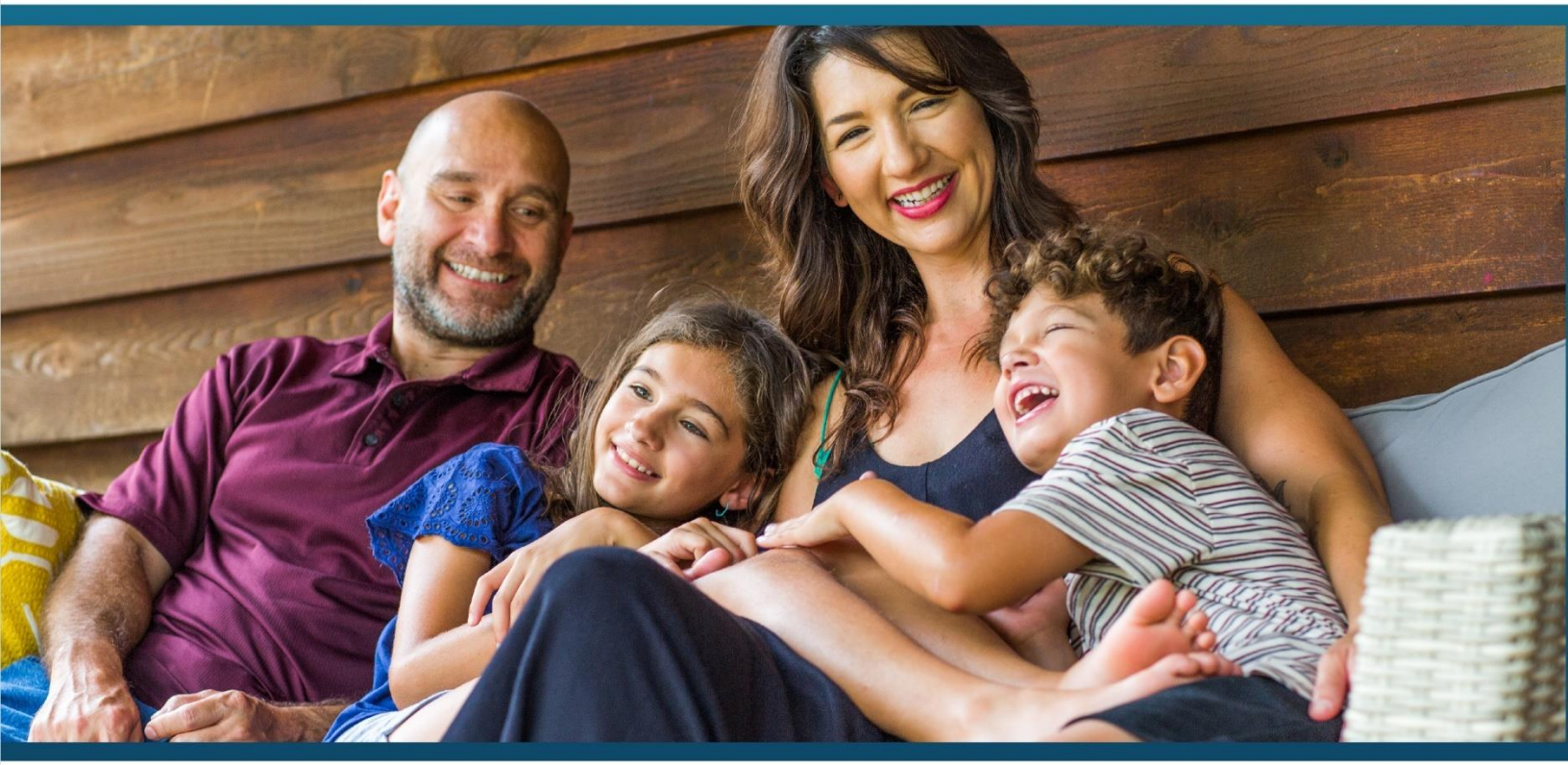
MODULE 6

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






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 6 Description & Objectives

The goal of module 6 is to provide in-depth knowledge and understanding about the needs of children and adolescents affected by parental substance use and co-occurring disorders. Child welfare workers will acquire knowledge and skills to improve their identification of short- and long-term effects of parental substance use and co-occurring disorders on the prenatal, postnatal, childhood, and adolescence periods; be able to discuss the prevalence of fetal alcohol spectrum disorders with information on symptoms, differences in disorder classifications, and treatment options; engage children, youth, and adolescents with age-appropriate tools and strategies for increased rapport and understanding of their individualized needs; utilize best practice screening tools for early identification and intervention for all indicated developmental, mental health, trauma, and substance use needs; and finally, awareness of the long-term effects of adverse childhood experiences including strategies to prevent or reduce toxic stress.

After completing this training, child welfare workers will:

- Identify the short- and long-term effects of parental substance use and co-occurring disorders on the prenatal, postnatal, childhood, and adolescence periods
- Discuss the prevalence of fetal alcohol spectrum disorders with information on symptoms, differences in disorder classifications, and treatment options
- Engage children, youth, and adolescents with age-appropriate tools and strategies for increased rapport and understanding of their individualized needs
- Utilize best practice screening tools for early identification and intervention for all indicated developmental, mental health, trauma, and substance use needs
- Understand the long-term effects of adverse childhood experiences including strategies to prevent or reduce toxic stress

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.

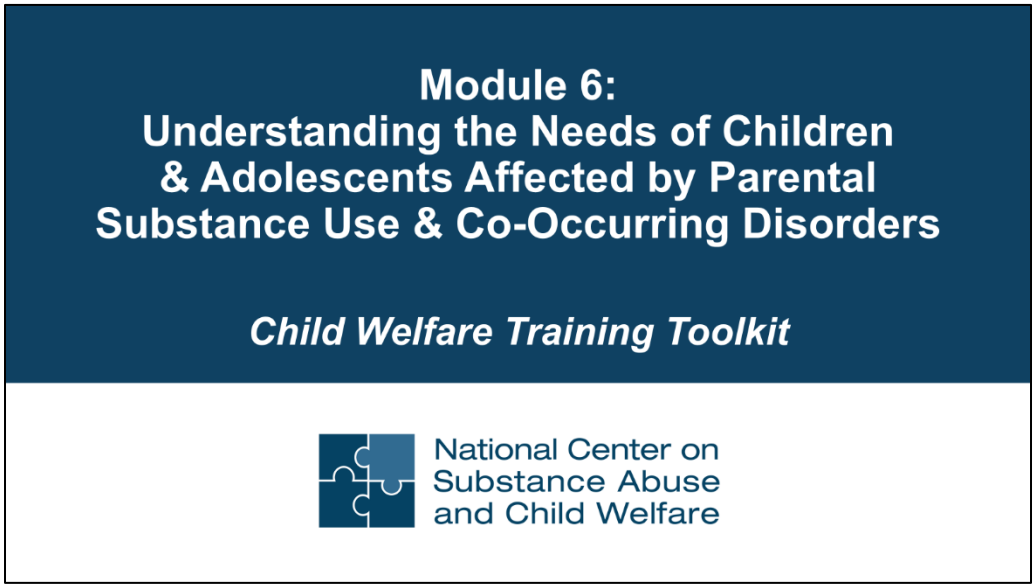
- Facilitative Prompts for Participants: content-specific inquiries developed to engage learners in further discussion and application of knowledge and skills (**bolded for easy reference**).

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

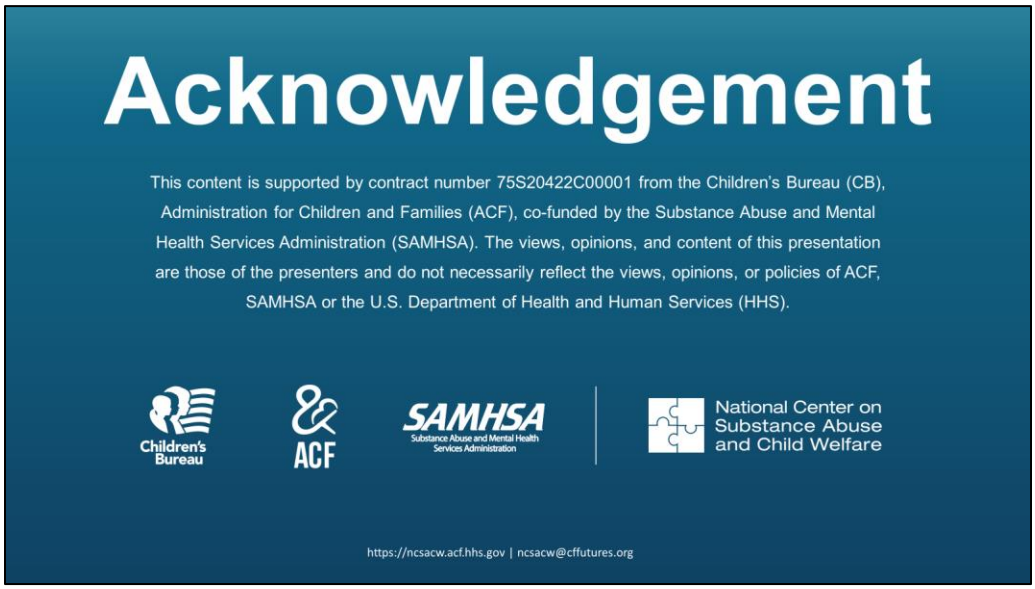


Facilitator Script:

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. Your active participation in the various adult learning exercises is encouraged, leading to a more in-depth understanding about the needs of children and adolescents affected by parental substance use and co-occurring disorders.

Slide 2

Acknowledgement

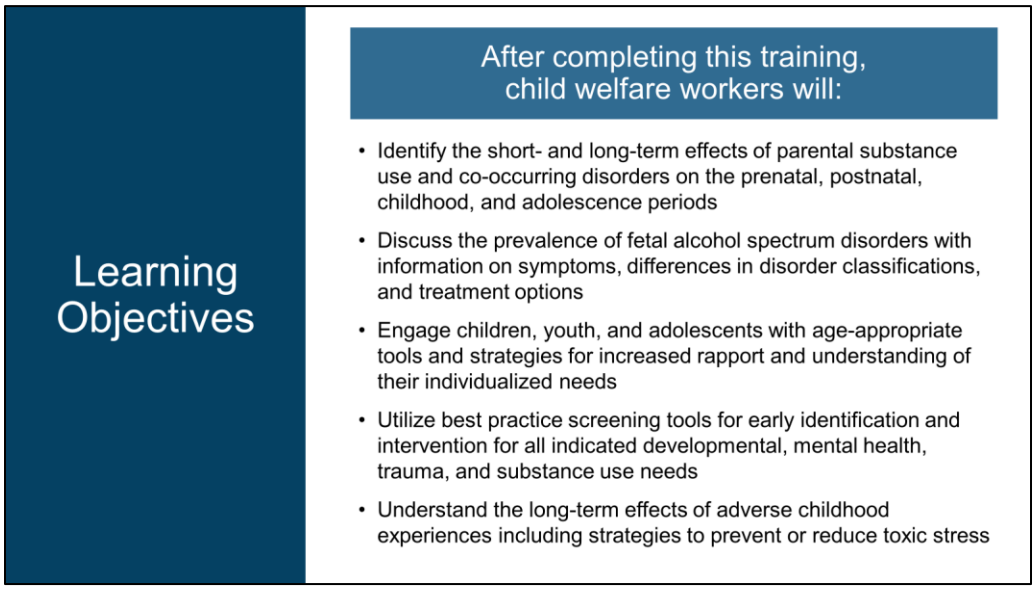


Facilitator Script:

Before we begin, I'd like to acknowledge that this training 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 and 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 6 is to provide in-depth knowledge and understanding about the needs of children and adolescents affected by parental substance use and co-occurring disorders. Child welfare workers will acquire knowledge and skills to improve their identification of short- and long-term effects of parental substance use and co-occurring disorders on the prenatal, postnatal, childhood, and adolescence periods; be able to discuss the prevalence of fetal alcohol spectrum disorders with information on symptoms, differences in disorder classifications, and treatment options; engage children, youth, and adolescents with age-appropriate tools and strategies for increased rapport and understating of their individualized needs; utilize best practice screening tools for early identification and intervention for all indicated developmental, mental health, trauma, and substance use needs; and finally, awareness of the long-term effects of adverse childhood experiences including strategies to prevent or reduce toxic stress.

Slide 4

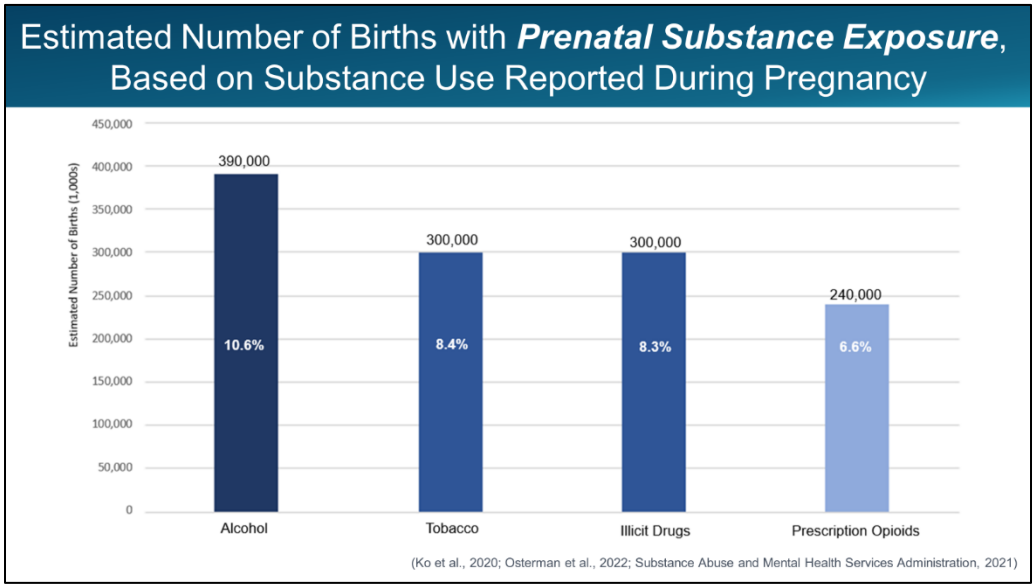
Effects of Prenatal Substance Exposure

Facilitator Script:

Let's start today's discussion by reviewing what the data on prenatal substance exposure tells us…

Slide 5

Estimated Number of Births with Prenatal Substance Exposure, Based on Substance Use Reported During Pregnancy



Facilitator Script:

Beginning with this bar graph, we have estimated number of births with prenatal substance exposure based on substance use reported during pregnancy for year 2020. The data presented has been made available through multiple sources including the National Survey on Drug Use and Health, National Vital Statistics Reports, and the Centers for Disease Control and Pregnancy Risk Assessment Monitoring System. Alcohol had the highest estimate at 10.6% of births or 390,000, followed by tobacco at 8.4% or 300,000, illicit drugs at 8.3%, which is also roughly 300,000, and prescription opioids at 6.6%, or 240,000 births.

