

**Substance Abuse: Working with Families
During Case Planning and Relapse**

Substance Abuse: Working with Families during Case Planning and Relapse



PARTICIPANT'S GUIDE

Substance Abuse: Working with Families During Case Planning and Relapse Course Objectives

- Become familiar with the identification of seven classifications of substances and accompanying paraphernalia
- Describe how substance abuse impacts brain function
- Describe the laws, policies and guidelines that guide services for children and families with drug and alcohol issues
- Discuss the connection of services between the drug and alcohol system and the child welfare system
- Recognize how drug and alcohol issues affect the case process in child welfare
- Describe how and when drug and alcohol issues affect the permanency planning process for Case Managers
- Identify the issues involved in planning a placement for a child and family involved in drug and alcohol
- Apply permanency-planning principles to the casework process when drug and alcohol issues are involved
- Define relapse and recovery.
- Recognize Relapse warning signs and behaviors.
- Define the purpose of relapse prevention planning.
- Recognize resources available for referring a relapsing client.
- Identify appropriate resources to meet the child's and the family's needs.

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Substance Abuse Statistics

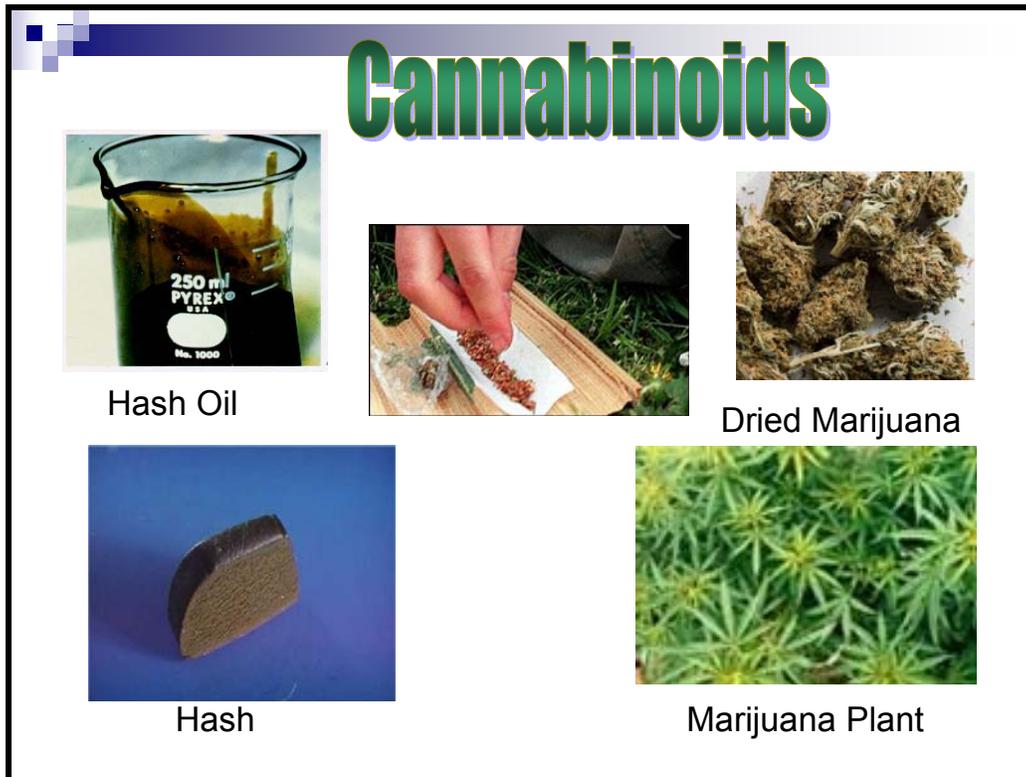
True & False Test

Read the statements below. Circle "True" if you believe the statement to be true. Circle "False" if you believe the statement to be false.

1. Many parents involved with the child welfare system need alcohol and other drug (AOD) treatment.	True	False
2. Child welfare agencies studied could refer for appropriate services (including reunification related services) to almost all parents in need.	True	False
3. More than half of all states report that training or recognizing and dealing with AOD problems is available for foster parents.	True	False
4. Only 9 percent of states studied provide AOD training for kinship care providers.	True	False
5. Most agencies could provide the number of youth in out-of-home care whose parents are chemically dependent.	True	False
6. Half of the states studied believe that children and parents with AOD problems can be treated in a timely manner (less than 1 month).	True	False
7. Many agencies rely on school-based education drug prevention programs as the only form of prevention services available for youth in out-of-home care.	True	False
8. Almost no agencies studied could provide the number of youth in out-of-home care known to abuse AOD themselves.	True	False

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Seven Classifications of Commonly Abused Drugs



These substances are all by-products of marijuana.

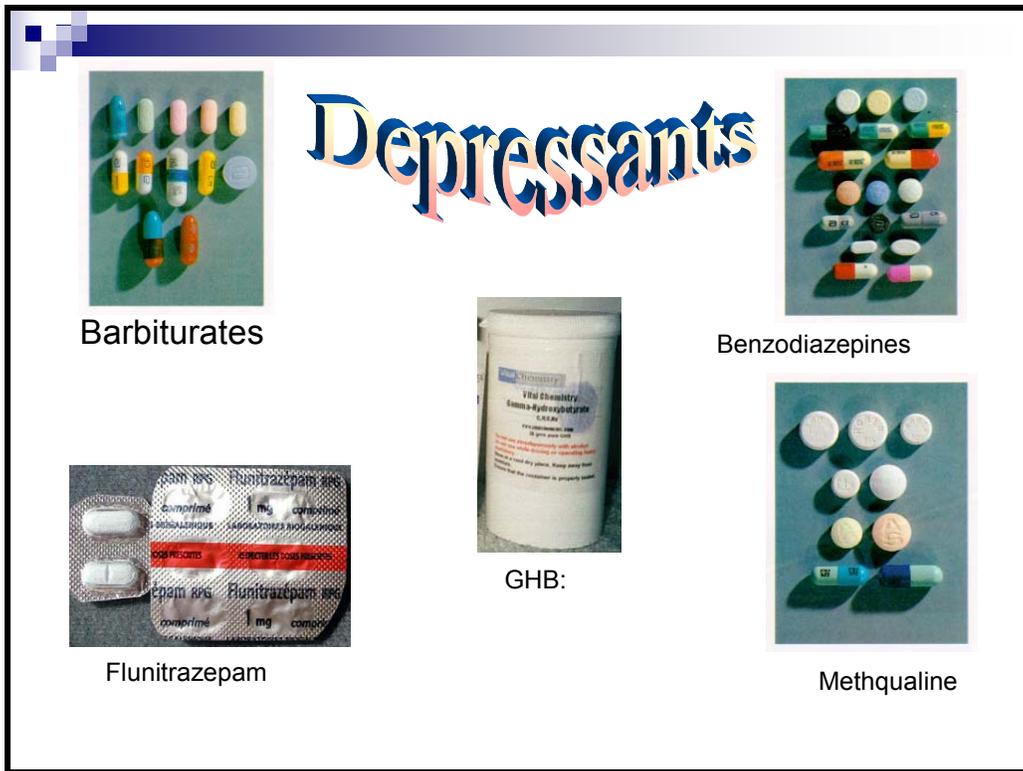
Hashish (Hash)- a potent form of cannabis produced by collecting and processing the most potent material that female marijuana plants naturally generate as part of their growth cycle. Trichomes are fine outgrowths or appendages on plants that produce a sticky resin.

