to reducing or eliminating opioid cravings.

Facilitator Note: Additional resources are available for more information on this topic: Opioid Use Disorder and Civil Rights Video and Webinar Series and Medication-Assisted Treatment and Common Misconceptions Video.

Source: (Substance Abuse and Mental Health Services Administration, 2021b)

Slide 37

Trauma-Informed Care



Facilitator Script:

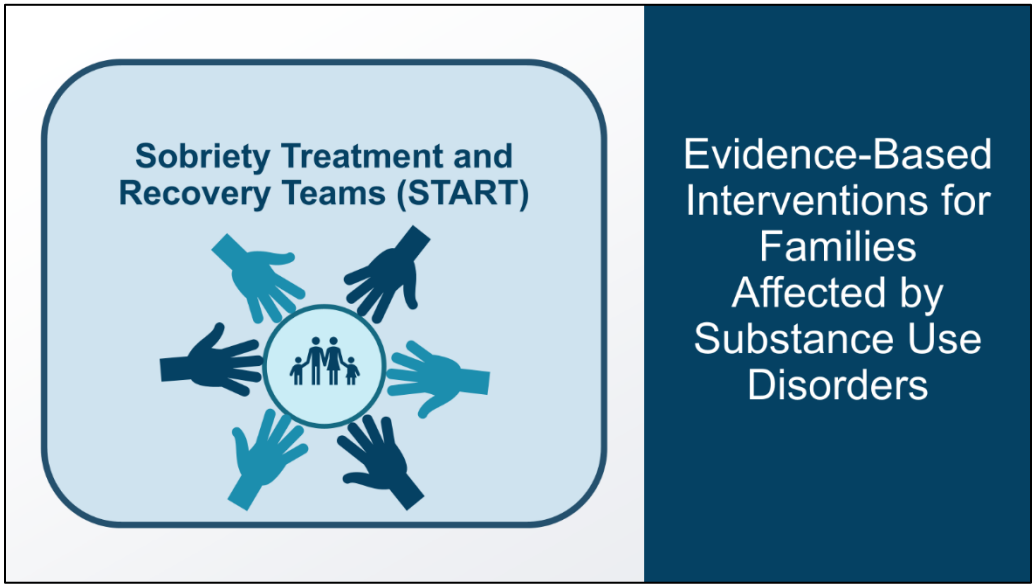
Trauma-Informed Care is especially important as individuals with substance use disorders who are receiving child welfare services often have a history of co-occurring trauma. As cross-system providers, it is critical that we understand how this may affect our interactions with parents. Trauma may lead to a lack of engagement in services, increased risk of return to use, and poor treatment outcomes, among many other possible outcomes. There are a number of evidence-based treatment models such as Trauma-Focused CBT, Seeking Safety, Dialectic Behavior Therapy, and EMDR, all with the goal of managing trauma symptoms and minimizing the potential for re-traumatization in the care setting.

Facilitator Note: Additional resources are available for more information on this topic: Collaborative Teams Toolkit for Trauma-Informed Care—Part 1: Trauma-Informed Care Tip Sheet for Collaborative Teams Serving Children, Parents, and Family Members Affected by Substance Use and Co-occurring Mental Health Challenges; Collaborative Teams Toolkit for Trauma-Informed Care—Part 2: Trauma-Informed Care Tutorial Video; and the Collaborative Teams Toolkit for Trauma-Informed Care—Part 3: Collaborative Trauma-Informed Care (C-TIC) Tool.

Sources: (Tkach, 2018; National Center on Substance Abuse and Child Welfare, n.d.)

Slide 38

Sobriety Treatment and Recovery Teams (START)



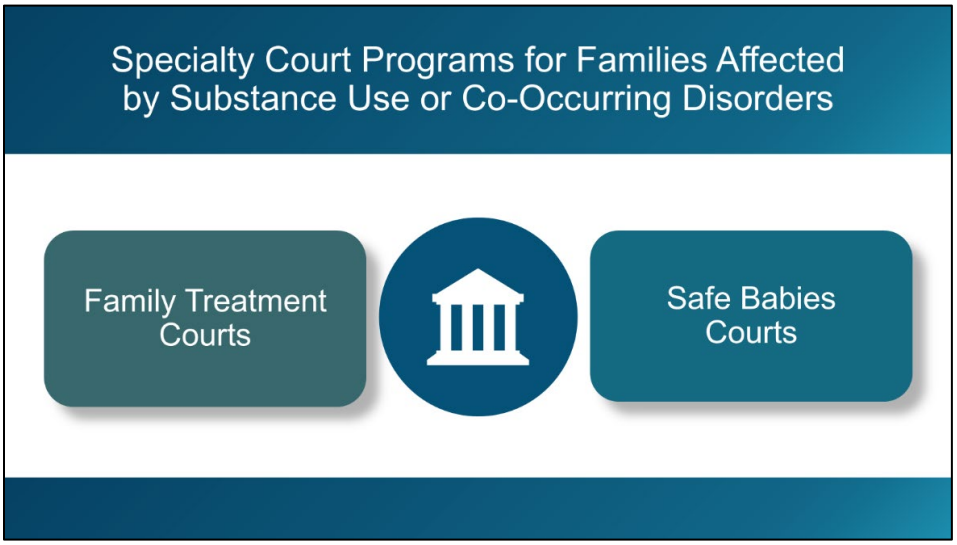
Facilitator Script:

Sobriety Treatment and Recovery Teams, also known as START, is a specialized child welfare service delivery model that has been shown, when implemented with fidelity, to improve outcomes for children and families affected by parental substance use and child maltreatment. Currently rated as supported by the Title IV-E Prevention Services Clearinghouse, the model uses a variety of strategies to promote collaboration and systems-level change within and between child welfare agencies, substance use and mental health treatment providers, the judicial system, and other family-serving agencies.

Sources:(Children and Family Futures, 2023)

Slide 39

Specialty Court Program for Families Affected by Substance Use or Co-Occurring Disorders



Facilitator Script:

Child welfare agencies also rely on partnerships with specialty court programs to meet the unique and complex needs of families affected by substance use or co-occurring disorders. These programs can be either evidence-based or evidence-informed and use a specialized court docket to promote greater access and utilization of comprehensive services for optimal parental recovery, child safety, and family stability.

Family Treatment Courts, also commonly referred to as FTCs, are designed to promote a non-adversarial court environment where judicial leadership is combined with multidisciplinary partnerships for enhanced service coordination. FTCs provide parents, children, and family members with timely access to comprehensive services and supports combined with intensive case management and judicial oversight with the goal of strengthening and preserving families, avoiding out-of-home placement whenever safely possible.

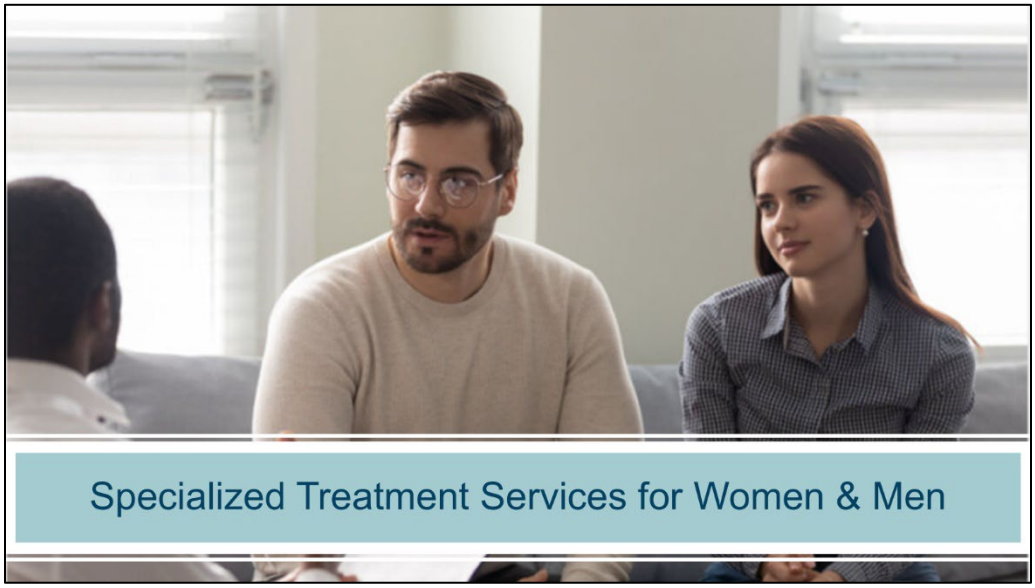
Safe Babies Courts, also commonly referred to as the Safe Babies Court Team (SBCT) approach, are designed to meet the urgent needs of infants, toddlers, and their families currently under dependency court jurisdiction, meaning those families at risk or who have experienced a removal. SBCTs promote increased coordination of early childhood prevention services with an emphasis on strengthening the parent-child relationship including bonding and attachment, and parental protective factors for improved child and family well-being.

Facilitator Note: Additional resources are available for more information on specialty court programs: What are family treatment courts and how do they improve outcomes for children and families? and Safe Babies Court Team™ Approach Infographic.

Source: (Children and Family Futures, 2024; Zero to Three, n.d.)

Slide 40

Specialized Treatment Services for Women & Men



Facilitator Script:

In addition to evidence-based and evidence-informed interventions, specialized treatment services are designed to meet the unique needs of men and women, respectively. While both men and women are affected by substance use disorders, how they are each affected may be different. Specialized 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.