Prompts for Participants:

- **Any initial reactions to these figures? Is this what you expected from the data based on your casework experience?**
- **What type of information or follow-up questions would you have to better understand the data related to prenatal substance exposure during pregnancy?**

When I first reviewed this data, I know one immediate follow-up question that came to mind was how does this data on prenatal exposure translate to short-term and long-term effects for these children. Let's take a closer examination over the next few slides…

Sources: (Ko et al., 2020; Osterman et al., 2022; Substance Abuse and Mental Health Services Administration, 2021)

Slide 6

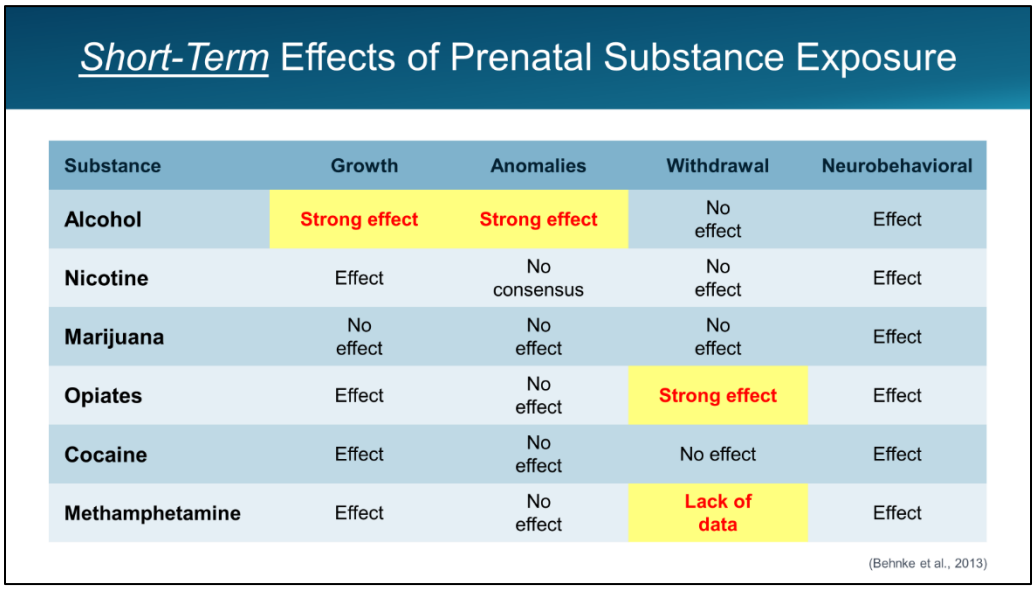
Short-Term & Long-Term Effects of Prenatal Substance Exposure

Facilitator Script:

These next few slides summarize the effects of prenatal substance exposure broken out by type of substance. The information was made available by the American Academy of Pediatrics technical report that included a comprehensive review of approximately 275 peer-reviewed articles spanning 40 years (1968–2006). Before we review the data tables, I did just want to note that this is not meant to be interpreted as a comparison of effects between substances—rather, just a summary of the comprehensive literature.

Slide 7

Short-Term Effects of Prenatal Substance Exposure



Short-Term Effects of Prenatal Substance Exposure

Substance	Growth	Anomalies	Withdrawal	Neurobehavioral
Alcohol	**Strong effect**	**Strong effect**	No effect	Effect
Nicotine	Effect	No consensus	No effect	Effect
Marijuana	No effect	No effect	No effect	Effect
Opiates	Effect	No effect	**Strong effect**	Effect
Cocaine	Effect	No effect	No effect	Effect
Methamphetamine	Effect	No effect	**Lack of data**	Effect

(Behnke et al., 2013)

Facilitator Script:

Listed in this table are the short-term effects of prenatal substance exposure for alcohol, nicotine, marijuana, opiates, cocaine, and methamphetamine across four domains—fetal growth, birth anomalies, withdrawal, and neurobehavioral effects. We used the red color font and highlights to draw your attention to the substances with either lack of data (methamphetamine) or strong effects. You'll notice that alcohol shows strong effects in both fetal growth and birth anomalies, whereas opiates showed strong effects specific to withdrawal symptoms.

Prompt for Participants:

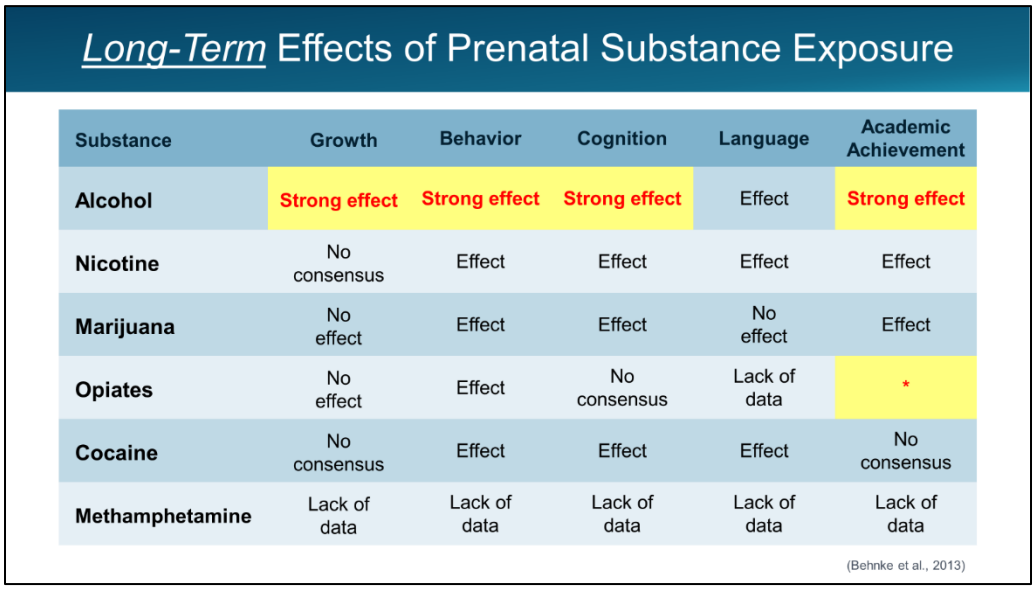
- **Any initial reactions or thoughts about these short-term effects?**

Alright, let's now review the long-term effects of prenatal substance exposure…

Source: (Behnke et al., 2013)

Slide 8

Long-Term Effects of Prenatal Substance Exposure



Substance	Growth	Behavior	Cognition	Language	Academic Achievement
Alcohol	**Strong effect**	**Strong effect**	**Strong effect**	Effect	**Strong effect**
Nicotine	No consensus	Effect	Effect	Effect	Effect
Marijuana	No effect	Effect	Effect	No effect	Effect
Opiates	No effect	Effect	No consensus	Lack of data	*
Cocaine	No consensus	Effect	Effect	Effect	No consensus
Methamphetamine	Lack of data	Lack of data	Lack of data	Lack of data	Lack of data

Facilitator Script:

Let's now direct our attention to the long-term effects of alcohol as it is the one substance demonstrating effects across all five domains: growth, behavior, cognition, language, and academic achievement. Again, this is not to be interpreted in comparison to the other substances long-term effects, as these findings may be better attributed to the fact that alcohol has been studied more frequently therefore has a larger body of evidence compared to other substances.

Also, highlighted on the slide, is the asterisk under academic achievement for opiates which indicates new literature available from 2017-2019 on the long-term effects of prenatal opioid exposure. Findings among school-aged children included significant effects on academic achievement with an increased need for special education services.

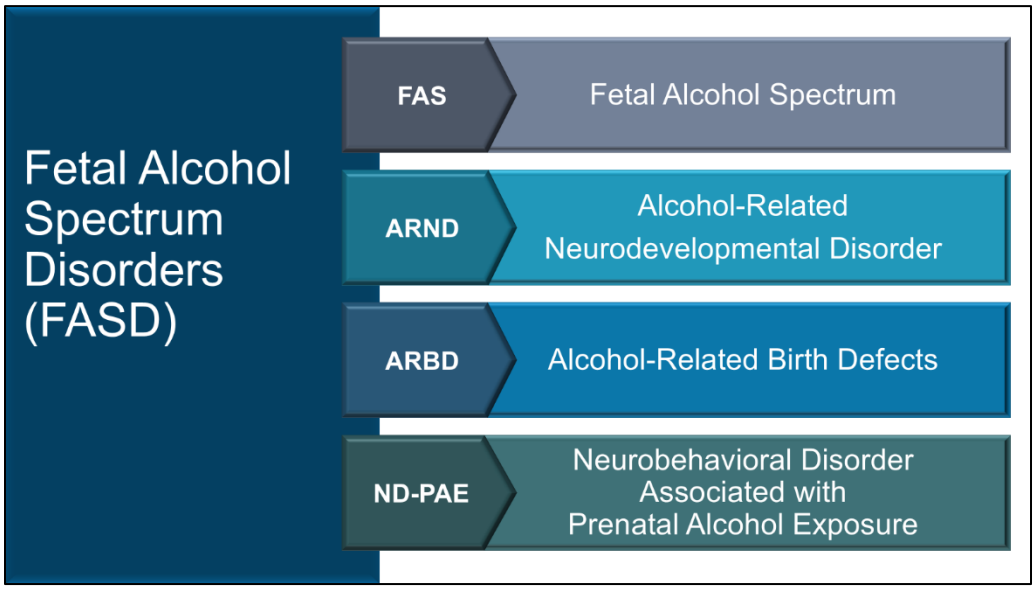
Overall, the long-term effects of prenatal exposure to alcohol and other drugs can include lower IQ, information processing difficulties, difficulties with motor skills and mood regulation, poor executive functioning, learning disabilities, attention deficits, hyperactivity, problems with impulse control, language, memory, and social skills, and emotional withdrawal. These behavioral needs can exacerbate the difficulties of parenting, especially while in early recovery and therefore will require careful consideration during the assessment and case planning process to ensure access to all indicated services and supports.

Facilitator Note: An additional resource is available for more information on this topic: Common Developmental Trajectories of Children with Fetal Alcohol Spectrum Disorder Webinar.

Sources: (Fill et al., 2018; Lee et al., 2019; National Center on Substance Abuse and Child Welfare, 2022; Oei et al., 2017; Behnke et al., 2013)

Slide 9

Fetal Alcohol Spectrum Disorders (FASD)



Facilitator Script:

As highlighted, prenatal exposure to alcohol has short-term and long-term effects that span across infancy, early childhood, and adolescence. Fetal alcohol spectrum disorders (or FASD) is an overarching term that describes the varying disorders that result from in-utero exposure to alcohol. Symptoms range from mild to severe and manifest differently in each person.

In infants, FASD may manifest as mild or severe developmental delays, challenges with self-regulation such as trouble with sleep, fussiness, difficulty being soothed, and sensitivity to being overstimulated, as well as disorganized or unfocused play. In addition to self-regulation, prenatal substance exposure to alcohol can also cause difficulties with memory and reasoning, which contributes to the misperception of disobedience in children and irresponsibility in adults.

There are many factors that influence the effect alcohol has during in-utero development, such as a pregnant woman's age, genetics, overall health and well-being, amount of use, timing of in-utero exposure, and use of other substances in combination with alcohol. While there is no known cure for FASD there are treatments that can help improve and manage symptoms and offer support to families. Treatment may include early intervention services, mental health therapy, medication, and parent or caregiver education and support.

Prompt for Participants:

- **By a show of hands, how many people are familiar with the specific FASD disorders highlighted here?** *[Pause to give the learners to raise their hands, then proceed with a high-level summary below]*

Fetal Alcohol Spectrum (FAS) represents the part of the FASD spectrum that includes specific facial features (small eye openings, thin upper lip, smooth ridge between nose and upper lip); small stature and a variable range of issues with learning, memory, attention, executive functioning, self-regulation, and communication.

Alcohol-Related Neurodevelopmental Disorder (ARND) represents Individuals who may have the same combination of impairments listed under FAS but none of the physical markers.

Alcohol-Related Birth Defects or ARBD represents individuals who have problems with the heart, kidneys, bones, or hearing.

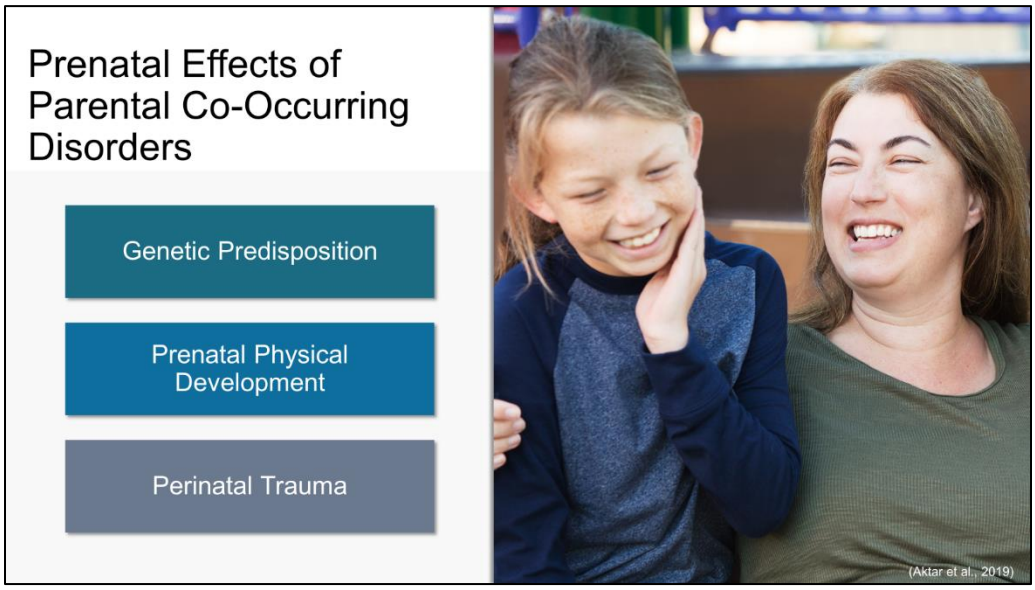
And Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (ND-PAE) is the emerging term encompassing all fetal alcohol-related conditions except ARBD. Although the range and types of impairments are the same as mentioned above, ND-PAE encompasses individuals with and without the facial features and small stature of FAS.

Facilitator Note: Additional resources are available for more information on this topic: Understanding Fetal Alcohol Syndrome Disorders: Child Welfare Practice Tips and Understanding Fetal Alcohol Spectrum Disorders for Substance Use Treatment Professionals.

Source: (National Center on Substance Abuse and Child Welfare, 2022)

Slide 10

Prenatal Effects of Parental Co-Occurring Disorders



Facilitator Script:

Prenatal effects of parental co-occurring disorders may also influence a child's development, well-being, and overall safety.

Genetic predisposition for mental disorders means that certain genes can be passed down from parent to child thereby placing them at an increased risk from a genetic standpoint. It's important to note, however, that gene inheritance varies; not all children of parents with mental disorders will inherit these genes, and the presence of the genes alone does not mean the child will develop their own mental disorder.

Similarly, the prenatal physical development is in great part dependent on the health and well-being of the individual carrying the developing child. Considerations such as their nutrition, use of drugs or alcohol, level of physical activity, and emotional state of well-being may all affect the developing fetus, especially the development of the nervous system. One example is untreated prenatal depression which is associated with poor birth outcomes, including low birthweight, premature birth, and obstetric complications.