In addition to being sticky, the trichomes of the female marijuana plant are a rich source of THC (the primary chemical that causes intoxication when marijuana, hashish, or hash oil are ingested). It contains the same active ingredients but in higher concentrations than other parts of the plant such as the buds or the leaves. Psychoactive effects are much the same as marijuana. Hashish is often a solid or paste-like substance of varying hardness and pliability, and will soften under heat. Its color can vary from green, black, reddish brown, or most commonly light to dark brown.

It is consumed in much the same way as cannabis buds, used by itself in a miniature smoking pipe, hookah, bong or bubbler, vaporized, hot knifed, or smoked in joints mixed with tobacco, cannabis buds or other herbs. It can also be eaten alone as well as used as an ingredient in food (baked into cookies, brownies, or cakes, or added to stews and chocolate).

Hash Oil- A thick liquid made from dissolving hashish or marijuana in solvents like acetone, alcohol, butane, or petroleum ether. The resulting liquid is then separated from any plant matter and the solvent is allowed to evaporate. The substance that remains is a concentrated form of cannabis. The more refined it is, the lighter the color and the higher the potency. THC is the primary chemical that produces intoxication when a person uses hash oil, hashish, or marijuana. The THC content of good to excellent hash oil varies from 30% to 80% THC. The THC content of good to excellent hashish varies from 20% to 60% THC. The THC content of good commercial grade marijuana available to most users has a THC content of about 5% to 15%. The maximum THC content of premium grade marijuana is about 35%.

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Barbiturates

Benzodiazepines



Flunitrazepam



GHB:



Methqualine

Depressants

Depressants are substances that depress the activity of the central nervous system. Depressants are often referred to as "downers" because of their sedative, hypnotic and tranquilizing effects. There are both legal and illegal depressants. Alcohol is the most common legal depressant. Other depressants that are legal are often prescribed medications used to induce sleep, relieve stress, and subdue anxiety. These prescriptions are often abused as well, such as the case with rohypnol (ruffies). GHB is an illegal depressant often used in drug-facilitated sexual assaults because of its sedative properties. (Date rape drug)

Barbiturates-Today there are only about a dozen in medical use. Barbiturates produce a wide spectrum of central nervous system depression, from mild sedation to coma, and have been used as sedatives, hypnotics, anesthetics, and anticonvulsants. The primary differences among many of these products are how fast they produce an effect and how long those effects last. Barbiturates are classified as ultra-short, short, intermediate, and long-acting.

Benzodiazepines (Bennies) The benzodiazepine family of depressants is used therapeutically to produce sedation, induce sleep, relieve anxiety and muscle spasms, and to prevent seizures. In general, benzodiazepines act as hypnotics in high doses, anxiolytics in moderate doses, and sedatives in low doses. Of the drugs marketed in the United States that affect central nervous system function, benzodiazepines are among the most widely prescribed medications. Fifteen members of this group are presently marketed in the United States, and about 20 additional benzodiazepines are marketed in other countries.

Flunitrazepam (Rohypnol)-most commonly known as a date rape drug, continues to be abused among teenagers and young adults, usually at raves and nightclubs. Rohypnol is legally sold in Latin America and Europe as a short-term treatment for insomnia and as a preanesthetic medication. One of the significant effects of the drug is anterograde amnesia, a factor that strongly contributed to its inclusion in

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the Drug Induced Rape Prevention and Punishment Act of 1996. Anterograde Amnesia is a condition in which events that occurred while under the influence of the drug are forgotten. The new tablet being produced by the drug company includes a dye that will be visible if it is slipped into a drink

GHB - Since about 1990, GHB (gamma hydroxybutyrate) has been abused in the U.S. for its euphoric, sedative, and anabolic (body building) effects. It is a central nervous system depressant that was widely available over-the-counter in health food stores during the 1980s and until 1992. It was purchased largely by body builders to aid in fat reduction and muscle building. Street names include "liquid ecstasy," "soap," "easy lay," "vita-G," and "Georgia home boy." Coma and seizures can occur following abuse of GHB. Combining use with other drugs such as alcohol can result in nausea and breathing difficulties. GHB may also produce withdrawal effects, including insomnia, anxiety, tremors, and sweating.

Methaqualone (Quaalude) Was introduced in 1965 as a safe barbiturate substitute. Experience demonstrated, however; that their addiction liability and the severity of withdrawal symptoms were similar to those of barbiturates. By 1972, "luding out," taking Methaqualone with wine, was a popular college pastime. Excessive use leads to tolerance, dependence, and withdrawal symptoms similar to those of barbiturates. In the United States, the marketing of Methaqualone pharmaceutical products stopped in 1984, and Methaqualone was transferred to Schedule I of the CSA. In 1991, Methaqualone was transferred into Schedule II in response to an upsurge in the prevalence of diversion, abuse, and overdose deaths. Today, there is little medical use of Methaqualone in the United States.

Alcohol- Alcohol, including beer, wine and hard liquor, is the most commonly used and widely abused psychoactive drug in the United States. Alcohol is absorbed by the stomach, enters the bloodstream and goes to all the tissues of the body. The effects of alcohol are dependent on a variety of factors, including a person's size, weight, age and gender, as well as the amount of food and alcohol consumed. Women are at much greater risk of the effects of alcohol. Research indicates that women become intoxicated more rapidly and produce less enzymes in their stomachs to break down alcohol. Women who consume three or more drinks a day may begin to have health problems that do not occur in men until they have nine drinks or more. Women also tend to have a higher fat concentration which keeps alcohol in the body longer. Additionally, estrogen enhances alcohol absorption, and this poses increased risks to women taking oral contraceptives or hormone replacement therapy.

Alcohol, even at low doses, significantly impairs the judgment and coordination required to drive a car safely. Low to moderate doses of alcohol can also increase the incidence of a variety of aggressive acts, including domestic violence and child abuse. In 1987, 64% of all reported child abuse and neglect cases in New York City were associated with parental alcohol and drug abuse. Additionally, alcohol is present in more than 50% of all incidents of domestic violence. The alcohol content varies between different beverages. Generally, beer is 4%, wine is 12% and hard liquor is up to 50% alcohol.

Prolonged and excessive use of alcohol can lead to addiction (alcoholism). Sudden cessation of long-term alcohol intake is likely to produce tremors, hallucinations and convulsions. Long-term effects of excessive consumption can result in permanent organ damage to the brain and liver. In addition, mothers who consume alcohol during pregnancy may give birth to infants with fetal alcohol syndrome, resulting in mental retardation and other irreversible physical abnormalities in the infant. Research indicates that children of alcoholic parents are at greater risk than other children of becoming alcoholics.

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Dissociative Anesthetics



PCP in tablet form is commonly sold under the guise of MDMA. Ketamine



PCP in liquid form



Analogs

Dissociative Anesthetics

A **dissociative** is a drug which reduces (or blocks) signals to the conscious mind from other parts of the brain typically, but not necessarily, limited to the [senses](#). Such a state of [sensory deprivation](#) and [dissociation](#) can facilitate self-exploration, [hallucinations](#), and [dreamlike](#) states of mind which may resemble some [psychedelic](#) mind states.