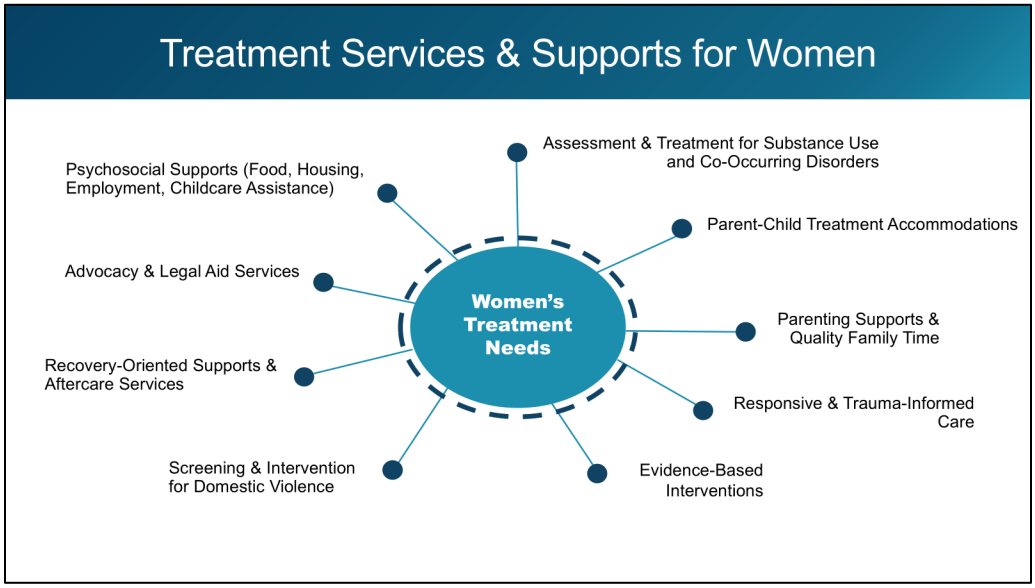
Let's now spend some more time speaking in detail about specialized treatment services for both women and men…

Facilitator Note: Additional resources are available for more information on this topic: #DADication Documentary Series of Public Service Announcements and Engaging Dads in Programs to Support Families Affected by Substance Use Disorders Webinar.

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

Slide 41

Treatment Services & Supports for Women



Facilitator Script:

Treatment for women should integrate the whole person, be trauma-informed, and address substance use and co-occurring disorders such as depression, anxiety, or PTSD. Treatment should also be relational and build a trusting and caring environment. It should include all identified family members or partners as appropriate and include services and supports like individual and group therapy, peer recovery services, and other recovery-oriented supports.

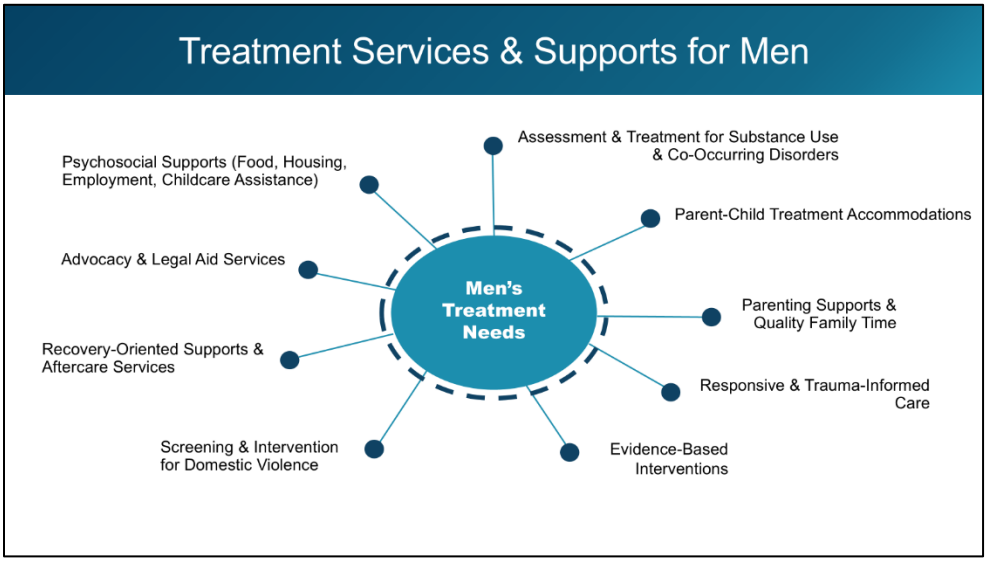
Treatment for women should focus on building and strengthening parenting capacities. Parent-child treatment accommodations like family-based residential programs, outpatient programs that accommodate mothers and their infants, or provide on-site childcare or subsidized childcare assistance are all proven strategies for increasing women's engagement and retention in substance use disorder treatment. Integrated parenting supports also enhance parent motivation as it affirms their identity as a mother and focuses on building capacities to safely parent their children while in recovery. For mothers in residential treatment who have had their children removed from their care, access to frequent quality family time (or visitation) is critical to improving and maintaining the parent-child bond and allowing real-time opportunities to implement and practice new strategies and tools obtained through their parenting programs. This process also allows child welfare workers to continuously assess for safety, risk, and protective capacities to help make an informed and objective decision regarding child safety and permanency planning.