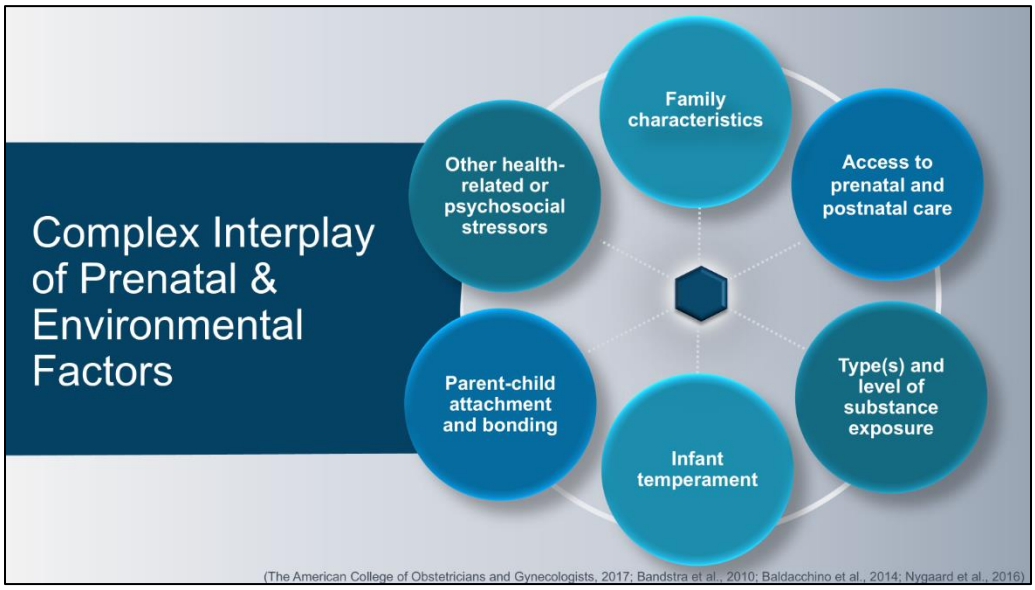
And finally, the perinatal or birth experience may have traumatic consequences on the child's development. This may be a result of prolonged or premature labor, head injury, or medication effects from the mother.

Gathering this type of historical information as part of the assessment process can help ensure infants, children, and their parents are connected to the needed services to support their overall health and development.

Source: (Aktar et al., 2019)

Slide 11

Complex Interplay of Prenatal & Environmental Factors



Facilitator Script:

Many factors influence how an infant is affected by prenatal and postnatal exposure to substances, not just the physical exposure to the substance in utero. This includes, but is not limited to:

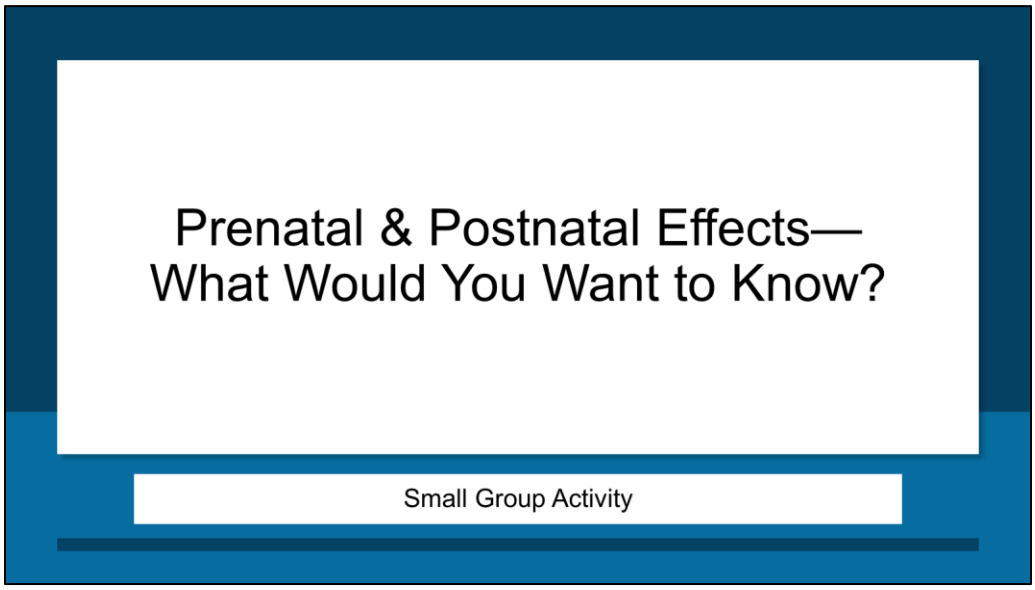
- Family characteristics,
- Access to prenatal and postnatal care,
- Types and level of substance exposure,
- Infant temperament,
- Parent-child attachment and bonding, and
- Other health-related or psychosocial stressors.

Through proper screening and assessment, we can gather important information to better support families in this critical period of recovery and well-being. Now, let's spend some time in our small groups honing our assessment skills.

Sources: (The American College of Obstetricians and Gynecologists, 2017; Bandstra et al., 2010; Baldacchino et al., 2014; Nygaard et al., 2016)

Slide 12

Prenatal & Postnatal Effects—What Would You Want to Know?



Facilitator Script:

Facilitator Notes: Instruct learners to convene in small groups for an activity on assessing the prenatal and postnatal environment.

Referencing the factors listed on the previous slide, use flip chart paper to highlight each category. Discuss with your group members the type of information you would want to know more about to support your assessment of prenatal and postnatal effects of substance exposure and co-occurring disorders. Identify a volunteer to scribe your responses as well as someone to lead your report out during our large group discussion. Let's plan to spend the next (X) minutes preparing our list before coming back together as a large group.

Materials Needed:

- *Easel Paper*
- *Markers*

**Alternative Instructions for Virtual Training*

Create an IdeaBoardz by visiting www.ideaboardz.com and click 'Create.' Complete the following prompts:

- *Name: Prenatal & Postnatal Effects—What Would You Want to Know?*
- *Description: Large Group Activity*
- *Format: Select 6 Sections*
- *Section Titles:*
  - *Family Characteristics*

  - *Access to Prenatal/Postnatal Care*
  - *Type(s) and Level of Substance Exposure*
  - *Infant Temperament*
  - *Parent-Child Attachment/Bonding Styles*
  - *Other Health and Psychosocial Factors*
- *Click on Create*
- *Copy the URL to the Chat Box*

Instruct learners to follow the URL provided in the chat box. Ask learners to add their input by listing the types of information that they would want to know more about related to each section to support their assessment of prenatal and postnatal effects of substance exposure and co-occurring disorders.

Let's spend the next [x] minutes adding to the IdeaBoardz before we review and discuss together as a large group.

Slide 13

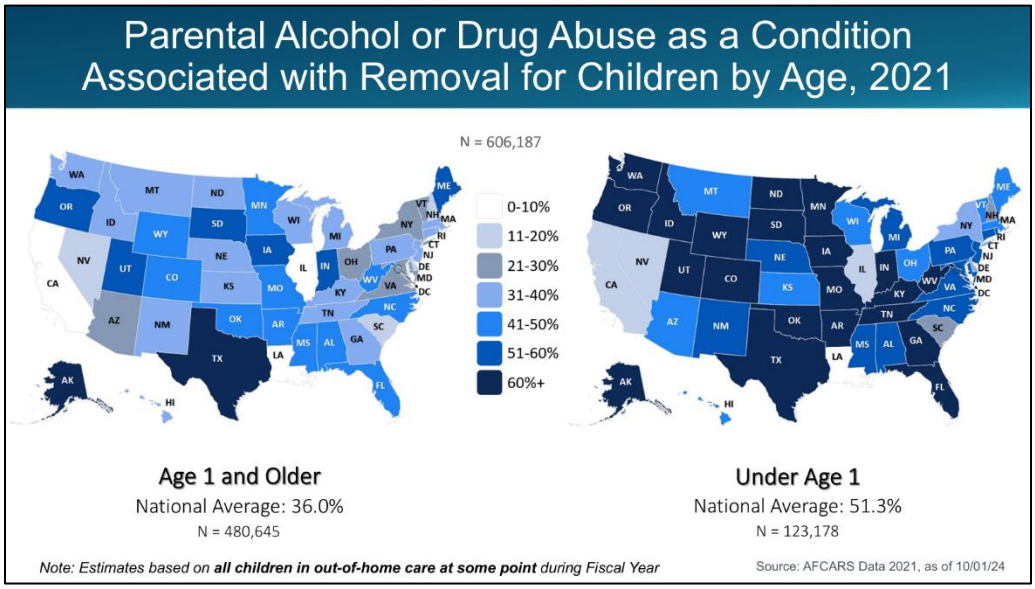
Effects of Parental Substance Use & Co-Occurring Disorders on Children, Youth & Adolescents

Facilitator Script:

Building on our discussion about infant prenatal substance exposure, let's now expand our learning to include the effects of parental substance use and co-occurring disorders on children, youth, and adolescents.

Slide 14

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



Facilitator Script:

This is a heat map comparison of the national and state-specific percentages for the number of children in out-of-home (OOH) care during FY2021 with parental alcohol or drug abuse as a condition associated with removal. Please note that figures on this heat map represent prevalence—meaning the total number of children who were served in OOH care at some point in time during that year. The left side shows children aged one and older and the right side are children under one year of age. The total number of children in OOH care was 606,187 with 236,143 of those listing parental AOD as a condition associated with removal. *[Add in reference to state-specific percentages based on region or locality of the training.]*

Prompts for Participants:

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

Additional State-specific Notes:

Total N with ANYAOD (numerator):

	Under Age 1		Age 1 and Older	
AK	75.00%	565	65.40%	2203
AL	60.80%	1108	43.30%	3142
AR	64.90%	855	47.10%	2755
AZ	47.80%	2166	30.90%	5474

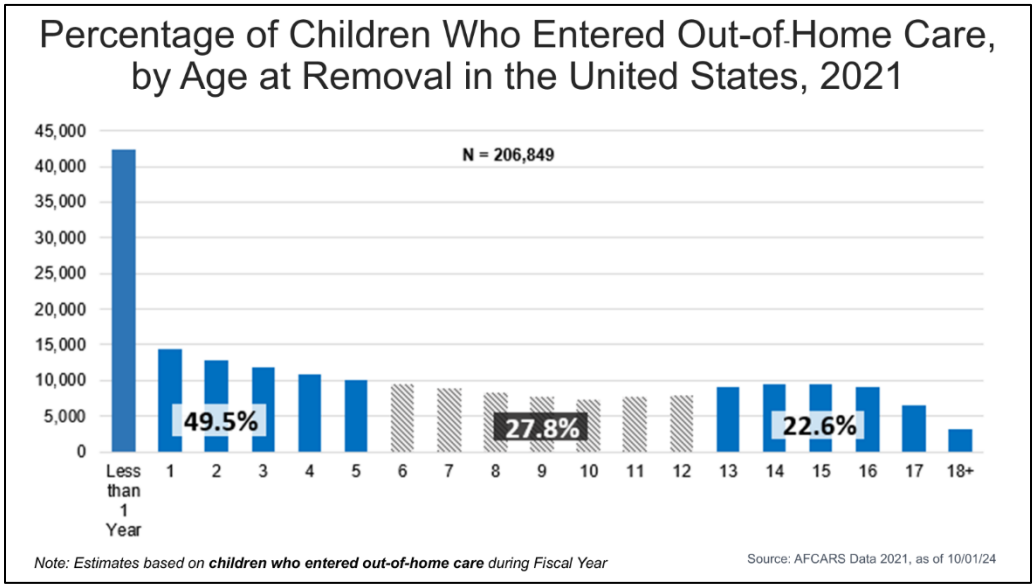
CA	16.70%	2612	10.30%	5767
CO	76.30%	1247	43.20%	2816
CT	54.00%	655	40.10%	1534
DC	27.00%	38	13.30%	89
DE	37.20%	55	15.10%	87
FL	66.00%	5152	47.90%	13593
GA	61.10%	1969	40.50%	5192
HI	48.30%	232	32.20%	623
IA	70.80%	908	57.70%	3540
ID	63.10%	320	37.00%	810
IL	14.00%	907	10.20%	2126
IN	72.50%	3180	59.00%	10324
KS	48.60%	731	33.30%	2923
KY	61.60%	1416	37.60%	4262
LA	2.00%	28	1.80%	81
MA	48.50%	1243	31.20%	3442
MD	51.90%	558	26.20%	1157
ME	50.70%	368	51.70%	1270
MI	53.10%	1657	35.50%	4036
MN	65.10%	1372	48.30%	4815
MO	70.50%	2654	46.70%	7270
MS	58.40%	687	45.20%	1981
MT	48.60%	476	37.20%	1508
NC	55.70%	1597	41.30%	5148
ND	67.10%	312	37.00%	741
NE	52.10%	440	33.50%	1563
NH	26.90%	72	13.20%	188
NJ	56.10%	840	38.60%	1463
NM	56.50%	316	40.60%	1003
NV	20.10%	332	14.60%	801
NY	39.20%	1844	28.30%	4337
OH	47.20%	2256	27.20%	5718
OK	65.30%	2015	48.40%	4073
OR	67.70%	1118	54.70%	3629
PA	53.40%	2284	32.70%	5612
RI	51.60%	320	35.10%	793
SC	30.20%	300	15.10%	862
SD	71.80%	328	55.00%	1194
TN	70.00%	1521	34.90%	4322
TX	76.70%	7564	62.60%	21959

UT	79.40%	540	57.50%	1834
VA	55.30%	591	30.30%	1971
VT	46.90%	123	28.60%	389
WA	66.20%	2324	36.80%	3620
WI	49.10%	1066	35.40%	2983
WV	75.90%	1611	50.70%	4963
WY	70.50%	146	47.80%	667
PR	31.10%	111	15.50%	360
Total US	51.30%	63130	36.00%	173013

Source: (AFCARS Data 2021, as of 10/01/24)

Slide 15

Percentage of Children Who Entered Out-of-Home Care, by Age at Removal in the United States, 2021



Facilitator Script:

Now let's turn our attention to a bar graph representing the percentage of children, youth, and adolescents who entered out-of-home care broken out by age at time of removal. While this data is reflective of the same year as the previous heat maps, it is different in that it speaks to incidence not prevalence—meaning these figures are reflective of only new OOHC entries during FY2021. This explains the variation in the total figure listed, which is down from 606,187 to 206,849 with nearly 50% of all new cases representing the age group of 0-5 followed by nearly 28% for 6-12, and 23% for 13-18+. Note, this data includes states who extend services to non-minor dependents ages 18-21.