Ketamine-A tranquilizer most commonly used on animals. The liquid form can be injected, consumed in drinks, or added to smokable materials. The powder form can be used for injection when dissolved. In certain areas, Ketamine is being injected intramuscularly. Ketamine, along with the other "club drugs," has become popular among teens and young adults at dance clubs and "raves." Higher doses produce an effect referred to as "K-Hole," an "out of body," or "near-death" experience. Use of the drug can cause delirium, amnesia, depression, and long-term memory and cognitive difficulties. Due to its dissociative effect, it is reportedly used as a date-rape drug.

Analogs- A [drug](#) whose structure is related to that of another drug but whose chemical and biological properties may be quite different.

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Hallucinogens

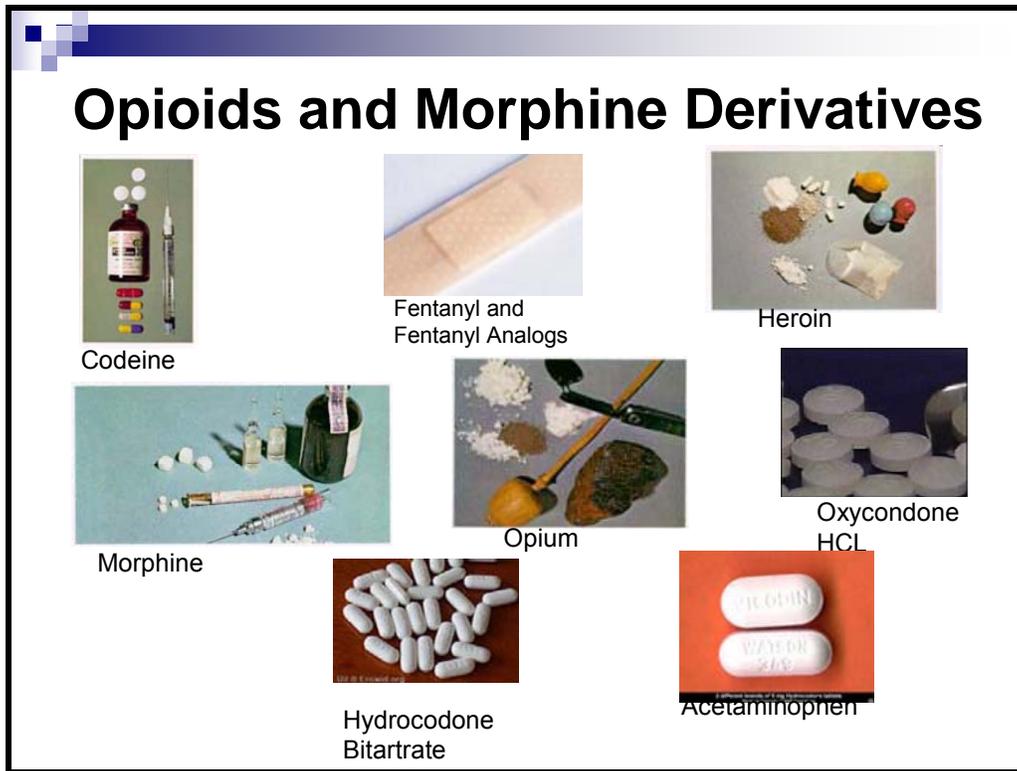
Hallucinogenic substances are characterized by their ability to cause changes in a person's perception of reality. Persons using hallucinogenic drugs often report seeing images, hearing sounds, and feeling sensations that seem real, but do not exist. In the past, plants and fungi that contained hallucinogenic substances were abused. Currently, these hallucinogenic substances are produced synthetically to provide a higher potency.

LSD is sold on the street in tablets, capsules, and occasionally in liquid form. It is an odorless and colorless substance with a slightly bitter taste that is usually ingested orally. It is often added to absorbent paper, such as blotter paper, and divided into small decorated squares, with each square representing one dose. LSD is not considered an addictive drug - that is, it does not produce compulsive drug-seeking behavior as cocaine, heroin, and methamphetamine do. Users refer to their experience with LSD as a "trip" and may experience panic, confusion, suspicion, anxiety and loss of control. Flashbacks can occur even when use has ceased. Most users of LSD voluntarily decrease or stop its use over time.

Mescaline-Mescaline is a hallucinogen obtained from a small, spineless cactus known as Peyote. Mescaline is also found in certain members of the Fabaceae (bean family). From earliest recorded time, peyote has been used by natives in northern Mexico and the southwestern United States as a part of traditional religious rites.

Psilocybin Mushrooms-Psilocybin is a hallucinogenic substance obtained from certain types of mushrooms that are indigenous to tropical and subtropical regions of South America, Mexico, and the United States. Psilocybin mushrooms are popular at raves, clubs and, increasingly, on college campuses and generally are abused by teenagers and young adults.

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Opioids and Morphine Derivatives

The term Opioids refers to both the drugs derived from opium containing seeds of the poppy plant and to the synthetic, morphine-like drugs. Stimulants

Opioids cause depression of the central nervous system, sedation, and analgesia along with euphoria and a sense of well-being. They are used medicinally for pain relief.

Codeine is used to treat moderate pain

Fentanyl is an odorless, rapid-acting Opioid which depresses central nervous system and respiratory function. It is the most powerful opioid known with a potency approximately 80 times that of morphine. Intravenous fentanyl is extensively used for anesthesia and analgesia, most often in the operating room and intensive care unit. Fentanyl is often used in cancer therapy and other chronic pain management due to its effectiveness in relieving pain. There is no known opioid stronger than Fentanyl in reducing cancer pain, which makes it the first choice for use in cancer patients. The biological effects of the fentanyls are similar to those of heroin, with the exception that many users report a noticeably less euphoric 'high' associated with the drug and stronger sedative and analgesic effects. Because the effects of fentanyl last for only a very short time, it is even more addictive than heroin, and regular users may become addicted very quickly.

Heroin

Heroin is a synthetic opiate drug that is highly addictive. It is made from morphine, a naturally occurring substance extracted from the seed pod of the Asian opium poppy plant. Heroin usually appears as a white or brown powder or as a black sticky substance, known as "black tar heroin." It is a "downer" that affects the brain's pleasure systems and interferes with the brain's ability to perceive pain. Heroin can be used in a variety of ways, depending on user preference and the purity of the drug. Heroin can be injected, snorted/sniffed, or smoked—routes of administration that rapidly deliver the drug to the brain.

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Injecting is the use of a needle to release the drug directly into the bloodstream. Snorting is the process of inhaling heroin powder through the nose, where it is absorbed into the bloodstream through the nasal tissues. Smoking involves inhaling heroin smoke into the lungs. All three methods of administering heroin can lead to addiction and other severe health problems. The high from heroin is experienced as intense pleasure. Users develop high tolerance levels very quickly, requiring more and more of the drug to reach the same effects.

Morphine-Morphine is used to treat moderate to severe pain. It works by dulling the pain perception center in the brain. Short-acting formulations are taken as needed for pain. Extended-release formulations are used when around-the-clock pain relief is needed.