Women should also be universally screened for domestic violence and trauma and referred to all indicated services and supports—including survivor advocacy and free or reduced legal aid services. This may also include help navigating access to psychosocial supports like the supplemental nutrition assistance program (SNAP) or women, infant, and children (WIC) program; access to affordable housing or voucher programs, employment readiness or vocational skills training programs; and free or subsidized childcare assistance programs and services.

Facilitator Note: An additional resource is available for more information on this topic: Treatment Improvement Protocol (TIP) 51: Substance Abuse Treatment: Addressing the Specific Needs of Women.

Slide 42

Treatment Services & Supports for Men



Facilitator Script:

Historically, systems have not done a great job engaging men or fathers in service delivery; however, we also know that outcomes for families improve when fathers are present to develop and nurture positive relationships with their children—leading to improved social and emotional well-being and a reduced likelihood of children engaging in high-risk behaviors such as generational misuse or abuse of alcohol or other drugs.

As shown on this slide, treatment services and supports for fathers are not all that different than for mothers. Compared to women with substance use and co-occurring disorders, men have a higher probability of engaging in poly-substance use, are more likely to be uninsured, and not seek out support for their substance use disorder. While men are exposed to violence and trauma at a higher rate than women, they are far less likely to be diagnosed with post traumatic stress disorder which speaks to the importance of screening men for co-occurring mental disorders and trauma, like women.

It's also important to recognize and understand how societal norms may affect a father's perception on seeking help and recognizing the effects of trauma and how the trauma is manifesting itself in behaviors. Societal norms also contribute to the belief that seeking help for a substance use or co-occurring disorder is a sign of weakness. As we mentioned in module one, men will benefit from specialized programming that allows them to warm up and build trust within the therapeutic setting—often this looks like programming dedicated to the physical health and wellness before diving deeper into cognitive and emotion well-being such as in individual and group therapy.

As we learned earlier, substance use and domestic violence can co-occur, and if the father is the person using violence or coercion, then interventions should be provided to help increase accountability through engagement in abusive partner intervention programs. At this same time, it is important to note that approximately 1 in 10 men experience sexual or physical violence and/or are victims of stalking by their partner in their lifetime and report some form of domestic

violence, and therefore it should never be assumed that men do not also need access to domestic violence survivor services.

Fathers may be reluctant to enter treatment if it prevents them from financially providing for their children and family. It may be necessary to help fathers connect with treatment programs that accommodate their employment or alternative work schedule. Men may also be hesitant about seeking treatment if they believe it may negatively affect their custody arrangement or visitation rights.

Acknowledging the importance of their role and identity as a father can help engage and retain them in treatment. As child welfare workers we do this by

- Providing fathers with services to build parental capacity and resiliency and connect to services specific to their role like fatherhood engagement programs or initiatives;
- Assisting them with establishing paternity and custodial rights;
- Providing resources or services specific to co-parenting;
- Encouraging, coaching, and guiding them to ensure they have quality family time or visits with their children to build and reinforce the parent-child bond;
- Acknowledging fathers and other paternal relatives as potential placement options for children if needed; and
- Actively engaging them for collaborative case planning and decision-making throughout the child welfare intervention period.

And lastly, fathers, like mothers, may also need help accessing psychosocial supports like housing assistance, employment readiness or vocational skills training programs.

Facilitator Note: An additional resource is available for more information on this topic: Treatment Improvement Protocol (TIP) 56: Addressing the Specific Behavioral Health Needs of Men.

Source: (National Responsible Fatherhood Clearinghouse, n.d.; National Responsible Fatherhood Clearinghouse, 2018; Substance Abuse and Mental Health Services Administration, 2013; Centers for Disease Control and Prevention, 2020)

Slide 43

Family-Centered Approach

Facilitator Script:

Now, in addition to specialized treatment services, a family-centered approach is designed to meet the unique needs of all families.

For each of us individually, the definition of family undoubtedly takes on its own unique meaning. As we know, family compositions are robust and can be made up of immediate, extended, and/or non-relative family members—as it is often about the unique bond and support that we form as human beings.

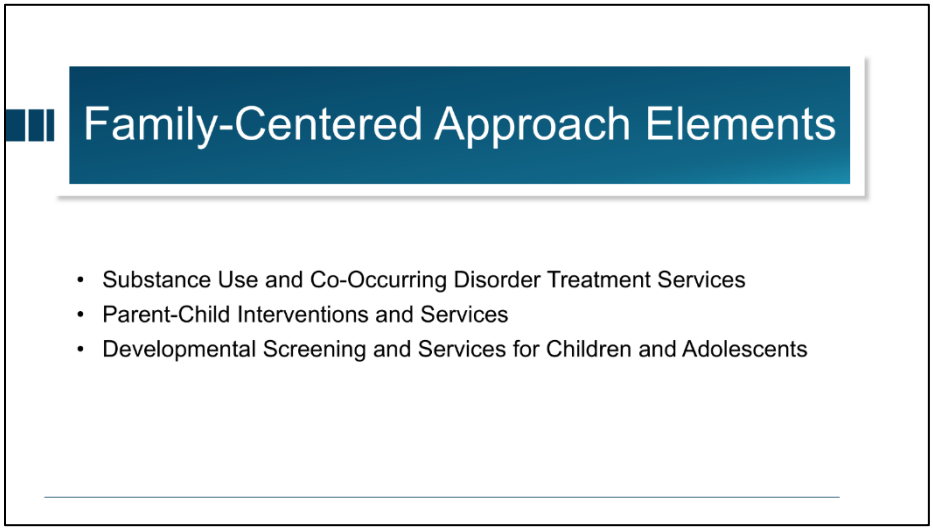
How systems, programs, and agencies define and recognize family units in our communities varies which in part contributes to the ongoing challenges with accessing quality comprehensive services for all individual family members in need—a defining characteristic of a family-centered approach.