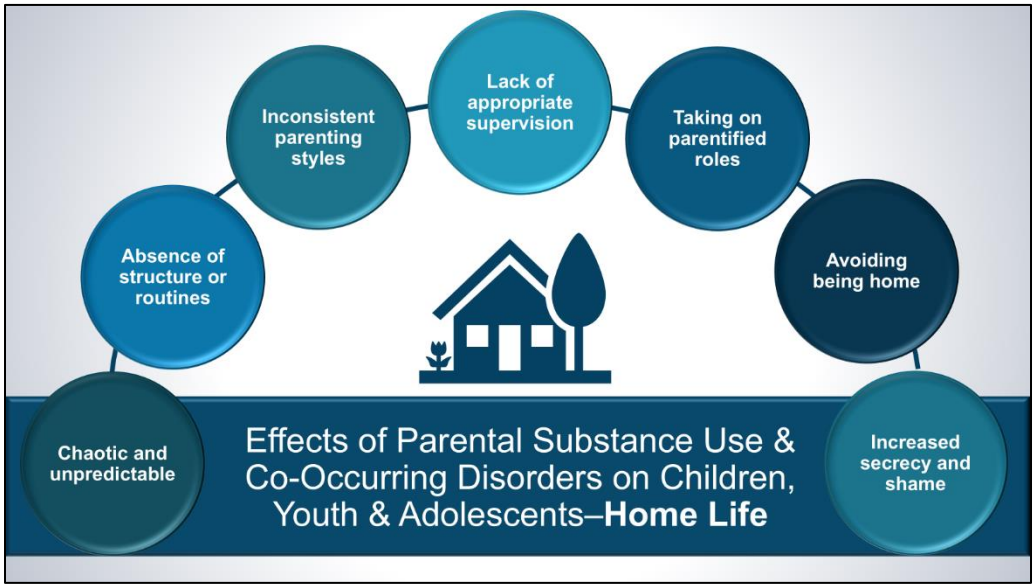
Prompts for Participants:

- **Any initial reactions to these incidence figures?**
- **Do these incidence figures better align with the breakdown of age groups on your caseloads?**
- **Does your state or local jurisdiction currently offer extended services for the 18-21 population? If so, can you share about how these services have been received—are young adults opting in for extended services beyond their 18th birthday? Any success stories to share with your peers? Or key lessons or takeaways?**

Source: (AFCARS Data 2021, as of 10/01/24)

Slide 16

Effects of Parental Substance Use & Co-Occurring Disorders on Children, Youth & Adolescents—Home Life



Facilitator Script:

Now that we have reviewed the data, let's transition to talking about the multifaceted and often complex effects of parental substance use and co-occurring disorders on children, youth, and adolescents.

We know that substance use coupled with co-occurring disorders can exacerbate stressors and further de-stabilize a parent's ability to consistently and safely care for their children. This might look like a home environment that is chaotic and unpredictable in nature, for example, never really knowing what to expect due to not having structure or routines in place or not knowing what type of parent they might be coming home to after school.

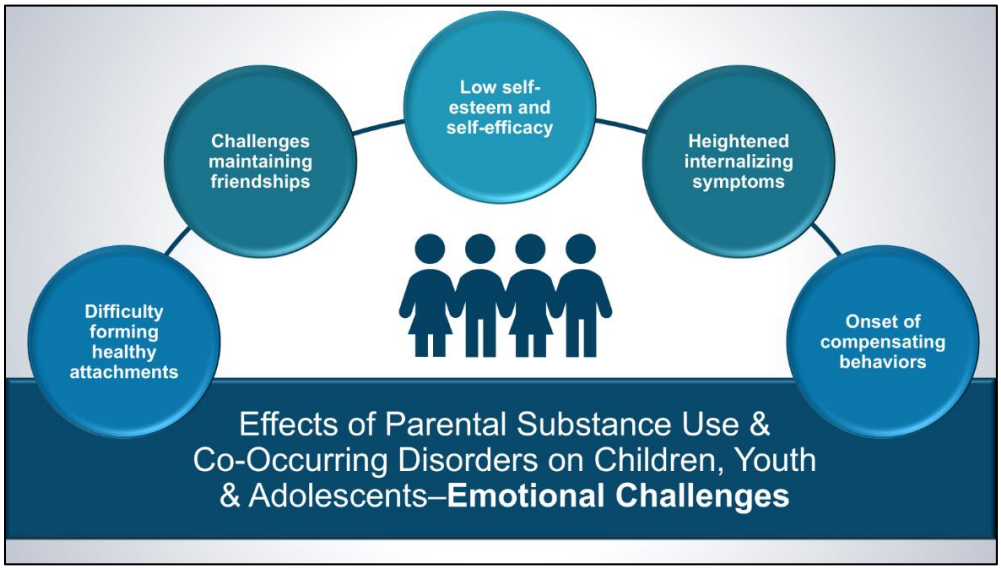
For others, coming home from school may mean coming home to no adult supervision. In families with multiple siblings, this can very much take on parentified roles where the older siblings are responsible for caring for their younger, more dependent siblings. For example, the older siblings may make sure their siblings make it home from school or daycare, help with homework, prep meals, handle baths, etcetera. For those not in parentified roles, this can look like increased avoidance of being home, including hanging out with friends, involvement in extracurricular activities, working, or anything to minimize their exposure to the stressors of their home life.

When you combine the complexities of all these factors with the amount of stigma associated with substance use and mental disorders, it helps to put in perspective the level of secrecy or shame that children, youth, and adolescents carry with them.

Sources: (Child Welfare Information Gateway, 2021; Solis et al., 2012)

Slide 17

Effects of Parental Substance Use & Co-Occurring Disorders on Children, Youth & Adolescents—Emotional Challenges



Facilitator Script:

Let's now review some potential emotional challenges to keep in mind. Difficulties forming healthy attachments can stem from early experiences of abrupt or repeated separation from a parent or caregiver. This could be a result of a substance use disorder, frequent inpatient treatment episodes or hospitalizations, and in some cases, incarceration. For other families, disrupted attachment may be due to active military service or deployment. For children, youth, and adolescents in out-of-home care, all of this may be at play in addition to multiple or frequent disruptions due to changes in their placement. The effects of these type of adverse experiences may have profound short-and long-term implications on well-being.

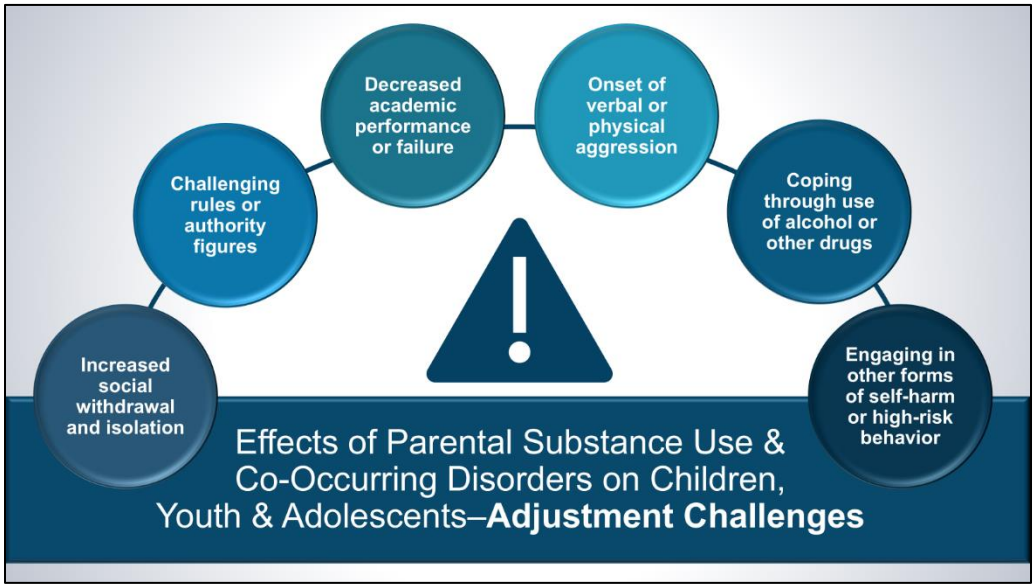
Critical social-emotional experiences such as opening up to others, developing trust, and becoming emotionally invested in peer or other supportive or adult relationships becomes a risk. A risk for future pain, sadness, confusion, anxiety, worry, and uncertainty, among many other emotions. When we factor in economic and housing instability, many may also face challenges maintaining the friendships or bonds they have established in response to frequent moves and changes in school placements, which is another layer of inconsistencies in their life adding to the unpredictability we just spoke on.

When children and adolescents do not have supportive caregivers and protective capacities, they often resort to internal coping mechanisms. Initially, this may serve as self-protection but can evolve into social-emotional challenges like low self-esteem and self-efficacy. Lacking confidence and not believing in their ability to persevere in the face of their adverse circumstances places them at increased risk for anxiety or depression. Understandably, these emotional challenges may trigger an inherent need for a greater sense of control which can look like compensating behaviors or new ways of coping that place children and adolescents at even greater risk for adjustment challenges. Let's spend some more time on this topic.

Sources: (Fraley, 2018; Sankaran et al., 2019; Turner et al., 2019)

Slide 18

Effects of Parental Substance Use & Co-Occurring Disorders on Children, Youth & Adolescents—Adjustment Challenges



Facilitator Script:

Adjustment challenges stem from an inability to cope with life stressors, often a result of not learning or acquiring healthy coping strategies or having the added buffer of caregiver protective capacities. For those we mentioned who turn inward, this can elevate into heightened levels of social withdrawal and isolation and/or mark the onset of externalizing symptoms.

This might start with what we'd observe as resistance to rules or authority figures, such as challenging parents, family members, teachers, and school administrators, which may also coincide with decreased academic performance or failure due to truancy issues.

This could also mark the onset of verbal or physical aggression in the home, school, or community settings. These behavioral-related challenges can be further exacerbated by the inherent risk associated with intergenerational substance abuse, where what may have started as an attempt to cope through experimentation with alcohol or other drugs can quickly evolve into misuse, abuse, or in some cases accidental overdose.

It is also not uncommon for youth and adolescents to begin engaging in other forms of self-harm or other high-risk behaviors such as cutting or burning, unprotected sex, reckless driving, and suicidality, which is an important reminder and indicator about the state of their internal emotional safety and well-being.

Source: (Seay, 2020)

Slide 19

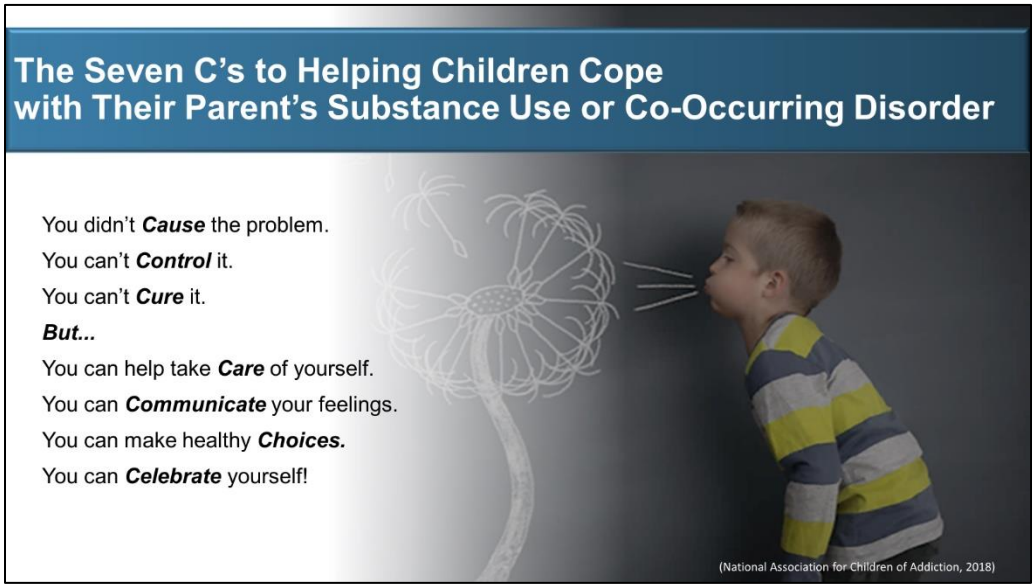
Tools for Talking About Parental Substance Use & Co-Occurring Disorders

Facilitator Script:

So, now that we have learned more about the effects of parental substance use on children, youth, and adolescents let's now focus our discussion on tools we can use to enhance our engagement—more specifically, age-appropriate ways to hold conversations about parental substance use and co-occurring disorders.

Slide 20

The Seven C's to Helping Children Cope with Their Parent's Substance Use or Co-Occurring Disorder



Facilitator Script:

The National Association for Children of Addiction developed the Seven C's as a resource tool for use with children. The first four c's emphasize that children are not responsible for their parent's substance use disorder (or mental disorder) while the remaining three c's highlight the need for and empower the use of healthy coping strategies and skills. The Seven C's include:

> You didn't *Cause* the problem.
>
> You can't *Control* it.
>
> You can't *Cure* it.
>
> But...
>
> You can help take *Care* of yourself.
>
> You can *Communicate* your feelings.
>
> You can make healthy *Choices*.
>
> [And] You can *Celebrate* yourself!

The seven C's have more recently been brought to life using a mini coloring poster that allows service providers to talk through each "C" in a developmentally appropriate manner, while children are invited to color and keep the poster for their personal space or safekeeping.

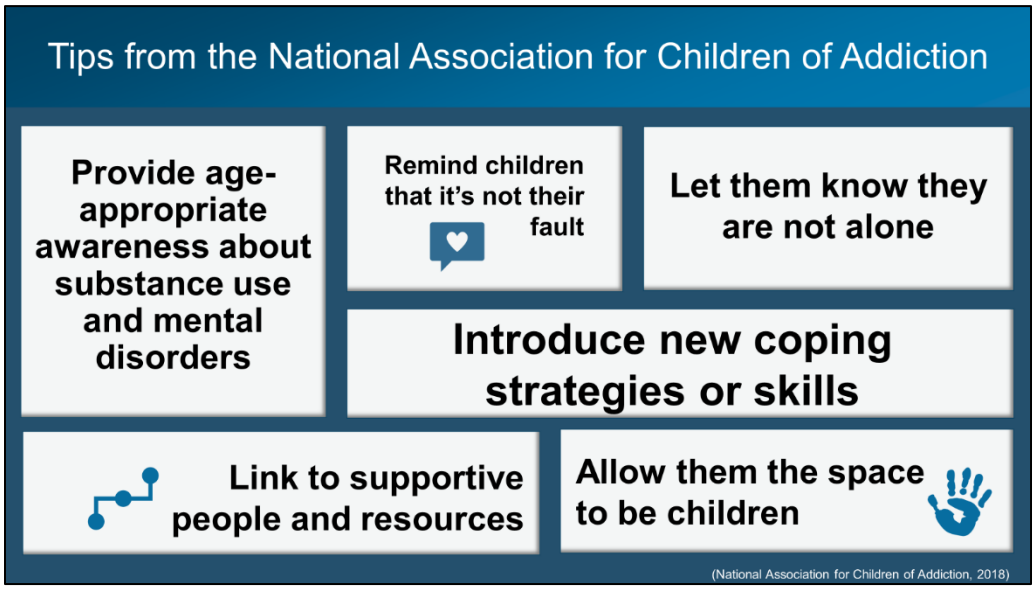
This is one of many resources and tools developed out of a partnership between Jerry Moe, the original developer of the seven C's, and Sesame Workshop, more commonly known as Sesame Street, to promote greater awareness and understanding of parental substance use. These resources are free and have been linked on the resource slide for easy access.

Facilitator Note: An additional resource is available for more information on this topic: Remember the 7 C's!.

Source: (National Association for Children of Addiction, 2018)

Slide 21

Tips from the National Association for Children of Addiction



Facilitator Script:

Discussions about a parent's substance use or co-occurring disorder should always take age and development into consideration. From a communication standpoint, it really is no different than how we approach our daily interactions—adjusting for things such as language level, types of examples, or the degree of details, etc.

Now of course, the context of these discussions is very sensitive in nature, so here we have some talking points from the National Association for Children of Addiction that have been adapted for use in our work with children, youth, and adolescents affected by parental substance use and/or co-occurring disorders.