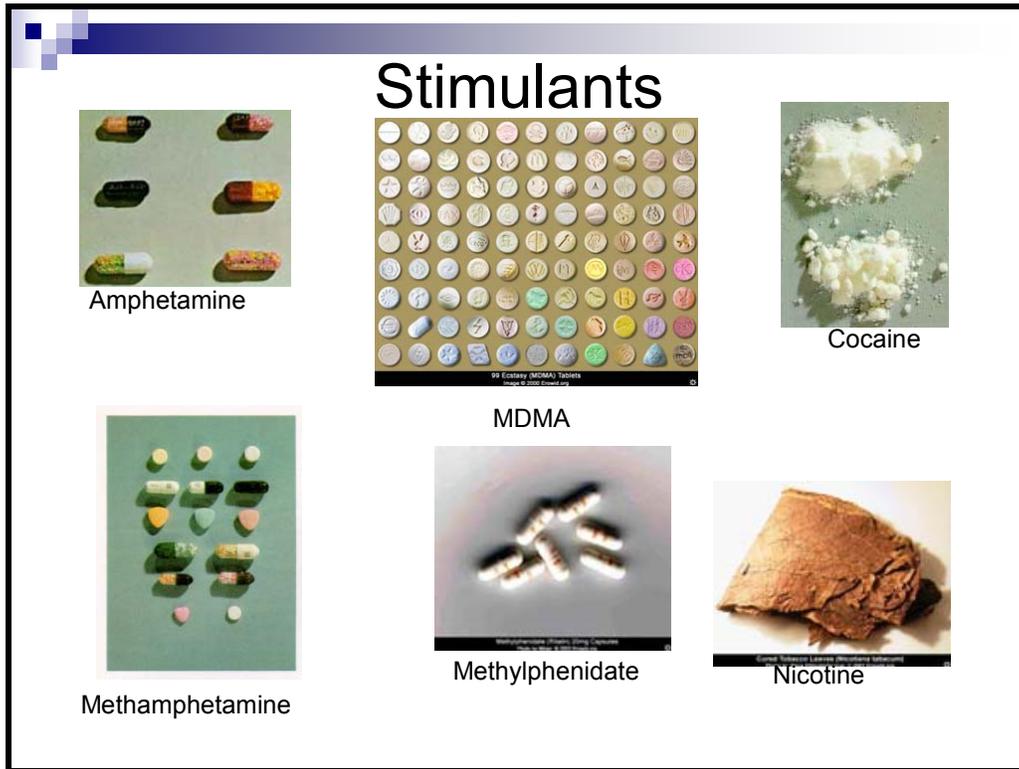
Opium-A naturally occurring substance found in the seeds of the opium poppy. Opium, which contains morphine, is extracted from the poppy seeds and used to produce heroin.

Oxycodone-Oxycodone is in a group of drugs called narcotic pain relievers. It is similar to morphine. Oxycodone is used to treat moderate to severe pain. The extended-release form of this medication is for around-the-clock treatment of pain. Rush Limbaugh was addicted to this drug.

Hydrocodone Bitartrate (Vicodin)-Management of mild to moderate pain..

Acetaminophen-A pain reliever and a fever reducer. Acetaminophen is used to treat many conditions such as headache, [muscle aches](#), arthritis, backache, toothaches, colds, and fevers.

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Stimulants

Stimulants are substances that stimulate the activity of the central nervous system. Stimulants are often referred to as "uppers" because they increase or speed up mental and physical processes in the body. There are both legal and illegal stimulants. Those stimulants that are legal include nicotine (found in tobacco products) and caffeine. Stimulants like methylphenidate are prescribed to increase alertness and physical activity. Illegal stimulants include methamphetamine, cocaine and crack.

Amphetamine/ Methamphetamine- Amphetamine, dextroamphetamine and methamphetamine, are collectively referred to as amphetamines. Their chemical properties and actions are so similar that even experienced users have difficulty knowing which drug they have taken. Extremely violent and erratic behavior is frequently seen among chronic abusers. Methamphetamine is a crystal-like powdered substance that sometimes comes in large rock-like chunks. When the powder flakes off the rock, the shards look like glass, which is another nickname for meth. Meth is usually white or slightly yellow, depending on the purity. Making and buying meth is cheaper and longer lasting than cocaine at \$25.00 for a four day high. Meth can be snorted, swallowed, injected or smoked. If smoked or injected, users report increased energy and motivation, often coupled with a false sense of invincibility. If snorted or swallowed, the onset is not as extreme and not accompanied by an initial "rush." Scientific research has shown that methamphetamine releases high levels of the neurotransmitter dopamine, which stimulates brain cells, causing enhanced mood and increased body movement. Initially, small doses of meth do increase the ability to concentrate. Meth enables people to work around the clock, often for days on end. Meth suppresses appetite, and in small doses is used to clinically treat obesity. Because of this, meth appeals to young women trying to lose weight. Meth is addictive, and users develop a tolerance very quickly, requiring higher and higher doses to get high and going longer

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and longer binges. Some users avoid sleep for 3 to 15 days while bingeing. Prolonged use of meth can result in symptoms resembling those of schizophrenia and are characterized by paranoia, hallucinations, repetitive behavior patterns, and delusions of parasites or insects on the skin. Users often obsessively scratch their skin to get rid of these imagined insects. Long term use, high dosages, or both can bring on full-blown toxic psychosis, exhibited by violent and aggressive behavior and extreme paranoia. As the user comes off a meth binge, behavioral indicators may include non-purposeful, repetitious, compulsive behavior such as picking at the skin, pulling out one's hairs, and compulsive cleaning.

MDMA (Ecstasy)- An illegally manufactured variation of mescaline and amphetamine. It is considered a designer drug---a substance on the drug market that is a chemical analogue or variation of another psychoactive drug. MDMA is marketed as a feel good drug. Devotees say it produces profoundly positive feelings, empathy for others, elimination of anxiety, and extreme relaxation--hence the nickname "hug drug," or "love drug." MDMA is also said to suppress the need to eat, drink, or sleep, enabling club scene users to endure all-night and sometimes two, or three-day parties. It depletes the brain chemical, serotonin, which affects mood, sleeping and eating habits, thinking processes, aggressive behavior, sexual impulse and function, and sensitivity to pain. Studies with rats and monkeys have shown that use of Ecstasy can reduce serotonin levels in the brain by 90% for at least two weeks.

Cocaine/Crack- Cocaine is a highly potent stimulant that is considered to be one of the greatest drug threats to the world because of the violence associated with trafficking and use, the physical and psychological effects associated with its use, and the costs to society as a whole. There is great risk whether cocaine is ingested by inhalation (snorting), injection, or smoking. It appears that compulsive cocaine use may develop even more rapidly if the substance is smoked rather than snorted. Smoking allows extremely high doses of cocaine to reach the brain very quickly and brings an intense and immediate high. The injecting drug user is at risk for transmitting or acquiring HIV infection/AIDS if needles or other injection equipment are shared. Heavy use of cocaine may produce hallucinations, paranoia, aggression, insomnia and depression. Cocaine's effects are short lived, and once the drug leaves the brain, the user experiences a "coke crash" that includes depression, irritability and fatigue.

Methylphenidate- Stimulant medications (e.g., methylphenidate and amphetamines) are often prescribed to treat individuals diagnosed with attention-deficit hyperactivity disorder (ADHD).