A family-centered approach also recognizes that a substance use disorder is a brain disease that affects the entire family, and that recovery and well-being occurs in the context of the family unit. For this reason, a family-centered approach offers a comprehensive array of clinical treatment and related support services that meet the needs of each member in the family, not only the individual requesting care. This extends well beyond the substance use disorder treatment system, the child welfare system, the courts, and mental health service providers—and should include all other agencies or individual practitioners that interact with or on behalf of children and families in our community. Let's now dive into how this may show up in practice.

Facilitator Note: An additional resource is available for more information on this topic: Family-Centered Approach for Families Affected by Substance Use Disorders Webinar.

Slide 44

Family-Centered Approach Elements



Facilitator Script:

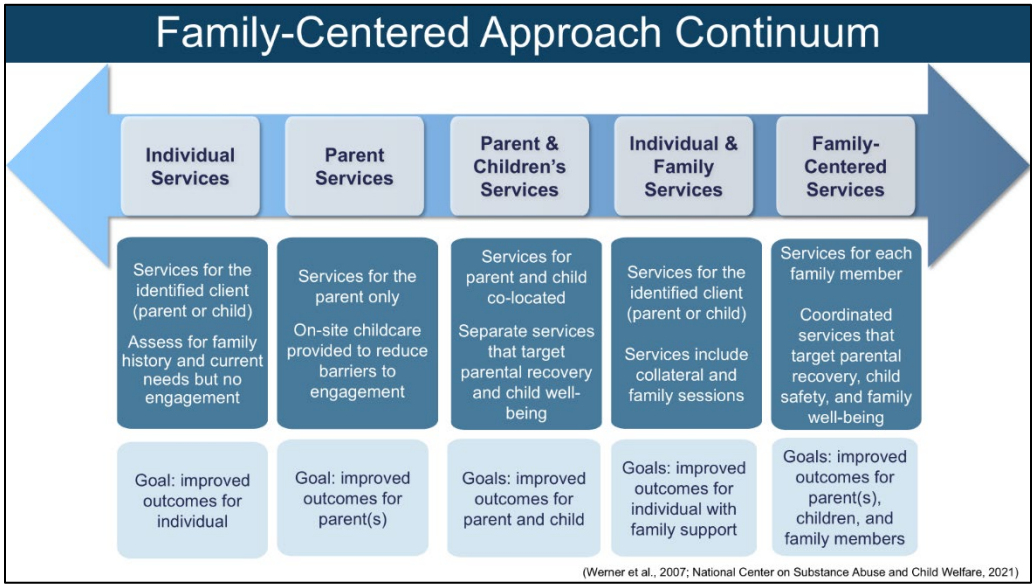
At the heart of a family-centered approach is a high-quality substance use disorder program that incorporates the use of evidence-based and trauma-informed interventions to deliver therapeutic services and recovery-oriented supports. As we touched on in module one, many parents will also meet criteria for a co-occurring mental disorder. Working with your community treatment providers to better understand the scope of their service array including options for specialized or dual diagnosis programs will help ensure referral and linkage to the most appropriate treatment for parents affected by substance use disorders.

Parent-child interventions and services are also an important element of a family-centered approach to substance use disorders. These interventions and services will vary in scope and practice, but most often center around improving the parent-child relationship through focusing on increased capacities such as safe, consistent, and recovery-oriented parenting; increased knowledge of developmental needs, and therapeutic intervention through individual, collateral, and/or family modalities. Assessment and referral to parent-child interventions and services should also be specific to each individual family to ensure the most appropriate and effective level of intervention. Examples of evidence-based parenting programs specific to substance use disorders and/or child maltreatment include the Nurturing Parenting Program, Celebrating Families, Parent-Child Interaction Therapy, and Multisystemic Therapy.