- Substance use and mental disorders are chronic health conditions—it is important to explain to the child that their parent is not a bad person. They have a disease that requires help from doctors and other professionals.
- It is also important to explain that the use of alcohol or other drugs may cause their parent to lose control. When a parent drinks or uses substances and has a co-occurring mental disorder, they may behave in ways that do not keep the child safe.
- Children, youth, and adolescents need to be reminded that their parent's condition is not their fault, "You are not the reason your parent drinks alcohol, uses drugs, or struggles with their mental or emotional well-being. You did not cause this disease. And no matter how much you hope to, you simply cannot stop or fix your parent's condition."
- It is important for children to realize that they are not alone, "There are a lot of children like you. In fact, there are millions of children whose parents use drugs or alcohol or who are affected by a mental disorder—some attend the same school as you, some may live in your same neighborhood. You are not alone."

- It may not feel like it, but it can really help to talk about what's going on, "Let's think of people you might talk to about your concerns or worries. You don't have to feel scared or ashamed or embarrassed. There are people in your life who will listen and support you. One option might be your teacher, a close friend, or another trusted adult.
- Normalize what it must feel like to be worried and concerned about your parent or taking on more responsibility at home to help care for younger siblings, etc. Let them know you are in their life to help and support them—a safe place for them to talk about their worries, concerns, hopes, dreams, desires, or needs.

Source: (National Association for Children of Addiction, 2018)

Slide 22

The Safety House Tool

Facilitator Script:

In addition to building our comfort level with discussing parental substance use and co-occurring disorders, we also need to advance our practice around engagement. The Safety House is a child protection tool designed to meaningfully involve children in the collaborative planning process. Both a practical and visual tool, the safety house provides a context for child welfare workers to:

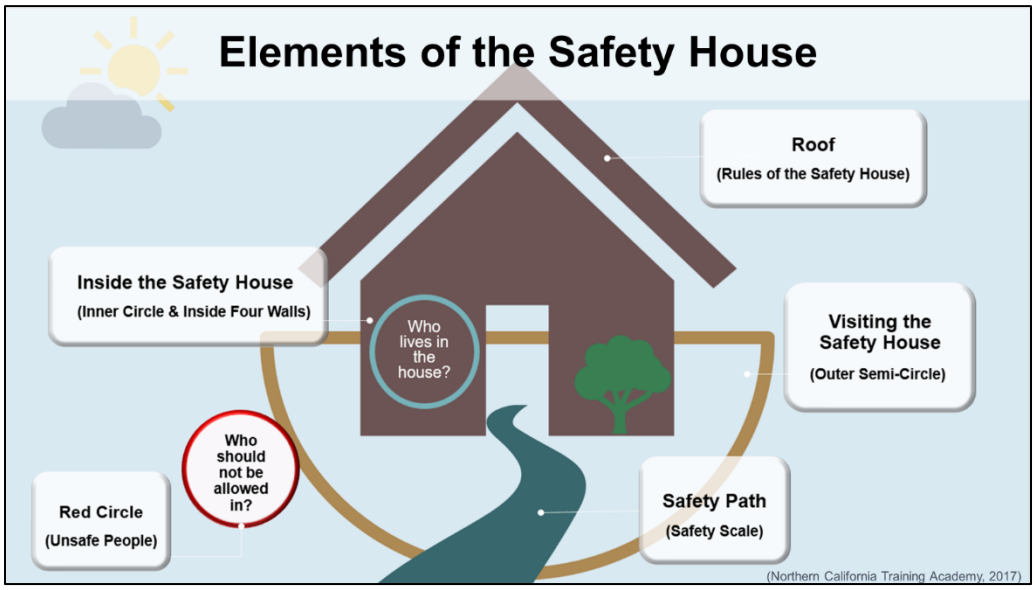
- Talk with children about what is meant by ‘safety’ and ‘risk’ and learn what these terms mean to the child;
- Learn about a child’s significant relationships and natural support networks; and
- Gain a better understanding of what is needed for a child to feel safe and cared for in their home.

Developed by Sonja Parker Consultancy, the Safety House tool is widely used both as a standalone tool or within the larger Safety Organized Practice framework. Let’s now learn more about the different elements of the safety house.

Source: (Parker, 2009)

Slide 23

Elements of the Safety House



Facilitator Script:

There are five main Elements of the Safety House:

- The inner circle and inside four walls represent Inside the Safety House. The child is asked to draw themselves followed by anybody else who they would want living in their safety house, and including details related to their day-to-day activities.
- The outer semi-circle represents Visiting the Safety House. In this section the child is asked to identify people who they would like to visit their safety house to help keep them feeling safe and cared for.
- Next, and totally separate from their safety house, is the Red Circle, which says, "Who should not be allowed in?" and represents unsafe people**.** The child is asked to identify people they do not want in their safety house, either living in the house or just visiting.
- The Roof represents the rules of the safety house. The child is asked to provide their own rules for their safety house, specifically addressing behaviors that will keep everyone feeling safe and cared for.
- And finally, the Safety Path represents a safety scale. The child is asked to rate their current level of safety and well-being with the beginning of the path representing 'very worried' to the end of the path or entry way of their safety path representing 'no worries."

Once done completing the safety house with a child be sure to talk about what happens next with the collaborative planning process; share the safety house with the child and family team to help inform and provide a voice to the child in the collaborative planning process. This tool is very easy to use and very child friendly—what's great is that it is also designed to work across the full child welfare services continuum—family preservation, family maintenance, family reunification. We've

included the link to access the full resource tool including blank templates for your use with families at the end of this slide deck.

Prompt for Participants:

- **Does anyone have any experience using this tool with children? Any key takeaways or lessons to share with your peers?**

Facilitator Note: An additional resource is available for more information on this topic: The Safety House.

Sources: (Parker, 2009)

Slide 24

Strategies to Support Authentic Youth & Adolescent Engagement

Facilitator Script:

Now, what works well with younger children may not land as well with older youth and adolescents. Authentic engagement for this population really centers around building trust and developing connections for meaningful and supportive relationships. Older youth and adolescents are very perceptive beings, and will thrive most when met with non-judgment, empathy, and compassion. Let's review some helpful strategies to support our practice:

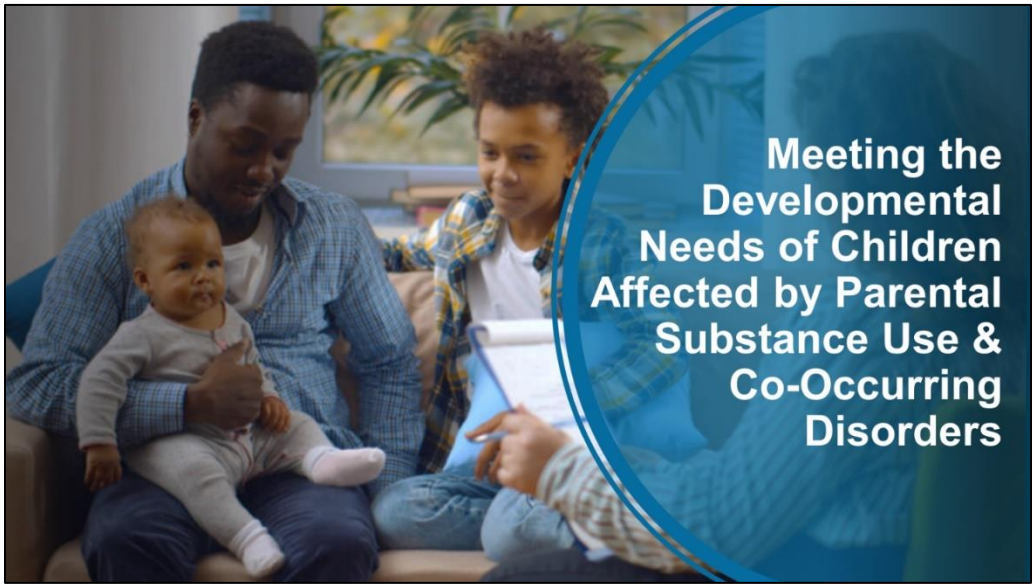
- Engage: Be sure to designate enough time to really foster and develop the relationship. Your contacts with them are an opportunity to engage and hear their story from their own perspective; and learn about what is going on and what is needed to help increase their safety, stability, and well-being;
- Assess: Approach your assessment more like a conversation versus a series of prescribed questions to increase greater levels of transparency and trust;
- Team: Create a teaming environment that encourages and promotes their active participation in shared decision-making and case planning that is strength-based, needs-driven, and responsive; and finally
- Empower: maintain an empowerment-based approach that truly respects and values their wisdom and lived experience, ensuring opportunities for voice and choice throughout the child welfare intervention period.

Facilitator Note: An additional resource is available for more information on this topic: Working with Adolescents: Practice Tips and Resource Guide.

Source: (Children's Bureau, 2022)

Slide 25

Meeting the Developmental Needs of Children Affected by Parental Substance Use & Co-Occurring Disorders

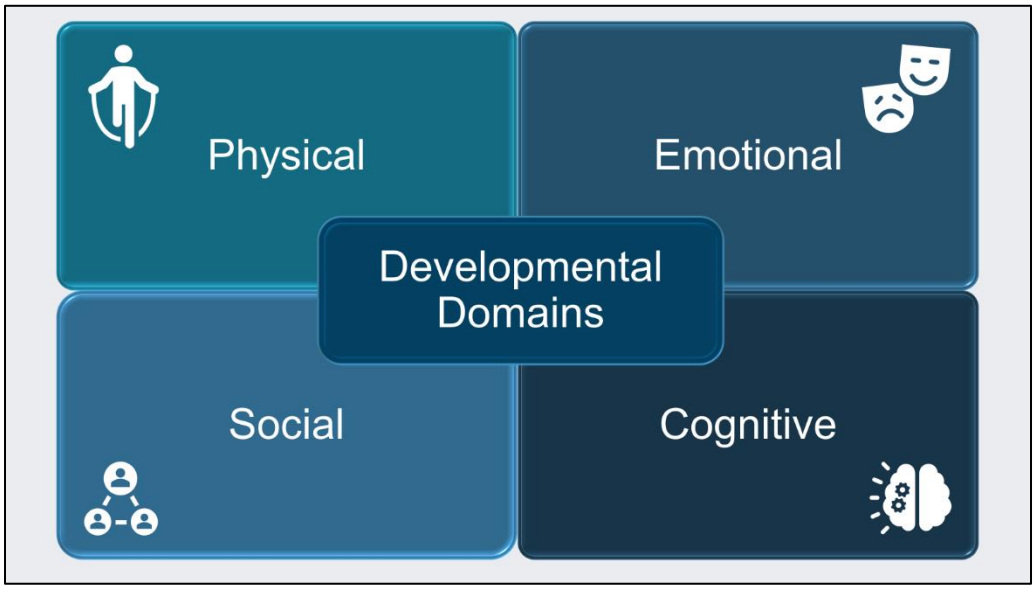


Facilitator Script:

Effective engagement of children, youth, and adolescents will also support our understanding of their developmental needs allowing for improved screening and identification followed by referral to all indicated services. Let's start by reviewing some important considerations about developmental domains.

Slide 26

Developmental Domains



Facilitator Script:

As child welfare workers we'll need to have a general understanding of developmental domains and milestones to support the assessment and identification (through referral and linkage) to all indicated services for children, youth, and adolescents.

As a reminder to the foundational onboarding or in-service training you received, the developmental process is a dynamic and ongoing experience that consists of continuous growth and change.

We know that it is directional in nature—meaning it often begins with mastery of small or simple skills before moving onto those that are larger or more complex. A perfect example of this I always like to use in training is the example of a baby needing to master skills like crawling, sitting, or standing before developing the skill of walking on their own.

We also know that development occurs in stages—let's take for example a toddler and the concept of play. Play for 1–3-year old's is more characteristic of parallel play (or playing alongside but not directly with other children) as compared to play for 4–6-year old's who have begun to develop and master more interactive patterns of play through concepts such as sharing, taking turns, and other social norms.

Lastly, we also know that development is cumulative in nature. So, when a child doesn't fully develop or master a skill at an earlier stage of development that means mastery at a later stage will become inherently more difficult.

This last point speaks to the significance of screening and early identification of any potential developmental delays allowing for timely intervention and remediation for children, youth, and adolescent's optimal health and well-being. Let's recap the four prominent domains to guide your casework practice. These include:

Physical Domain:

The physical domain includes all aspects of a child, youth, or adolescent's growth and development. This is often understood within the categories of gross motor and fine motor skills. The first referring to examples of the baby who learns to crawl, sit, stand, walk, and with time skip, hop, run, and jump. Fine motor skills center around the use of smaller muscles in the body to perform skills such as grasping or holding objects, holding a pencil, tying shoelaces, or manipulating buttons or zippers. This domain of course also includes reference to a child's developing body with things such as height, weight, hearing, vision, etc.

Social Domain:

The social domain encompasses a child, youth, or adolescent's ability to develop and form interpersonal relationships. The earliest and most formidable example of this domain centers around early bonding and attachment—particularly with parents or caregivers but also includes other meaningful social interactions with other adults and peers. This domain represents the stage of development where children begin to learn and acquire critical social skills—like awareness of norms, rules, cues, etc. that help shape and navigate social interactions in the home, school, and community settings.

Emotional Domain:

The emotional domain centers around a child, youth, or adolescent's increased capacity and awareness of their own internal feeling state and that of others; increased mastery of concepts and skills such as identifying, expressing, and coping with complex emotions or stressors. This domain also includes reference to a child, youth, or adolescent's emerging sense of self through concepts such as personal identity, self-esteem, and self-efficacy.

Cognitive Domain:

The cognitive domain includes skills related to thinking, reasoning, problem solving, attention, memory, and language development. The latter is one of the most significant milestones for all children as they begin to master both receptive and expressive language. For instance, infant language development begins with producing sounds of partial words often referred to as babbling. By year one, they are capable of understanding a handful of spoken words or phrases which evolves to nearly 300 words by the time they are three.