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Other Compounds



Anabolic Steroids



Inhalants

Inhalants and Anabolic Steroids

Inhalants- Breathable chemical vapors that produce psychoactive effects. There are four main types of inhalants: Volatile solvents, gases, aerosols, and nitrites. Volatile solvents, gases and aerosols can alter moods and create a high. Nitrites are believed to create sexual stimulation and enhancement. These are usually in the form of ordinary household products which are inhaled or sniffed to get high such as model airplane glue, nail polish remover, hair spray, gasoline, the propellant in aerosol whipped cream, spray paint, fabric protector, air conditioner fluid (freon), cooking spray and correction fluid. These products are sniffed, snorted, bagged (fumes inhaled from a plastic bag) or “huffed” (inhalant-soaked rag, sock, or roll of toilet paper in the mouth) to achieve a high. Inhalants are also sniffed directly from the container. The user may feel stimulated, disoriented, out-of-control, giddy, light-headed and even display violent behavior. Inhalant abuse can cause severe damage to the brain and nervous system, leading to impaired mental and physical functioning. Because inhalants deprive the body of oxygen, they can lead to unconsciousness and death, commonly referred to as sudden sniffing death (SSD).

Anabolic Steroids- Steroids are synthetic substances similar to the male sex hormone testosterone. They do have legitimate medical uses. Sometimes doctors prescribe anabolic steroids to help people with certain kinds of anemia and men who don't produce enough testosterone on their own. Doctors also prescribe a different kind of steroid, called corticosteroids, to reduce swelling. Corticosteroids are not anabolic steroids and do not have the same harmful effects.

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Drug Paraphernalia

Information on Drug Abuse, Consequences



Scale to weigh drugs



Lipstick dispenser hides drug pipe.



Soft drink can with false bottom.



Gas mask converted to a drug pipe

Information on Drug Abuse, Consequences



Squeeze bottle filled with GHB.



Hollow pager adapted to conceal drugs.



Assorted collection of drug pipes.



Felt tip marker with internal drug pipe.

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More assorted drug pipes



Various clips for holding marijuana cigarettes



Spoon and matches used to "cook up" drugs. Syringe and rope tie for shooting drugs into system.

Photos Retrieved September 28, 2005 from Public Domain Resource Sites: <http://www.usdoj.gov/dea/concern/paraphernaliafact.html> and http://www.ohsine.com/photos_drug_photos_pictures_drug_paraphernalia_drug_lab_photos.htm

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COMMONLY ABUSED DRUGS Visit NIDA at www.drugabuse.gov			
Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule*/How Administered	Intoxication Effects/Potential Health Consequences
Cannabinoids			
hashish	Boom, chronic, hash, hash oil, hemp, gangster	I/swallowed, smoked	Euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination/ cough, frequent respiratory infections; impaired memory and learning; increased hear rate, anxiety, panic attacks; tolerance, addiction
marijuana	Blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, week	I/swallowed, smoked	
Depressants			
barbiturates	Amytal, Nembutal, Seconal, Phenobarbital: barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II,III,V/injected, swallowed	<p>Reduced anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration/ fatigue; confusion; impaired coordination, memory, judgment; addiction; respiratory depression and arrest; death</p> <p>Also, for barbiturates – sedation, drowsiness/ depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness, life-threatening withdrawal</p> <p>For benzodiazepines – sedation, drowsiness/ dizziness</p> <p>For flunitrazepam – visual and gastrointestinal disturbances, urinary retention, memory loss for the time under drug's effects</p> <p>For GHB – drowsiness, nausea / vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death</p> <p>For methaqualone – euphoria/ depression, poor reflexes, slurred speech, coma</p>
Benzodiazepines (other than flunitrazepam)	Ativan, Halcion, Librium, Valium, Xanax; candy, downers, sleeping pills, tranks	IV/swallowed, injected	
Flunitrazepam***	Rohypnol: Forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies	IV/swallowed, snorted	
GHB	Gamma-hydroxybutyrate; G, Georgia home boy, grievous bodily harm, liquid ecstasy	I/swallowed	
methaqualone	Quaalude, Sopor, Parest: ludes, mandrex, quad, quay	I/injected, swallowed	
Dissociative Anesthetics			
ketamine	Ketalar SV: cat Valiums, K, Special K, vitamin K	III/injected, snorted, smoked	<p>Increased heart rate and blood pressure, impaired motor function / memory loss; numbness; nausea / vomiting</p> <p>Also, for ketamine – at high doses, delirium, depression, respiratory depression and arrest</p> <p>For PCP and analogs – possible decrease in blood pressure and heart rate, panic, aggression, violence/ loss of appetite, depression</p>
PCP and analogs	Phencyclidine: angel dust, boat, hog, love boat, peace pill	I,II/injected, swallowed, smoked	
Hallucinogens			

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COMMONLY ABUSED DRUGS Visit NIDA at www.drugabuse.gov			
LSD	Lysergic acid diethylamide: acid, blotter, boomers, cubes, microdot, yellow sunshines	I/swallowed, absorbed through mouth tissues	<p>Altered states of perception and feeling; nausea; persisting perception disorder (flashbacks)</p> <p>Also , for LSD and mescaline – increased body temperature, heart rate, blood pressure; loss of appetite, sleeplessness, numbness, weakness, tremors</p> <p>For LSD – persistent mental disorders</p> <p>For psilocybin – nervousness, paranoia</p>
mescaline	Buttons, cactus, mesc, peyote	I/swallowed, smoked	
psilocybin	Magic mushroom, purple passion, shrooms	1/swallowed	
Opioids and Morphine Derivatives			
codeine	Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine: Captain Cody, Cody, schoolboy; (with glutethimide) doors & fours, loads, pancakes and syrup	II, III, IV, V/injected, swallowed	<p>Pain relief, euphoria, drowsiness / nausea, constipation, confusion sedation, respiratory depression and arrest, tolerance, addiction, unconsciousness, coma, death</p> <p>Also, for codeine – less analgesia, sedation, and respiratory depression than morphine</p> <p>For heroin – staggering gait</p>
Fentanyl and fentanyl analogs	Actiq, Duragesic, Sublimaze: Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	I, II/injected, smoked, snorted	
heroin	Diacetylmorphine: brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse	I/injected, smoked, snorted	
morphine	Roxanol, Duramorph: M, Miss Emma, monkey, white stuff	II, III/injected, swallowed, smoked	
opium	Laudanum, paregoric: big O, black stuff, block, gum, hop	II, III, V/swallowed, smoked	
Oxycodone HCL	OxyDontin: Oxy, O.C., killer	II/swallowed, snorted, injected	
Hydrocodone bitartrate, acetaminophen	Vicodin: vike, Watson-387	II/swallowed	
Stimulants			
amphetamine	Biphphetamine, Dexedrine: bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/injected, swallowed, smoked, snorted	<p>Increased heart rate, blood pressure, metabolism; feelings of exhilaration, energy, increased mental alertness; rapid or irregular heart beat; reduced appetite, weight loss, heart failure, nervousness, insomnia</p> <p>Also, for amphetamine – rapid breathing/tremor, loss of coordination, irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness,</p>
cocaine	Cocaine hydrochloride: blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II/injected, smoked, snorted	
MDMA (methyl-enedioxymethamphetamine)	Adam, clarity, ecstasy, Eve, lover's speed, peace, STP, X, XTC	I/swallowed	