Developmental screening and services for children and adolescents is another important element to a family-centered approach to substance use disorders. We know that prenatal exposure to substances and/or ongoing exposure due to a parent's substance use disorder can increase the risk for an array of developmental needs (physical, social-emotional, cognitive, and language) for children and adolescents. Early identification through comprehensive screening and assessment is critical for mitigating future risk and ensuring optimal functioning. Examples of possible service referrals include maternal, infant, and early childhood home visiting programs and comprehensive developmental assessments and formal supports which are covered more in-depth in modules 6 and 10 of this toolkit but for now, let's stay focused on our understanding of the family-centered approach continuum…

Slide 45

Family-Centered Approach Continuum



Facilitator Script:

A family-centered approach extends well beyond child welfare services, as it also includes substance use and mental health treatment providers, the courts, and other family-serving entities. On one end of the continuum, we have what most would consider business as usual, where services are focused on the traditional identified client. On the opposite end, we have what often requires a paradigm shift, as services are designed and coordinated to meet the needs of each individual family member, otherwise referred to as family-centered service provision.

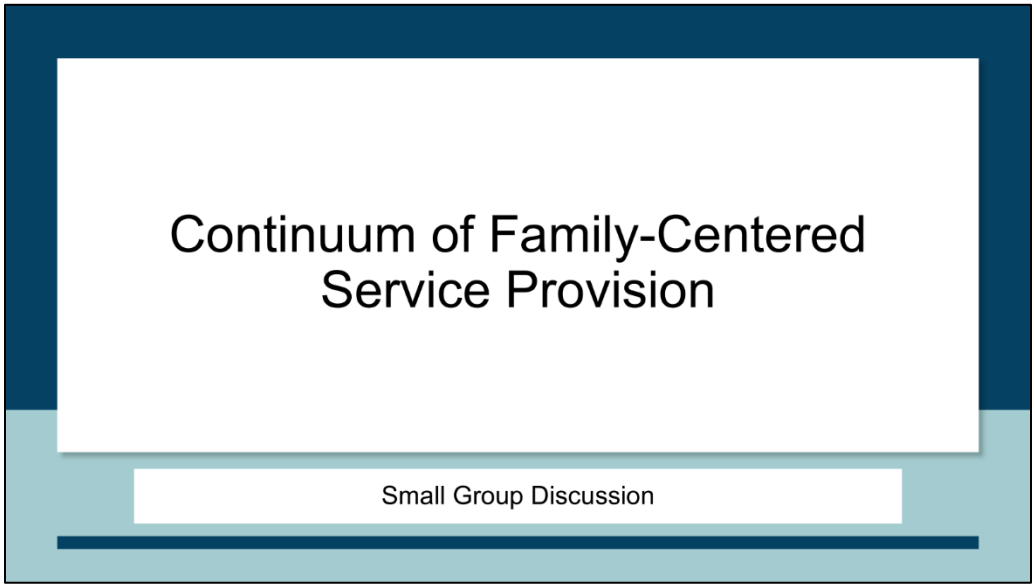
For families affected by co-occurring substance use, mental disorders, and trauma, family-centered service provision is especially important as we know that parental recovery and child safety are critically linked to one another and require a holistic approach among all service providers to ensure the best possible family outcomes. Now, while this is the goal, we also understand that implementing changes or improvements to service provision take time, and as a result, many community providers fall within different points along this continuum.

Facilitator Note: An additional resource is available for more information on this topic: Implementing a Family-Centered Approach (Companion Modules) Series.

Source: (Werner et al., 2007; National Center on Substance Abuse and Child Welfare, 2021)

Slide 46

Continuum of Family-Centered Service Provision



Facilitator Script:

*Facilitator Note: Ask learners to return to their small groups for a discussion on the continuum of family-centered service provision. *Or proceed with a large group discussion for virtual training*

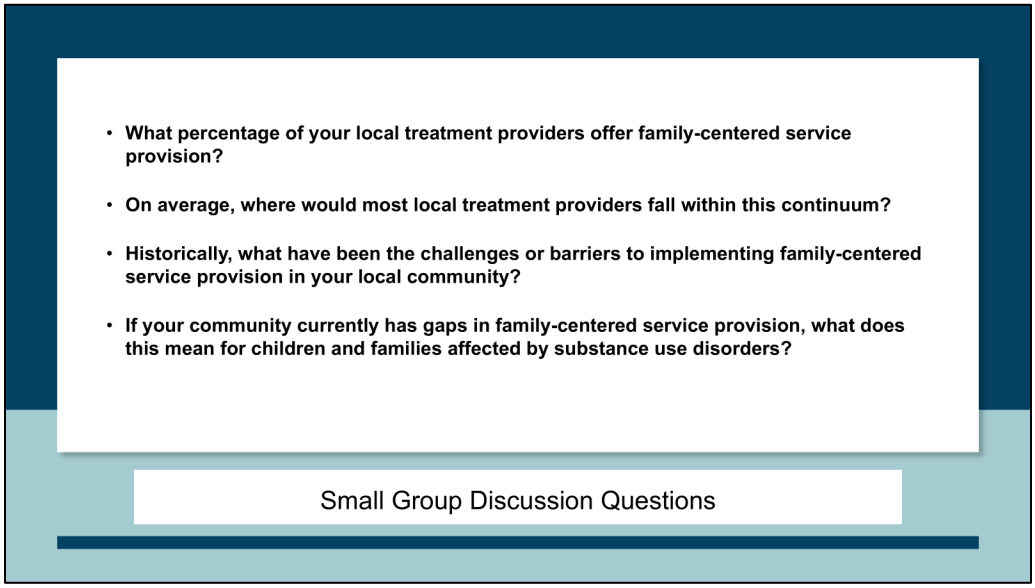
Now that we've reviewed the continuum of family-centered service provision, let's return to our small groups for table discussions about where our local treatment providers fall within this continuum.