Source: (Centers for Disease Control and Prevention, 2023)

Slide 27

Developmental Screening Tools

Facilitator Script:

Our contacts with families are often the first opportunity to formally screen and discuss age-appropriate developmental domains and milestones, helping families better understand any areas of potential delays, and providing referral and linkage where indicated. Use of validated and reliable screening tools are the standard practice across child welfare agencies, which include brief and easy to administer questionnaires designed for early identification. Some commonly used developmental screening tools include:

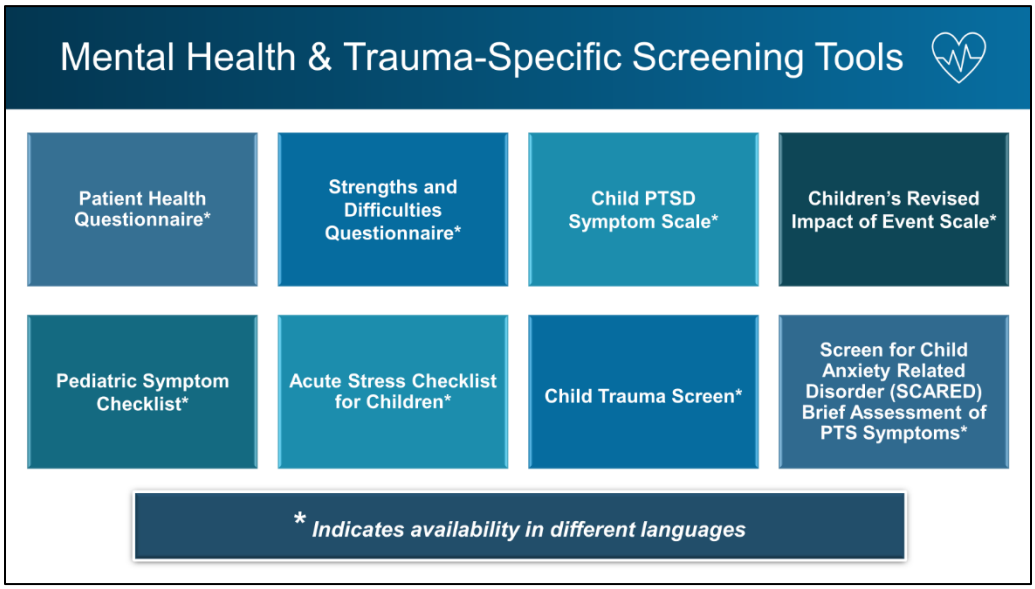
- Ages and Stages Questionnaire, 3rd Edition (Available in English, Spanish, Arabic, Chinese, French, and Vietnamese)
- Ages and Stages Questionnaire: Social-Emotional, 2nd Edition (Available in English, Spanish, Arabic, and French)
- Brigance Early Childhood Screens III (Available in English and Spanish)
- Developmental Assessment of Young Children, 2nd Edition
- Early Screening Inventory- Revised (Available in English and Spanish)
- Learning Accomplishment Profile—Diagnostic Tools (Available in English and Spanish)
- Parents' Evaluation of Developmental Status (Available in more than 50 languages; PEDS: Developmental Milestones also available in 12 different languages)

Prompts for Participants:

- **Which developmental screening tools does your child welfare agency use?**
- **Are there any specific policies and procedures guiding your practice of developmental screening?**

Slide 28

Mental Health & Trauma-Specific Screening Tools



Facilitator Script:

In addition to policies and procedures for developmental screening, child welfare agencies have also moved toward implementing universal screening for children, youth, and adolescents' mental health and trauma-related needs. This practice change was in large part shaped by the Child and Family Services Improvement and Innovation Act of 2011—requiring child welfare agencies to identify and respond to the developmental and mental health needs of children, including specifically addressing their trauma-related needs. Similar to the previous slide, there are numerous options for validated and reliable screening tools specific to both mental health and trauma. Here we have compiled a brief list of some of the most commonly used tools across child welfare jurisdictions. These include broadband mental health screening tools such as:

- The Patient Health Questionnaire (available in over 30 languages),
- The Pediatric Symptom Checklist (also available in over 30 languages),
- And the Strengths and Difficulties Questionnaire (also available in over 30 languages).

As well as more trauma-specific screening tools, including:

- Acute Stress Checklist for Children (available in English and Spanish)
- Child PTSD Symptom Scale (available in English, Spanish, Hebrew, Portuguese, Slovenian, and Swedish)
- Child Trauma Screen (available in English, Spanish, Portuguese, and Chinese)
- Children's Revised Impact of Event Scale (available in over 25 languages)

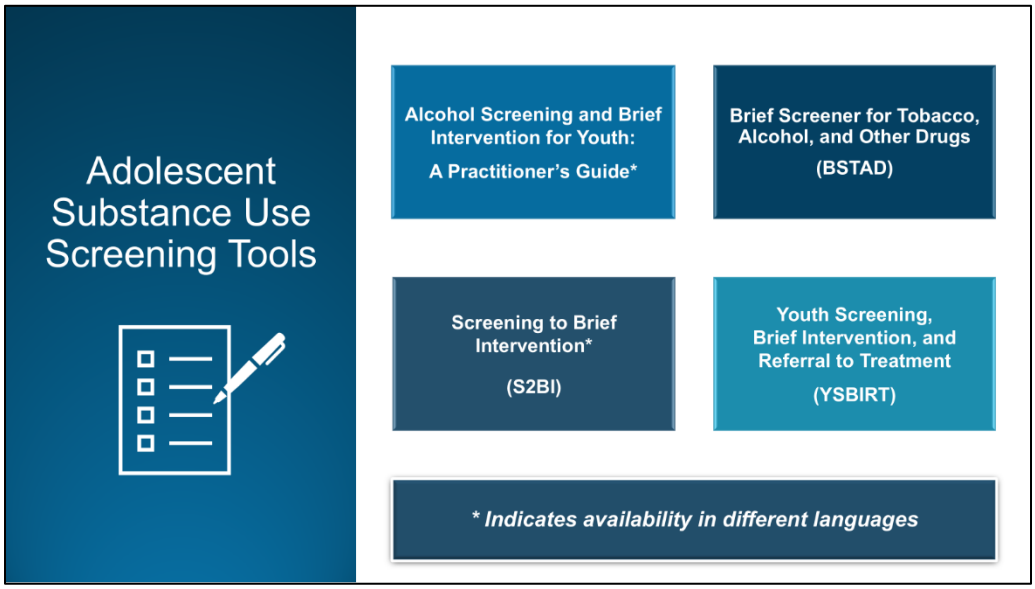
- Screen for Child Anxiety Related Disorder (SCARED) Brief Assessment of PTS Symptoms (available in English, Spanish, Arabic, Chinese, French, German, Italian, Portuguese, and Thai)

Prompts for Participants:

- **Does your child welfare agency use any of the listed screening tools? If not, what alternative tools are you using?**
- **How has the practice of universal mental health and trauma-related screening helped improve early interventions efforts in your agency?**
- **As referring caseworkers, are you required to collect any data on the child's mental health or trauma-related service utilization?**

Slide 29

Adolescent Substance Use Screening Tools



Facilitator Script:

An additional area of consideration for screening involves adolescents at-risk for developing a substance use disorder.

The adolescent period alone poses unique challenges based on the tremendous amount of growth and change mixed with all the social, emotional, and cognitive complexities of this particular stage of development—balancing increased independence with increased responsibilities; navigating peer and societal pressures related to alcohol, drugs and other high-risk behaviors; managing a desire to explore or experiment while also having the ability to exercise healthy boundaries and impulse control.

Let's now layer in the added complexities of having a stressful home environment—economic and housing instability; food insecurities; lack of parental supervision or in-home structure, rules, or expectations; history of maltreatment or family violence; parental and/or intergenerational patterns of substance use.

These are all common realities of youth and adolescents served by the child welfare system and all represent risk factors for adolescent substance use and/or the development of substance use disorders. The American Academy of Pediatrics recommends universal screening for all youth and adolescents ages 12-17. While less exhaustive of a list, here we have four options for validated and reliable screening tools. These include:

- Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (available in English and Spanish)
- Screening to Brief Intervention (S2BI) (also available in English and Spanish)
- Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)

- Youth Screening, Brief Intervention, and Referral to Treatment (YSBIRT)

Results from adolescent substance use screening tools will inform the need for a referral for a comprehensive assessment with a licensed or qualified professional to determine appropriate levels of intervention, such as prevention services for adolescents who remain at-risk, and substance use disorder treatment services where indicated.

Prompts for Participants:

- **Does your child welfare agency have specific policies and procedures for adolescent substance use screening?**
- **Does this include universal screening for youth 12 and older? Or what is your current practice?**
- **Does your community have providers who specialize in adolescent substance use disorder assessments including options for age-appropriate prevention and treatment services?**

Slide 30

An Important Reminder About This Need…

Facilitator Script:

Comprehensive screening and assessments for children, youth, and adolescents is becoming increasingly clear with our knowledge of adverse childhood experiences. Let's quickly review some poignant data points…

Slide 31

Youth Mental Health Crisis

Facilitator Script:

Our country is facing an unprecedented youth mental health crisis. These figures alone speak to the need for improved policies and practices. Pulled from the 2022 National Survey on Drug Use and Health Data, an estimated 4.8 million adolescents aged 12-17 experienced a major depressive episode in the past year. An additional 3.4 million adolescents also experienced serious thoughts of suicide with 1 in 15 making plans and nearly 1 in 25 making attempts. Our systems must do better on behalf of children, youth, and adolescents.

Facilitator Note: An additional resource is available for more information on this topic: Meeting the Moment: How Child Welfare and Substance Use Disorder Treatment Professionals Can Address the Needs of Adolescents at Risk of Suicide and Mental Health Concerns Webinar.

Source: (U.S. Department of Health and Human Services, 2023)

Slide 32

Dr. Vivek H. Murthy Quote

Facilitator Script:

It's important that we never lose sight of the fact that substance use and mental health challenges continue to remain the leading cause of disabilities and poorer life outcomes. As child welfare workers we play a critical role in ensuring referral, access, and utilization for the full spectrum of needs related to the optimal health and well-being of our nation's children, youth, and adolescents.

Quoting Dr. Vivek H. Murthy, "If we seize this moment, step up for our children and their families in their moment of need, and lead with […] kindness and respect, we can lay the foundation for a healthier, more resilient, and more fulfilled nation."

Sources: (Centers for Disease Control and Prevention, 2024b; Office of the Surgeon General, 2021)

Slide 33

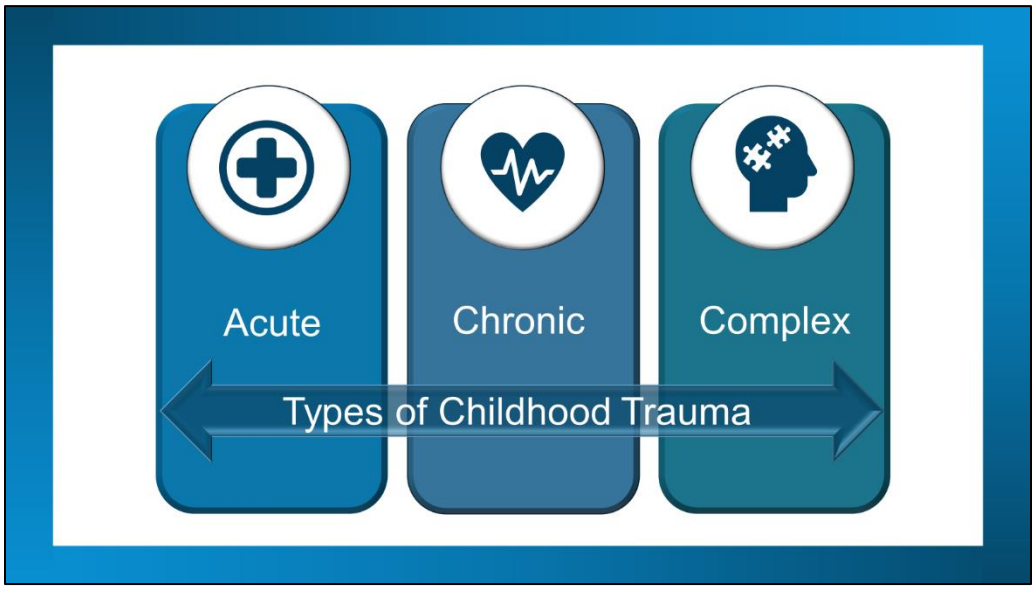
Understanding the Long-Term Effects of Adverse Childhood Experiences

Facilitator Script:

Now let's spend some time understanding the long-term effects of adverse childhood experiences…

Slide 34

Types of Childhood Trauma



Facilitator Script:

Understanding the effects of adverse childhood experience starts with an understanding of the various types of childhood traumas. While models will vary, these generally fall into three main categories:

Acute Trauma refers to a single traumatic event that lasts for a limited period—often with a defined beginning, middle, and end. Some examples of acute traumas may be an accident, causing serious injury, witnessing an act of community violence, or surviving a natural disaster such as an earthquake, tornado, or fire. Acute trauma can have varying effects on children—some with no observable stress response, while others may develop symptoms that persist for weeks or months requiring a level of therapeutic intervention or support to reduce the progression of the anxiety-based symptoms.

Chronic Trauma**,** rather, refers to multiple traumatic events that occur over a long period of time and can be related or unrelated in nature. This type of trauma can include any combination of the acute traumas mentioned but often also often involve a form of interpersonal trauma such as physical, emotional, or sexual abuse, neglect, exposure to various forms of domestic violence, commercial sexual exploitation, effects of housing instability or homelessness, parental substance use and/or parental mental health, a contentious parental divorce, etc.

Whereas Complex Trauma refers to the cumulative effects of multiple and varied traumatic experiences that are often invasive and highly interpersonal in nature—meaning caused by persons who children depend on for their safety and well-being (often parents or other caregivers)—causing long-lasting effects to both physical health and emotional well-being. Concrete examples of complex trauma will overlap with chronic trauma but with differentiation in terms of frequency, chronicity, and severity.

Source: (National Child Traumatic Stress Network, 2018)

Slide 35

The Relationship Between Childhood Trauma & ACEs

Facilitator Script:

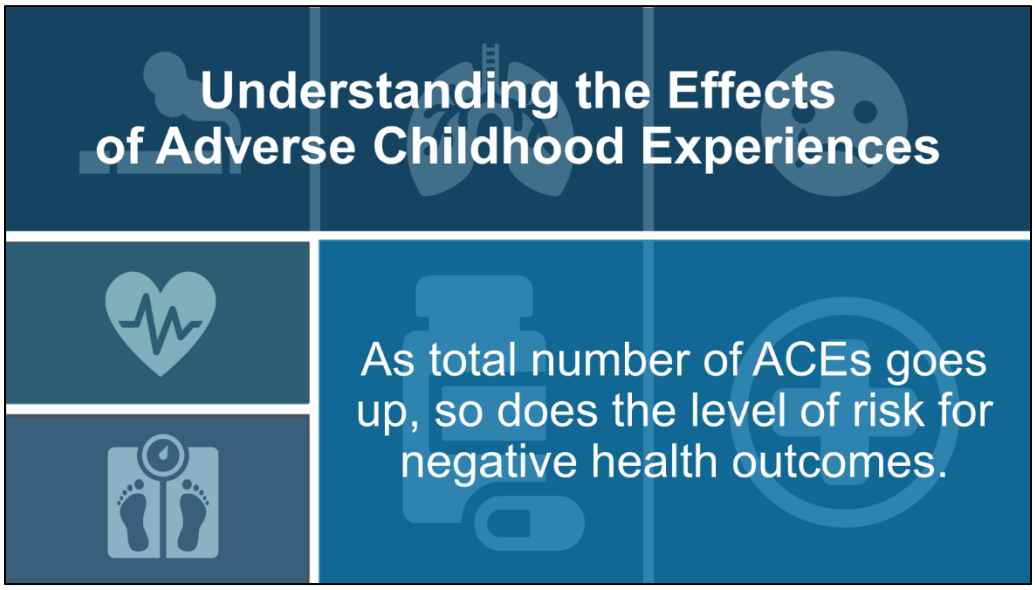
The relationship between childhood trauma and ACEs begins with an understanding of toxic stress. When faced with any stressful or traumatic event, our bodies signal and activate our automatic stress response, a literal internal sounding of the alarms.

Normally, this level of stress response is a good thing as it helps alert us to potential danger, thereby allowing for acts of protection or safety through healthy coping strategies and supports. However, overexposure to trauma can send our body into over-drive causing excessive activation of our body's stress response system. This overactivation in the absence of protective factors such as supportive adults, healthy coping strategies, access to therapeutic interventions or supports, is what is called toxic stress and its impact on our bodies can be debilitating.

Source: (Center on the Developing Child, 2020)

Slide 36

Understanding the Effects of Adverse Childhood Experiences



Facilitator Script:

Who recalls the introductory video on adverse childhood experience from module one of this toolkit? Does someone want to take a try at defining what ACEs are along with some examples of the different types? *[Encourage a volunteer from the group of learners before jumping in]*

That was great, thank you for volunteering.

So yes, ACEs are traumatic experiences during childhood from birth to 18. These experiences include the examples we just covered, as well as larger systemic contributors, which are tied to conditions in the environments where people are born, live, learn, work or play. An individual's exposure to adverse experiences increases their risk of developing toxic stress and ACE-associated health conditions, such as substance use disorders.