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COMMONLY ABUSED DRUGS Visit NIDA at www.drugabuse.gov			
methamphetamine	Desoxyn: chalk, crank, crystal, fire, class, go fast, ice, meth, speed	II/injected, swallowed, smoked, snorted	tolerance, addiction, psychosis For cocaine – increased temperature / chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition, panic attacks. For MDMA – mild hallucinogenic effects, increased tactile sensitivity, empathic feelings/ impaired memory and learning, hyperthermia, cardiac toxicity, renal failure, liver toxicity For methamphetamine – aggression, violence, psychotic behavior/ memory loss, cardiac and neurological damage; impaired memory and learning, tolerance, addiction For nicotine – additional effects attributable to tobacco exposure; adverse pregnancy outcomes; chronic lung disease, cardiovascular disease, stroke, cancer; tolerance, addiction
Methylphenidate (safe and effective for treatment of ADHD)	Ritalin: JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	II/injected, swallowed, snorted	
nicotine	Cigarettes, cigars, smokeless tobacco, snuff, spit tobacco, bidis, chew	Not scheduled/ smoked, snorted, taken in snuff and spit tobacco	
Other Compounds			
anabolic steroids	Androl, Oxandrin, Durabolin, Depo-Testosterone, Equipoise: Roids, juice	III/injected, swallowed, applied to skin	No intoxication effects / hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, hostility and aggression, acne; in adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females, menstrual irregularities, development of beard and other masculine characteristics
inhalants	Solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexyl): laughing gas, poppers, snappers, whippets	Not scheduled/inhaled through nose or mouth	Stimulation, loss of inhibition; headache; nausea or vomiting; slurred speech, loss of motor coordination; wheezing/unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death

Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Most Schedule V drugs are available over the counter. ** Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.* Associated with sexual assaults.*

Public Domain Source for Chart: National Institute on Drug Abuse. (May 2003). Retrieved September 22nd, 2005 from the World Wide Web:

<http://www.nida.nih.gov/PDF/CADChart.pdf>

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POSSIBLE SIGNS OF DRUG USE

One must emphasize the word “possible” because other factors might resemble signs of drug use. One’s ability to identify patterns of problem behavior that emerge over time will prove particularly useful.

GENERAL APPEARANCE

The person using substances might exhibit diminished hygiene, grooming, sense of wellbeing, or healthy facial *glow*. The individual might look as if she/he stayed up all night. When engaged in conversation with the individual, one might observe a higher level of anxiety or passiveness, a slower response to questions, and minimal or reduced eye contact. Specifically, one might notice the following in the listed areas.

- Face:**..... Presence of puffiness, flushed appearance, broken capillaries around cheeks and nose, unhealthy skin color
- Eyes:**Dilated pupil or very small pupils, red eyes, roving eye movements, visual complaints, light sensitivity, unusual tearing
- Nose:**.....Rhinitis, runny nose, frequent sniffing (excuse may be allergy problems); frequent nosebleeds, puffy and red nose.
- Skin:**Excessive sweating, track marks, bruises, abscesses on legs and arms, excessive scratching and itching
- Nails:**Gray, blue, and/or ashen-color
- Movement:**.....Trembling hands, uncoordinated movements

One might observe, on clothes, small dots of blood from injections. In the home, one might notice unfamiliar or distinctive odors. In addition, one might notice, regarding the individual using substances, a strong or old odor of alcohol on the breath or clothes.

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POSSIBLE SIGNS OF DRUG USE

(Continued)

PHYSICAL INDICATORS

- Change in appetite, erratic eating habits
- Loss of coordination
- Slurred speech
- Incoherence
- Inattention to dress and personal hygiene
- Overall changes in physical appearance
- Weight loss
- Change in vitality and sleep
- Tired, lethargic
- Dreamy, blank expression
- Loss of memory
- Dilated or constricted pupils
- Needle (“Track”) marks
- Trembling
- Drug-oriented magazines
- Marijuana seeds
- Smell of marijuana
- Attempts to disguise odor of marijuana with cigarettes, incense, room deodorizer, etcetera
- Possession of drugs
- Chronic sinus problems
- Smell of alcohol on breath

SOCIAL INDICATORS

- Changes in friends
- Unknown friends
- Association with known drug users
- Changes in hangouts
- Always going “nowhere special”
- Secretive phone conversations
- Receive calls from individuals that refuse to identify themselves
- Hang-up phone calls
- Constant lying
- Overt hostility and outbursts
- Withdrawal from family
- Stealing small items
- Disappearance of money
- Often borrowing money
- Unexplained influx of money

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POSSIBLE SIGNS (Continued)

PSYCHOLOGICAL INDICATORS

- Personality changes
- Depression or over-activity
- Mood Swings
- Talkativeness
- Irritability, hostility
- Secretiveness
- Over reaction to criticism
- Confusion
- Anxiety, paranoia
- Lack of ambition or drive, apathy
- Unpredictable behavior
- Hallucinations
- Uncharacteristic behavior for individual's personality

WORK/EDUCATIONAL INDICATORS

- Truancy
- Frequently skips work/class
- Constantly late
- General loss of interest in work/school
- Declining work/school performance
- Change from normal capabilities
- Poor conduct and attitude
- Dropping out of organized activities
- Quitting job or dropping out of school

ENVIRONMENTAL INDICATORS

- Containers of alcohol
- Pills/drugs lying around
- Tinted windows in the home (possibly signifying a drug lab)
- Abundant known chemicals used in making drugs
- Smell of drugs or alcohol in the home
- Visible drug paraphernalia (such as syringes, razor blades, marijuana and other pipes, and other devices that facilitate drug use)
- Marijuana seeds
- Drug-oriented magazines
- Smell of marijuana
- Attempts to disguise odor of marijuana with cigarettes, incense, room deodorizer, etcetera

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Family Characteristic Patterns

Negativism

Parental Inconcsistency

Parental Denial

Miscarried Expression of Anger

Self Medication

Unrealistic parental expectations

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Roles Children Might Assume in Substance Using/Abusing Families



The Hero – These children try to make sure that the family appears normal to the rest of the world. They develop a strong sense of responsibility and project an image of competence and achievement. This is often, but not always, the first-born child. They learn as children that someone has to be responsible for the family, and if the parents induce chaos, it is up to the “hero” to provide stability. These people grow up to become academically or professionally successful; although, they are prone to denying their own emotions and feeling like imposters.

Characteristics: perfectionist, self-worth is activity based, and individual feels inadequate



The Lost Child – Often the third or latter child in an alcoholic family is the “lost child.” This child is unable to have his/her needs met; becomes overwhelmed, and withdraws from the world. In both childhood and adulthood, the child might appear unfocused, unmotivated, and helpless. “Lost” children might tend to try to attach to partners or groups that substitute for their unmet need for a family.

Characteristics: independent, withdrawn, and individual feels unworthy



The Placater – These siblings are the ones who learn early to smooth over potentially upsetting situations in the family. At the expense of their own feelings, they develop a good ability to read the feelings of others. They may go into “caretaking” professions later in life, even though this reinforces their tendency to ignore their own feelings.

Characteristics: people pleaser, submissive, and have a hard time saying no



The Scapegoat – Individuals know these children as the family problem. They are the children who get into trouble, including alcohol and drug abuse, as a way of expressing their anger at the family. They serve as the “pressure valve” in the family: When tension builds, they misbehave as a way of relieving pressure while allowing the family to avoid dealing with the parent’s drinking and/or drug problem. When they grow up, they are unaware of feelings other than anger.