Prompts for Participants:

- **What percentage of your local treatment providers offer family-centered service provision?**
- **On average, where would most local treatment providers fall within this continuum?**
- **Historically, what have been the challenges or barriers to implementing family-centered service provision in your local community?**
- **If your community currently has gaps in family-centered service provision, what does this mean for children and families affected by substance use disorders**

Slide 47

Small Group Discussion Questions



Facilitator Script:

Facilitator Notes: In-person training: ask learners to identify a scriber for their small group discussion to support readiness for large group debrief. After [x] minutes, bring the learners back for a large group debrief asking for volunteers to share highlights or key takeaways from their table discussions.

Virtual training: proceed with facilitating a large group discussion.

Slide 48

Recovery Is Possible!

Facilitator Script:

The last critical point of intervention for children, parents, and families affected by substance use and co-occurring disorders involves access and utilization of recovery support. Let's spend some time on this very important topic…

Facilitator Note: Additional resources are available for more information on this topic: Building Hope for Families Affected by Substance Use and Mental Health Disorders—A Blueprint for an Effective System of Care to Promote Lasting Recovery and Family Well-Being and Building Hope for Family Healing and Recovery Webinar.

Slide 49

SAMHSA's Guiding Principles of Recovery

Facilitator Script:

SAMHSA defines recovery as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential." Let's now spend some time orienting ourselves to SAMHSA's Guiding Principles of Recovery:

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.

Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s).

Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, and backgrounds, including trauma experiences, that affect and determine their pathway(s) to recovery. Abstinence is the safest approach for those with substance use disorders.

Recovery is holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.

Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.

Recovery is personalized and responsive: Services should be personalized to meet each individual's unique needs and pathway to recovery, including information related to values, traditions, and beliefs.

Recovery is supported by addressing trauma: Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.

Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by substance use and mental disorders—including protecting their rights and eliminating stigma and bias—are crucial in achieving recovery.

Source: (Substance Abuse and Mental Health Services Administration, 2012)

Slide 50

Recovery Support Services

Facilitator Script:

As we know, recovery is a process! Recovery support services, also known as aftercare services, are designed to support individuals on their journey to life-long recovery. These services are vast but often fall into four main categories:

Mutual-Help Organizations, also commonly referred to as self-help groups or mutual aid, bring together individuals in recovery to share their experiences and to provide support to one another. While every community will vary, common self-help groups include Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Al-Anon or Alateen, SMART Recovery, Women for Sobriety, Celebrate Recovery, and Moderation Management.

Recovery Communities, also known as recovery centers or recovery cafes, are non-residential community-based hubs designed to provide individuals access to a host of recovery-oriented supports and services including but not limited to alumni or peer-facilitated groups, employment and housing assistance, childcare and other financial, health, and legal services.

Recovery Residences, also known as sober living experiences or SLEs, offer individuals in recovery a safe living environment through room and board with other individuals in recovery.

Recovery Coaches, also commonly referred to as peer recovery specialists, are individuals in long-term recovery (typically at minimum 2-3 years) who are trained and certified in recovery coaching models. Recovery coaching or peer-based recovery support services have a long history in substance use and mental health disorder treatment and more recently within child welfare services.

Facilitator Note: Additional resources are available for more information on this topic: The Use of Peers and Recovery Specialists in Child Welfare Settings and Peer Support Specialist Programs for Families Affected by Substance Use and Involved with Child Welfare Services: A Four-Module Implementation.

Sources: (National Center on Substance Abuse and Child Welfare, 2019; Peer Recovery Center of Excellence, 2022)

Slide 51

What is Peer Support?

Facilitator Script:

As we just learned, peer recovery support can take on many forms. Let's now watch a short-animated video from the Center for Peer Excellence.

Prompts for Participants (after the short-animated video):

- **Any initial thoughts or reactions to the animated video?**
- **Who here has experience working with or collaborating with peer recovery specialists? If so, in what capacity? And can you share a little about your experience?**
- **For those who do not have experience, what do you think might be some potential benefits to having peer recovery specialists in child welfare settings to support children and families affected by substance use disorders?**

This was great, thank you all for sharing from your experience (or perspective) about the benefits of peer recovery support. I think we can all agree that the one undeniable benefit is that peers embody a real-life example that recovery is possible.

Video Source: Center for Peer Excellence

Slide 52

Key Practice Strategy Reminders

Facilitator Script:

We covered a lot of information in today's module. So, before we wrap up, let's take a moment to recap some key practice strategy reminders to support your work with children, parents, and families.