While all vast in their differences, what these traumatic experiences have in common is their ability to disrupt a child's sense of safety and stability. High levels of toxic stress can have major implications for physical, mental, emotional, and behavioral health. As the total number of ACEs goes up, so does the level of risk for long-term negative health outcomes. These include:

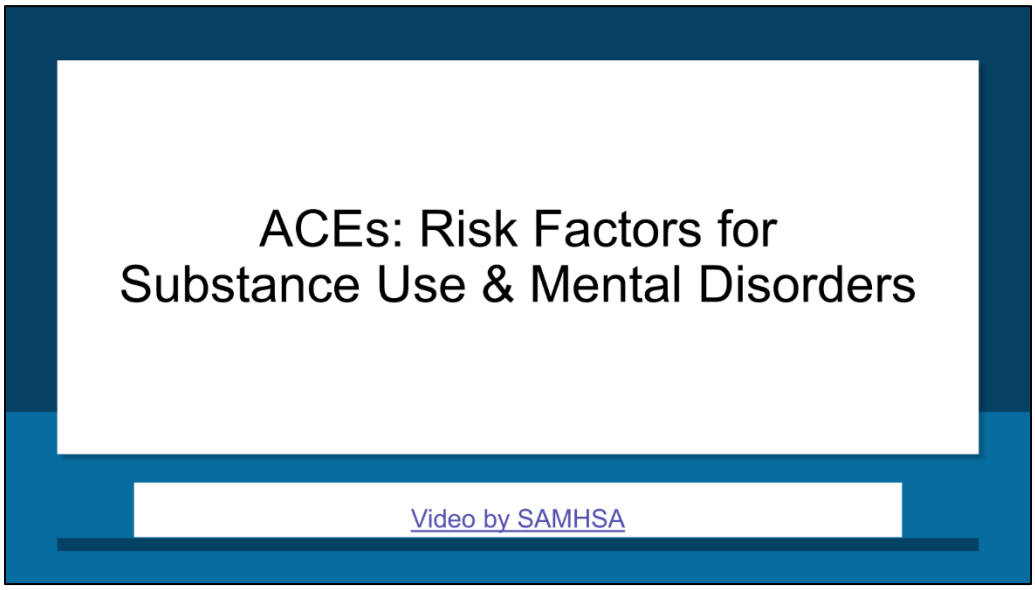
- Chronic health conditions such as heart disease, asthma, chronic obstructive pulmonary disease (COPD), cancer, diabetes, and obesity
- Other health related risk behaviors include physical inactivity, smoking, heavy drinking, substance misuse or abuse, and high-risk sexual behavior
- And a higher propensity for mental disorders like depression and suicidality

We also learned from the ACEs study that these negative health outcomes often co-occur and can lead to early mortality. Let's watch a brief video explaining the powerful relationship between childhood adversity and substance abuse and mental disorders.

Source: (Centers for Disease Control and Prevention, 2021)

Slide 37

ACEs: Risk Factors for Substance Use & Mental Disorders



Facilitator Script:

Facilitator Notes: Play the 3-minute video produced by SAMHSA then bring the learners back together for a large group discussion…

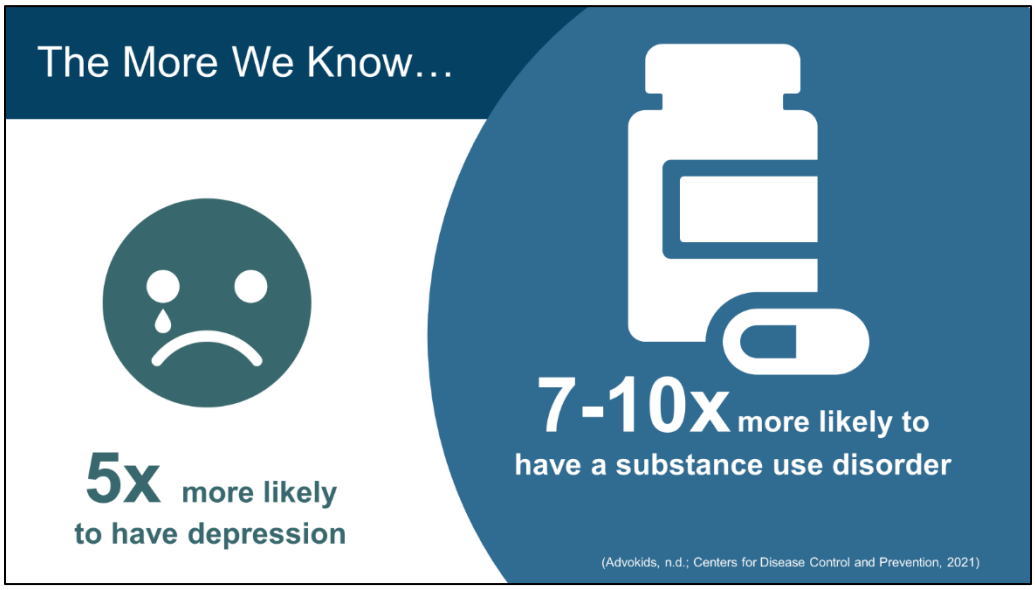
Prompts for Participants:

- **Any initial thoughts or reactions? Anything stand out to you?**
- **What about the part about where he says ACEs are the leading cause of substance use and mental disorders—was this new information you were hearing?**
- **Do most folks in child welfare agree with this view? Or what needs to happen to help increase awareness in our field about this powerful relationship?**

Video Source: (Substance Abuse and Mental Health Services Administration)

Slide 38

The More We Know…



Facilitator Script:

As a refresher, the ACE Study was a longitudinal examination of the effect of adverse childhood experiences. Results from this study found that for adults with four or more ACEs without formal intervention were 5x more likely to experience depression at some point in their lifetime.

This study also found that individuals who reported experiencing 5 or more ACEs, again without formal intervention, were 7 to 10 times more likely to have problems with substance misuse or abuse during their lifetime.

An important takeaway from this study that the video also pointed out is that despite the nature of their prevalence, ACEs are largely preventable with appropriate and timely intervention.

Facilitator Note: Additional resources are available for more information on this topic: Navigating Risk: Five Facts About Substance Use Prevention Video and Adverse Childhood Experiences (ACEs) Prevention Resource for Action: A Compilation of the Best Available Evidence.

Sources: (Advokids, n.d.; Centers for Disease Control and Prevention, 2021)

Slide 39

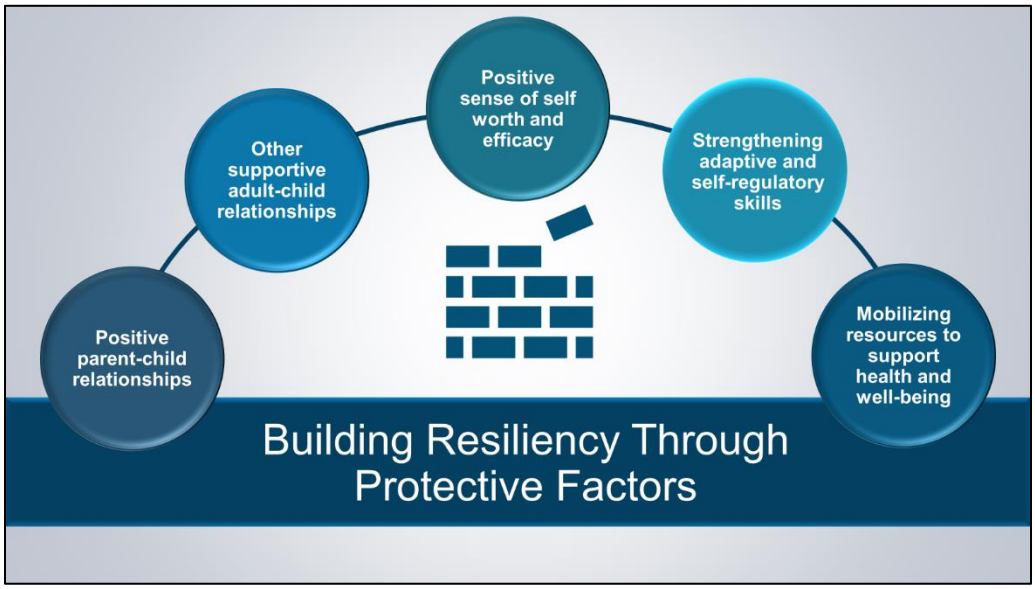
Preventing & Reducing Toxic Stress

Facilitator Script:

So, with what we now know about the relationship between adverse childhood experiences and trauma or toxic stress, including the significant implications for long-term health and well-being, what can we do as child welfare workers to intervene and improve the trajectories for children, youth, and adolescents?

Slide 40

Building Resiliency Through Protective Factors



Facilitator Script:

One strategy for preventing or reducing toxic stress is to focus on building resiliency through increased protective factors. To do this, we must understand the role resiliency plays in relation to toxic stress. Resilience is an individual's ability to demonstrate early and effective adaptation in response to a traumatic event.

For some, resilience is inherent while for others it is not. For example, children can witness the same act of community violence but have two completely different responses; siblings can grow up in the same household with a parent with a severe substance use or mental disorder and have different experiences or needs. Understanding why some children fare well in the face of adversity helps inform how we can then promote resiliency for all children.

The research tells us:

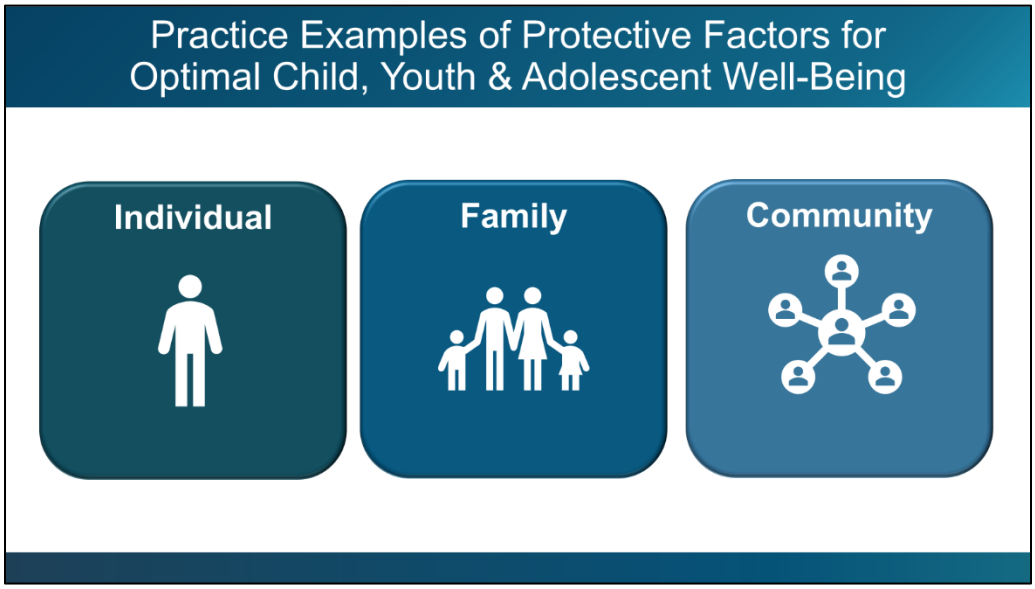
An emphasis on developing or strengthening positive parent-child relationships is the single most critical factor in promoting resilience along with other supportive adult-child relationships, including family, family friends, teachers, coaches, or religious leaders, etc., as these relationships form the foundation for safety and protection in turn supporting a child's adaptive coping.

At an individual level, working to develop children's positive sense of self-worth and efficacy, a belief that no matter their circumstances they are capable of great things, was also found to enhance resiliency. Efforts to strengthen or acquire healthy coping tools including techniques to manage stress levels along with mobilizing other community resources to support a child's full health and well-being are also integral to this process.

Sources: (Center on the Developing Child at Harvard University, 2020; The National Child Traumatic Stress Network, n.d.)

Slide 41

Practice Examples of Protective Factors for Optimal Child, Youth & Adolescent Well-Being



Facilitator Script:

Let's now highlight practice examples of protective factors supporting optimal child, youth, and adolescent well-being.

At the individual level, examples of protective factors include developing good coping and problem-solving skills for the parent, and the child, youth, or adolescent such as strategies for identifying and expressing feelings and emotions, and adaptive ways for managing stress and everyday challenges. Supporting their academic achievement and intellectual development including engagement or connections in two or more of the following areas—school, peers, and extracurriculars like sports, clubs, employment, or involvement in religious or spiritual groups—are also key to optimal health and well-being.

At the family level, examples of protective factors include the presence of supportive relationships with family members including chosen family; having clear expectations with daily structure and predictability such as consistent rules, limits, supervision, and monitoring. Strengthening economic supports for families such as ensuring that basic needs are being met or providing access to resources to support greater economic stability also play a significant role in preventing or reducing toxic stress leading to greater opportunities for optimal health and well-being.

At the community level, examples of protective factors include the presence of mentors or supportive adults who are actively promoting the development of the child, youth, or adolescent's special skills or interests; setting a foundation for a strong network of supports and a path toward their full potential; and finally of great importance, is the commitment to ensuring the physical and psychological safety of all children, youth, and adolescents by promoting social norms that protect against all forms of adverse childhood experiences and intervening where needed with services

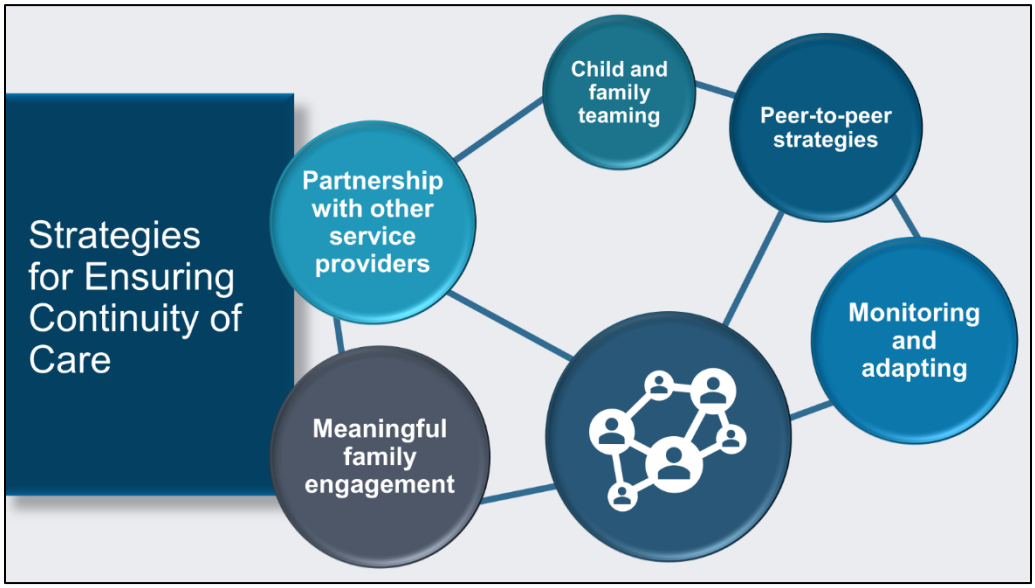
and supports to improve the trajectory for all children, youth, adolescents, parents, and family members.

Facilitator Note: An additional resource is available for more information on this topic: Adverse Childhood Experiences (ACEs) Prevention Resource for Action: A Compilation of the Best Available Evidence.