Characteristics: defiant, falsely accused, individual feels rejected

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RISK IN FAMILIES WITH SUBSTANCE ABUSE CONCERNS

Specific Risks:

- Alcohol seems to produce the greatest violence. Alcohol and other substance use often causes fighting between adults. Children caught in between, sometimes inadvertently used as shields, may suffer physical harm.
- Prolonged alcohol usage causes BLACKOUTS; (ex., the user cannot recall activities during a blackout, such as abuse of a child).
- Cases of incest and sexual abuse often occur with alcohol abuse; alcohol lowers the inhibitors allowing the individual more easily to ignore the taboos.
- Parental crack/cocaine causes children at particular risk for neglect of proper nourishment; cocaine is an appetite suppressant. Those using the drug, as a result, do not concern themselves with eating.
- Crack/cocaine causes heightened sexual feelings, thus putting children at greater risk for sexual abuse.
- People on crack have poor impulse control and can be extremely abusive; they are often guilty of “overkill,” (ex. news reports of persons stabbed repeatedly).
- Illegal drugs tend to put children at risk for neglect because the user leaves the home in search of the drug.
- Illegal drugs often put children at risk because of the parent’s illegal actions in buying, dealing, and etcetera.

Risks during Withdrawal and Recovery:

- When the cocaine addict comes down from a high, she/he is often very irritable.
- Tranquilizer withdrawal (Valium in particular) is very debilitating and can last for months.
- People in recovery struggle to be clean, sober and learn new ways of living. Such stressors often cause them to be very irritable during this period.

Specific Children at Risk Include:

- Infants and young children who cannot care for themselves;
- Colicky or sickly infants and children;
- Children who need specific medications (ex., diabetic children);
- Disabled children;
- Withdrawn children;
- Stepchildren; and,
- Children whom individuals deem as not particularly attractive.

Other Concerns:

We consider newborn children of addicted women as high-risk. Some possible effects are: low birth weight and length, small head size, other long-term medical consequences, (ex., cerebral palsy), and have increased likelihood of dying from SIDS (Sudden Infant Death Syndrome). Withdrawal symptoms often occur after birth, as a result, individuals find these infants hard to console; consequently, this situation places the child at a higher risk for physical abuse.

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DFCS Values

- Children need and deserve to grow-up safe, free, and protected from abuse and neglect.
- Children do best when they have strong families, preferably their own and when that is not possible, a stable relative, foster or adoptive family.
- All families need community support and genuine connections to people and resources.
- Families have the capacity to change with the support of individualized service responses.
- Government cannot do the job alone; community partnerships are essential to ensure child safety and build strong families.
- No family who needs and wants help to keep their children safe will be left without the help it needs.
- No child in our care will leave us without a caring, committed, permanent family
- Every child we come into contact with will get the help (s)he needs to be healthy and achieve his/her full educational and developmental potential
- No child we come in to contact with will be left to struggle alone with abuse or neglect

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Guiding Principles for Child Welfare

Established by the Child Welfare League of America (CWLA)

Principle #1:

Child welfare policies and services must reflect an understanding and appreciation of factors that positively or negatively affect child development and family systems.

Principle #2:

Research and empirical data must guide child welfare policies and services related to serving all children and families.

Principle #3:

P.L. 105-89, the Adoption and Safe Families Act (ASFA), mandates that child safety, well-being, and permanency achieved in a timely manner serve as the cornerstone of our work with children and families. ASFA establishes timelines under which those serving children must achieve permanency for children whether that be through reunification, adoption, or some other court-approved permanent living arrangement.

Principle #4:

Families are important to the development of children. All children need a sense of belonging. The biological family, within a community that supports a positive cultural and ethnic identity, usually best promotes this sense of belonging.

Principle #5:

All parents coming to the attention of the child welfare system must receive services and supports to prevent their unnecessary separation from their children. When necessary, parents must also receive services that support ongoing safe and healthy relationships with their children and facilitate family reunification.

Principle #6:

Many families have multiple problems that require coordinated services and effective case management.

Principle #7:

Effective delivery of services to all children and families is dependent on a well-trained and well-compensated workforce and adequate funding to support an array of services and cross-system approaches.

Principle #8:

Child Welfare Professionals must base child welfare services on a respect for and sensitivity to the racial, cultural, and ethnic diversity represented in our society. Furthermore, child welfare agencies must identify and help to remedy economic conditions that place the well-being of children and families at risk.

[Click her to view Principles of Drug Addiction Treatment](#)

Substance Abuse: Working with Families During Case Planning and Relapse

Principles of Drug Addiction Treatment

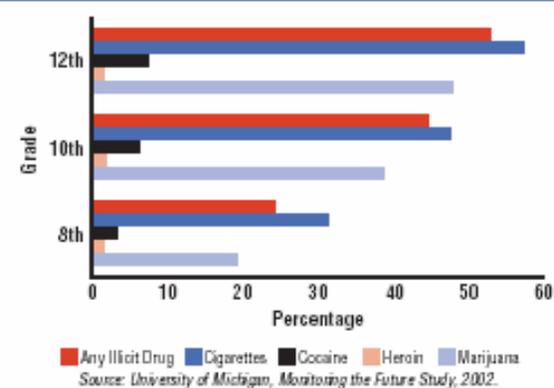
Nearly three decades of scientific research have yielded 13 fundamental principles that characterize effective drug abuse treatment.

These principles are detailed in NIDA's *Principles of Drug Addiction Treatment: A Research-Based Guide*

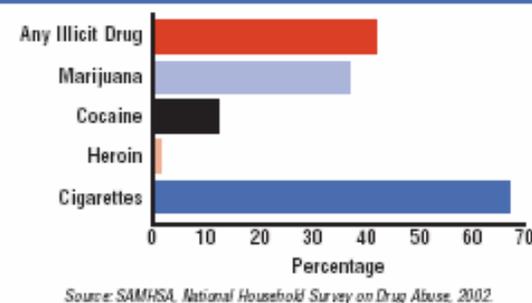
- No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each patient's problems and needs is critical.
- Treatment needs to be readily available.** Treatment applicants can be lost if treatment is not immediately available or readily accessible.
- Effective treatment attends to multiple needs of the individual, not just his or her drug use.** Treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems.
- At different times during treatment, a patient may develop a need for medical services, family therapy, vocational rehabilitation, and social and legal services**
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The timeframe depends on an individual's needs. For most patients, the threshold of significant improvement is reached at about 3 months in treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.
- Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address motivation, build skills to resist drug use, replace drug using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.
- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Buprenorphine, methadone, and levo-alpha-acetylmethadol (LAAM) help persons addicted to opiates stabilize their lives and reduce their drug use. Naltrexone is effective for some opiate addicts and some patients with co-occurring alcohol dependence. Nicotine patches or gum, or an oral medication, such as bupropion, can help persons addicted to nicotine,
- Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.**
- Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification manages the acute physical symptoms of withdrawal. For some individuals it is a precursor to effective drug addiction treatment.
- Treatment does not need to be voluntary to be effective.** Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.
- Possible drug use during treatment must be monitored continuously.** Monitoring a patient's drug and alcohol use during treatment, such as through urinalysis, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that treatment can be adjusted.
- Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk of infection.** Counseling can help patients avoid high-risk behavior and help people who are already infected manage their illness.
- Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Participation in self-help support programs during and following treatment often helps maintain abstinence.