Collaborate: As child welfare workers, we have a responsibility to build relationships with substance use disorder experts in our communities to better understand and facilitate referral and linkage to appropriate supports and services for each family member, including parents, children, and family members.

Talk: We should also be talking with substance use disorder treatment professionals to increase our awareness and understanding of evidence-based treatment models or interventions and any new and emerging practice considerations specific to substance use disorders as what works for one substance may not work for others. Learning what works best for each specific substance use disorder. Including what the data and research says will help us tailor interventions and case plan objectives that account for the various complexities and nuances.

Understand: Understand that all treatment levels of care can be effective or enhanced to better meet the needs of parents and their family members. For some parents, outpatient treatment with the right amount of additional supports and services will be sufficient. For others, the structure and intensity of inpatient treatment may be required for a greater likelihood of treatment engagement and retention. Having awareness of residential family-centered treatment programs where families are allowed to remain together during treatment or with frequent quality family time visits when living together is not a safe option, have continually shown significant improvements to parental recovery and child welfare outcomes.

Refer: Use your increased knowledge and community partnerships to refer and link parents and families to tailored services and supports that meet their unique needs. For families affected by

substance use disorders, this may include peer recovery support services or mutual aid for real-time coaching and support with things well beyond abstinence-oriented programming such as housing and employment resources, healthcare coverage, and improved management of activities of daily living.

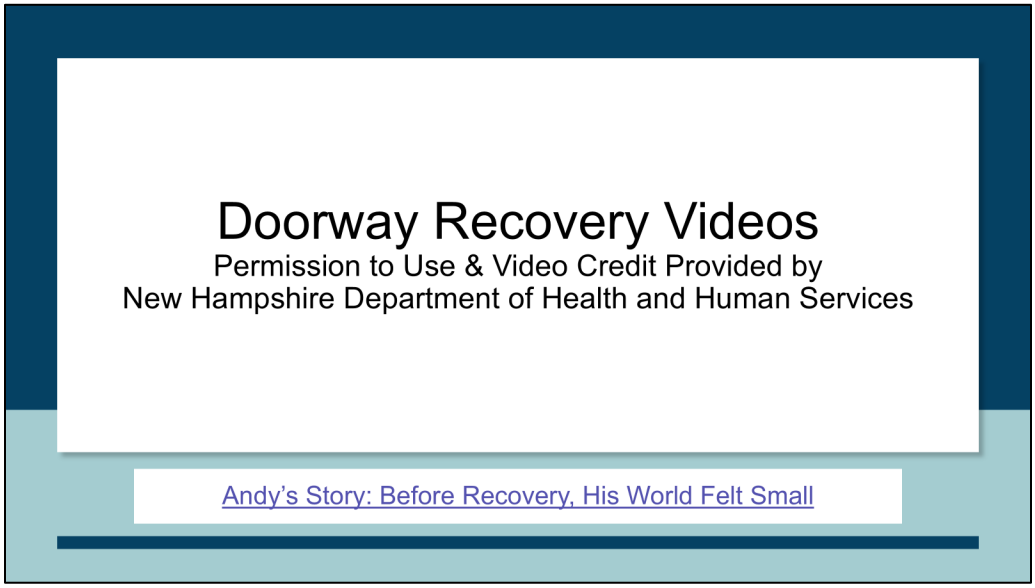
Ensure: This also includes ensuring access to concurrent mental health services to manage comorbidity such as depression and anxiety; as well as indicated supports and services for each family member—ensuring children and adolescents are receiving proper screening and assessment for their developmental and social-emotional health needs; making appropriate and timely referrals for all indicated services and following up to ensure access and utilization of said services and supports.

Support: Belief and understanding that despite all the challenges and complexities that substance use disorders present, parents and their families are very much capable of a full recovery—they may just need a little extra support from us along the way.

Convey: This last one is a good reminder to ourselves to convey empathy and instill hope in our work with all parents and families on their path toward long-term recovery and family stability. Remember, recovery is absolutely possible with the right interventions and support services.

Slide 53

Doorway Recovery Videos: Andy's Story



Facilitator Script

Andy's story embodies this possibility! Let's now close out today's training with his recovery video; made possible by Doorway Recovery and the New Hampshire Department of Health and Human Services.

Prompts for Participants:

- **What part of Andy's story resonated with you the most?**
- **Andy's story embodied hope; what treatment and recovery support services appeared most influential to his long-term recovery?**

Video Source: New Hampshire Department of Health and Human Services

Slide 54

Contact the NCSACW TTA Program

Facilitator Script:

Alright, this wraps up the instructional content for module two. 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 discussion today and for your continued work on behalf of children, parents, and families affected by substance use and co-occurring disorders. Take care, everyone!

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- National Center on Substance Abuse and Child Welfare: *Collaborative Teams Toolkit for Trauma-Informed Care—Part 1: Trauma-Informed Care Tip Sheet for Collaborative Teams Serving Children, Parents, and Family Members Affected by Substance Use and Co-occurring Mental Health Challenges* (2024)
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