Source: (Centers for Disease Control and Prevention, 2019; Centers for Disease Control and Prevention, 2024a)

Slide 42

Strategies for Ensuring Continuity of Care



Facilitator Script:

As child welfare workers, our part in preventing and reducing toxic stress and building children, youth, and adolescent's protective capacities relies heavily on the level of continuity of care received during the child welfare intervention period. This is especially important due to the nature of their complex needs and cross-system service provision. Like previous discussions on engagement and retention, these practice strategies can ensure that a child and family's cross-system experience is as seamless and effective as possible.

Meaningful Family Engagement: A child's needs are better met when people whom the child considers "family" participate in planning, delivering, and evaluating services. But parents and other caregivers are not always well-prepared to participate meaningfully in system processes. Sometimes our role as child welfare workers is to focus our efforts on educating and encouraging parents to be involved in their child's cross-system service provision. Things like helping parents understand:

- What is expected of them?
- What are their child's needs?
- Who will participate in the meeting?
- How will questions be asked?
- What questions will be asked?
- What decisions might the parents have to make during the meeting?

Partnership with Other Service Providers: No single agency can do this work alone. Optimal family outcomes rely on systems or agencies working together to meet the needs of children and families affected by substance use and co-occurring disorders. This work will require collaboration among the entire child and family team bringing together various levels of knowledge, skills, and resources. Examples include:

- Networking between professionals to exchange information about resources, systems, requirements, and clients
- Coordination between professionals to schedule activities and requirements with each other's needs in mind
- Cooperation between professionals to work toward common outcomes for specific clients by developing a common or joint plan
- Collaborative strategies between workers to carry out a commonly defined and supported set of agency or system outcomes

Child and Family Teaming: Child and family teaming provides an opportunity to bring everyone together, such as family, natural supports, cross-system providers, etc. to identify goals of service provision, discuss any concerns or worries, assess progress, and share in decision-making.

Peer-to-Peer Strategies: Current best practices recognize that peers can accomplish things a professional, paraprofessional, or family member cannot. Someone who is "similar" or who can "speak the same language," who can provide support to the family as they navigate cross-system involvement on their journey to long-term recovery and family stability.

Monitoring and Adapting: Monitoring and adapting serves as a critical feedback loop during cross-system service provision. It allows for discussion about what is working well and creating moments to celebrate children and families' successes while also equally talking about what isn't working well—thereby allowing for modifications or enhancements to service provision as needed.

Slide 43

Jessica's Story: Connections Changed Her Life

Facilitator Script:

Let's now pause and take a few minutes to watch Jessica's story about how connections changed her life, a recovery video made possible by Doorway Recovery and the New Hampshire Department of Health and Human Services.

Prompts for Participants to Close Out Today's Training Discussion:

- **What part of Jessica's story resonated with you the most?**
- **How did Jessica's stepfather's substance use affect her home environment, including any emotional and adjustment challenges?**
- **With the limited information we have, what type of services, supports, or resources would have benefited Jessica during her adolescent period?**

Video Source: (Doorway Recovery Videos and the New Hampshire Department of Health and Human Services)

Slide 44

Contact the NCSACW TTA Program

Facilitator Script:

Alright, this wraps up the instructional content for module six. 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 parental substance use and co-occurring disorders. Have a nice day, everyone!

References

Advokids. (n.d.). *Adverse childhood experience study (ACES)*. https://advokids.org/adverse-childhood-experience-study-aces/

Aktar, E., Qu, J., Lawrence, P. J., Tollenaar, M. S., Elzinga, B. M., & Bögels, S. M. (2019). Fetal and infant outcomes in the offspring of parents with perinatal mental disorders: Earliest influences. *Frontiers in Psychiatry, 10*, 391. https://doi.org/10.3389/fpsyt.2019.00391

American College of Obstetricians and Gynecologists. (2017). Committee opinion No. 711: Opioid use and opioid use disorder in pregnancy. *Obstetrics & Gynecology, 130*(2), e81–e94. https://doi.org/10.1097/AOG.0000000000002235

Baldacchino, A., Arbuckle, K., Petrie, D. J., & McCowan, C. (2014). Neurobehavioral consequences of chronic intrauterine opioid exposure in infants and preschool children: A systematic review and meta-analysis. *BMC Psychiatry, 14*, 104. https://doi.org/10.1186/1471-244X-14-104

Bandstra, E. S., Morrow, C. E., Mansoor, E., & Accornero, V. H. (2010). Prenatal drug exposure: Infant and toddler outcomes. *Journal of Addictive Diseases, 29*(2), 245–258. https://doi.org/10.1080/10550881003684871

Behnke, M., Smith, V. C., Committee on Substance Abuse, & Committee on Fetus and Newborn. (2013). Prenatal substance abuse: Short- and long-term effects on the exposed fetus. *Pediatrics, 131*(3), e1009–e1024. https://doi.org/10.1542/peds.2012-3931

Center for Children and Family Futures. (2024). *Analyses of the 2021 Adoption and Foster Care Analysis and Reporting System from the National Data Archive on Child Abuse and Neglect* (file number 274) [Data set]. NDACAN. https://www.ndacan.acf.hhs.gov/

Centers for Disease Control and Prevention. (2019*). Adverse childhood experiences (ACEs) prevention resource for action: A compilation of the best available evidence.* National Center for Injury Prevention and Control. https://www.cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf

Center on the Developing Child. (2020). *ACEs and toxic stress: Frequently asked questions.* Harvard University. https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/

Centers for Disease Control and Prevention. (2021). *We can prevent childhood adversity.* National Center for Injury Prevention and Control, Division of Violence Prevention. https://vetoviolence.cdc.gov/apps/aces-infographic/

Centers for Disease Control and Prevention. (2023). *Milestone moments checklist.* The National Center on Birth Defects and Developmental Disabilities, U.S. Department of Health and Human Services. https://www.cdc.gov/ncbddd/actearly/pdf/LTSAE-Checklist_COMPLIANT_30MCorrection_508.pdf

Centers for Disease Control and Prevention. (2024a). *Child abuse and neglect prevention: Risk and protective factors*. https://www.cdc.gov/child-abuse-neglect/risk-factors/?CDC_AAref_Val=https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html

Centers for Disease Control and Prevention. (2024b). *Youth risk behavior survey data summary & trends report: 2013-2023.* https://www.cdc.gov/yrbs/dstr/index.html

Child Welfare Information Gateway. (2021). *Parental substance use: A primer for child welfare professionals*. Administration for Children and Families, U.S Department of Health and Human Services, Children's Bureau. https://www.childwelfare.gov/pubPDFs/parentalsubuse.pdf

Children's Bureau. (2022). *Quality improvement center on engaging youth in finding permanency - QIC-EY.* Administration for Children and Families, U.S Department of Health and Human Services. https://qic-ey.org/wp-content/uploads/2022/02/QIC-EY-2022-Summary-final.pdf

Fill, M-M. A., Miller, A. M., Wilkinson, R. H., Warren, M. D., Dunn, W. S., & Jones, T. F. (2018). Educational disabilities among children born with neonatal abstinence syndrome. *Pediatrics, 142*(3). https://doi.org/10.1542/peds.2018-0562

Fraley, C. R. (2018). *Adult attachment theory and research: A brief overview.* University of Illinois at Urbana-Champaign, Department of Psychology. http://labs.psychology.illinois.edu/~rcfraley/attachment.htm

Ko, J. Y., D'Angelo, V. D., Haight, S. C., Morrow, B., Cox, S., Salvesen von Essen, B., Strahan, A. E., Harrison, L., Tevendale, H. D., Warner, L., Kroelinger, C. D., & Barfield, W. D. (2020). *Vital signs: Prescription opioid pain reliever use during pregnancy — 34 U.S. jurisdictions, 2019* (Morbidity and Mortality Weekly Report, Vol. 69 No. 28, 897–903). U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6928a1-H.pdf

Lee, S. J., Woodward, L. J., & Henderson, J. M. T. (2019). Educational achievement at age 9.5 years of children born to parents maintained on methadone during pregnancy. *PLoS One, 14*(10), e0223685. https://doi.org/10.1371/journal.pone.0223685

National Association for Children of Addiction (NACoA). (2018). *Children of addiction: A kit for educators* (5th ed.). https://nacoa.org/wp-content/uploads/2018/04/Kit-For-Educators.NACoA_.2018-1.pdf

National Center on Substance Abuse and Child Welfare. (2022). *Understanding fetal alcohol spectrum disorders for substance use treatment professionals*. Administration for Children and Families, Substance Abuse and Mental Health Services Administration. https://ncsacw.acf.hhs.gov/files/fasd-tipsheet-cw.pdf

National Child Traumatic Stress Network. (n.d.). *Resilience and child traumatic stress*. https://www.nctsn.org/sites/default/files/resources/resilience_and_child_traumatic_stress.pdf

National Child Traumatic Stress Network. (2018). *What is child trauma?* https://www.nctsn.org/what-is-child-trauma

Northern California Training Academy. (2017). *Safety organized practice quick guide: The safety house.* UC Davis. https://ucdavis.app.box.com/s/kach1ze6pzl3jv773yoegn2k3bjwapq8

Nygaard, E., Slinning, K., Moe, V., & Walhovd, K. B. (2016). Behavior and attention problems in eight-year-old children with prenatal opiate and poly-substance exposure: A longitudinal study. *PLoS One*, *11*(6), e0158054. https://doi.org/10.1371/journal.pone.0158054

Oei, J. L., Melhuish, E., Uebel, H., Azzam, N., Breen, C., Burns, L., Hilder, L., Bajuk, B., Abdel-Latif, M. E., Ward, M., Feller, J. M., Falconer, J., Clews, S., Eastwood, J., Li, A., & Wright, I. M. (2017). Neonatal abstinence syndrome and high school performance. *Pediatrics, 139*(2), e20162651. https://doi.org/10.1542/peds.2016-2651

Office of the Surgeon General. (2021). *Protecting youth mental health: The U.S. Surgeon General's advisory*. https://pubmed.ncbi.nlm.nih.gov/34982518/

Osterman, M. J. K., Hamilton, B. E., Martin, J. A., Driscoll, A. K., Valenzuela, C. P., & National Center for Health Statistics. (2022). Births: Final data for 2020. *National Vital Statistics Reports, 70*(17). https://dx.doi.org/10.15620/cdc:112078

Parker, S. (2009). *The 'safety house': A child protection tool for involving children in safety planning.* SP Consultancy. https://www.partneringforsafety.com/_files/ugd/c64e56_ba7201ae13e84897b4c85ec6f96cfa25.pdf

Sankaran, V., Church, C., & Mitchell, M. (2019). A cure worse than the disease? The impact of removal on children and their families. *Marquette Law Review 102*(4), 1163-94. https://scholarship.law.marquette.edu/cgi/viewcontent.cgi?article=5407&context=mulr

Seay, K. D. (2020). Pathways from parental substance use to child internalizing and externalizing behaviors in a child protective services sample. *Child Maltreatment*, *25*(4), 446–456. https://doi.org/10.1177/1077559520913638

Solis, J. M., Shadur, J. M., Burns, A. R., & Hussong, A. M. (2012). Understanding the diverse needs of children whose parents abuse substances. *Current Drug Abuse Reviews*, *5*(2), 135–147. https://doi.org/10.2174/1874473711205020135

Substance Abuse and Mental Health Services Administration. (2020). *Recovery and recovery support.* U.S. Department of Health and Human Services. https://www.samhsa.gov/find-help/recovery

Substance Abuse and Mental Health Services Administration. (2021). *National survey on drug use and health: Tobacco, cigarette, and daily cigarette use in past month: Among females aged 15 to 44; by pregnancy status, demographic, socioeconomic, and pregnancy characteristics, percentages, 2019 and 2020.* (210615; Table 6.22B) [Data set]. Center for Behavioral Health Statistics and Quality. https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020/NSDUHDetailedTabs2020/NSDUHDetTabsSect6pe2020.htm?s=pregnant&#tab6-21a

Turner, M., Beckwith, H., Duschinsky, R., Forslund, T., Foster, S. L., Coughlan, B., Pal, S., & Schuengel, C. (2019). Attachment difficulties and disorders. *InnovAiT*, *12*(4), 173. https://doi.org/10.1177/1755738018823817

U.S. Department of Health and Human Services. (2023). *HHS, SAMHSA release 2022 national survey on drug use and health data.* https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report

Resources

- Centers for Disease Control and Prevention: *Adverse Childhood Experiences (ACEs) Prevention Resource for Action: A Compilation of the Best Available Evidence* (2019)
- Centers for Disease Control and Prevention: *Developmental Milestones* (2017)
- Centers for Disease Control and Prevention: *Youth Risk Behavior Survey Data Summary & Trends Report* (2013-2023)
- Children and Family Futures: *Navigating Risk: Five Facts About Substance Use Prevention Video* (2024)
- Children of Parents with a Mental Illness Website
- Health Resources & Services Administration, Maternal & Child Health: *Early Periodic Screening, Diagnosis, and Treatment* (2016)
- Lander, L., Howsare, J., & Byrne, M.: *The Impact of Substance Use Disorders on Families and Children: From Theory to Practice* (2013)
- National Academies of Sciences, Engineering, and Sciences: *Promoting Positive Adolescent Health Behaviors and Outcomes: Thriving in the 21st Century* (2020)
- National Association for Children of Addiction Website (2024)
- National Center on Substance Abuse and Child Welfare: *Common Developmental Trajectories of Children with Fetal Alcohol Spectrum Disorder Webinar* (2022)
- National Center on Substance Abuse and Child Welfare: *Engaging Parents and Youth with Lived Experience: Strengthening Collaborative Policy and Practice Initiatives for Families with Mental Health and Substance Use Disorders* (2022)
- National Center on Substance Abuse and Child Welfare: *Engagement and Safety Decision-Making in Substance Use Disorder Cases* (2023)
- National Center on Substance Abuse and Child Welfare: *Infants with Prenatal Substance Exposure and their Families: Five Points of Family Intervention* (2023)
- National Center on Substance Abuse and Child Welfare: *Meeting the Moment: How Child Welfare and Substance Use Disorder Treatment Professionals Can Address the Needs of Adolescents at Risk of Suicide and Mental Health Concerns Webinar* (2022)
- National Center on Substance Abuse and Child Welfare: *Newborns Exposed to Substances Understanding Their Needs and Supporting Their Caregivers Webinar* (2022)
- National Center on Substance Abuse and Child Welfare: *Planning for Safety in Cases When Parental Substance Use Disorder is Present* (2023)
- National Center on Substance Abuse and Child Welfare: *Screening, Assessing, and Treating Pregnant Women with Substance Use Disorder* (2022)
- National Center on Substance Abuse and Child Welfare: *Understanding Fetal Alcohol Spectrum Disorders: Child Welfare Practice Tips* (2022)

- National Center on Substance Abuse and Child Welfare: *Working with Adolescents: Practice Tips and Resource Guide* (2021)
- National Council for Mental Wellbeing: *Youth Mental Health First Aid* (n.d.)
- Sesame Workshop: Remember the 7 C's! (2019)
- Smith, V. C., & Wilson, C. R.: *Families Affected by Parental Substance Use* (2016)
- Substance Abuse and Mental Health Services Administration: *Talk They Hear You Campaign* (2023)
- U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families: *Prevention Resource Guide: Keeping Children Safe and Families Strong in Supportive Communities* (2018)