[Click here Guiding Principles for Child Welfare](#)

Teens Who Have Ever Used Illicit Drugs or Cigarettes



Percentage of U.S. Population (Aged 12 and Over) Who Have Ever Used Drugs of Abuse



Order NIDA publications from NCADI:
1-800-729-6686
or TDD: 1-800-487-4889

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Five Clocks



TANF Timelines



ASFA Timelines



Recovery Timelines



Developmental timelines



System timelines

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Drug and Alcohol System Significant Laws that Affect Child Safety

Federal:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, Parts A and E

Many individuals in many Human Services agencies, including Child Welfare, fall under the law's jurisdiction. HIPAA further clarified and set the confidentiality standards, within the Drug & Alcohol System relating to 42 CFR Part 2.1 and 42 CFR Part 2.2, of individuals receiving substance abuse treatment.

[42 CFR Part 2.1.](#)

[42 CFR Part 2.2](#)

**CLIENT PRIVACY IS
YOUR RESPONSIBILITY**

The Privacy Rule

Issued in December 2000 by the Department of Health and Human Services (HHS), the Privacy Rule (by its full name know as the Standards for Privacy of Individually Identifiable Health Information), offers that those agencies that must comply with the confidentiality standards in HIPAA must comply with the stricter standards of the Privacy rule, except where conflicts arise in which case those agencies should refer to 42 CFR Part 2.



**HIPAA
IT'S THE LAW**

Meth Law

STATE: GA. Code Ann. § 16-5-73(b)

Statute Text:

Any person who intentionally causes or permits a child to be present where any person is manufacturing methamphetamine or possessing a chemical substance with the intent to manufacture methamphetamine shall be guilty of a felony and, upon conviction thereof, shall be punished by imprisonment for not less than 2 nor more than 15 years.

Any person who violates the paragraph above wherein a child receives serious injury as a result of such violation shall be guilty of a felony and, upon conviction thereof, shall be punished by imprisonment for not less than 5 nor more than 20 years.

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Collaborative Sharing of Information with a Signed Release of Information Request

Information needed by DFCS case manager from the treatment provider includes:

- Whether the client is or is not in treatment;
- The prognosis of the client;
- A brief description of the progress of the client; (degree of participation: whether regularly attending, not missing appointments and demonstrating a willingness to engage in treatment)
- A short statement as to whether the client has relapsed into drug, or alcohol abuse and the frequency of such relapse.
- The continuing care plan of the client if in residential treatment

Information needed by **substance abuse treatment counselors** from DFCS Case managers includes:

- ◆ Whether the family is a family preservation case or if the child has been removed from the home
- ◆ Whether some children have been removed while others remain at home
- ◆ The permanency goal for the child
- ◆ Whether reunification is a goal
- ◆ Whether there is a concurrent plan for both foster care and adoption
- ◆ The court requirements and deadlines for specific hearings and achieving necessary outcomes.

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PATIENT CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, Jane Doe, authorize
(Name of Client)

ABC Treatment Program to disclose to
(Name or General Designation of Program making disclosure)

Fayette County DFCS the following information:

Initial each category that applies:

- my name and other personal identifying information;
- my status as a patient in [alcohol and/or drug] treatment;
- initial evaluation;
- date of admission;
- assessment results and history;
- summary of treatment plan, progress, and compliance;
- attendance;
- urinalysis results;
- changes in address, household composition, or personal relationships that could result in child neglect/abuse or domestic violence;
- observations of visitation of children;
- relapse plan
- discharge plan/summary;
- date of discharge and discharge status; and
- other _____

The purpose of the disclosure authorized herein is to:

Assist the Fayette County Dept. of Family and Children Services (DFCS) to evaluate my readiness/ability to parent and provide for the permanency, safety, and well-being of my child(ren)

(Purpose of Disclosure, as specific as possible)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Upon termination of the child abuse/neglect case against me _____
(Specification of the date, event, or condition upon which this Consent expires)

(Signature of Client)

(Date)

(Signature of Parent, Guardian or Authorized Representative, When Required)

Substance Abuse: Working with Families During Case Planning and Relapse Ideas that Increase Collaboration

Development of Communication Protocols

- ◆ County-level MOUs
- ◆ Development of appropriate Release of Information forms
- ◆ Protocols for obtaining signed forms
- ◆ Discussions and agreements about how shared information is to be used
- ◆ Progress report forms
- ◆ “Urgent Notice” forms (Allow professionals to provide notification about an urgent problem or important change in status)

Building relationships

- ◆ Within and between all levels of the organizations
- ◆ Recognize the SA staff as the experts on Substance Issues

Acculturation to Collaborative Practice

- ◆ Create a culture which allows continued learning and problem solving
- ◆ Provide ongoing efforts to address problems and ensure continuity and accountability in service provision.
- ◆ Employ a combination of formal and informal efforts to address issues related to funding and conflict between people or programs as they arise.

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Conditions that Increase Risk and

◆ Increase Chances for Unsuccessful Treatment

- **Parents whose drug abuse seriously impairs their judgment, reliability, and ability to meet their children's needs.**
- **Parents whose involvement in a drug culture lifestyle places their children at continuous and serious risk of harm.**
- **Drug abusing parents, who deny the existence of the problem, refuse to consider treatment, or who verbalize a desire for help but never follow through.**
- **Parents with no history of adequate social, occupational, and personal functioning prior to the onset of drug use.**
- **Parents whose primary social contacts and support networks are also habitual drug users (parents with no social support network of non-using family or friends).**
- **Parents with little or no history of successful parenting prior to onset of drug use and limited identity as a parent.**

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Conditions that Decrease Risk and Increase Chances for Successful Treatment

- Parents acknowledge their substance abuse and fully understand the negative impact it has on their children.
- Parents are willing to engage in some form of substance abuse treatment and attempt to remain involved in a treatment program. This may include self-help and peer-help organizations such as Alcoholics Anonymous and Narcotics Anonymous.
- Parents make alternative care giving arrangements for their children when they recognize themselves to be incapable of providing proper care.
- Parents are willing and able to separate themselves from friends, family members, spouses, or others who continue to use drugs.
- Parents have a strong support network of family and friends who do not use drugs, and who support their attempts to discontinue drug use.
- Parents have a history of adequate social, occupational, and personal functioning prior to the onset of drug use.
- Parents are able to recognize when a relapse is likely, and make plans for their children, call in friends or family members to provide care for the children, or seek help.
- Parents exhibit shame and distress about the effects of drug use on their parenting.
- Parents have a history of successful parenting prior to the onset of drug use, and have a strong identity as a parent.

**Substance Abuse: Working with Families
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Types of Treatment Programs

Outpatient Drug Free Treatment

Short-term Residential Program

**Long-term Residential Program/ Therapeutic
Communities**

Opioid Addiction Outpatient Treatment

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**Division of Mental Health, Developmental
Disabilities and Addictive Diseases
(MHDDAD)**

<http://mhddad.dhr.georgia.gov/portal/site/DHR-MHDDAD/>

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Goals of Treatment

Primary Goal: To promote longstanding abstinence from alcohol and other drugs by achieving certain sub-goals

Sub-Goals:

1. Identify Chemical Dependency
2. Help individual to identify the denial; confront that denial:
3. Teach individual about his/her illness.
4. Teach individual what to do about it (ex., Twelve Step and other support groups).
5. Teach individual how to prevent relapse.
6. Work with individual to resolve problems (Post-Acute Withdrawal Syndrome).

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Guidelines for Recognizing Effective Treatment Programs

- Programs should treat addiction, as a primary condition, but at the same time, the needs of the total person. Treatment should explore factors contributing to addiction and those contributing to recovery. Treatment should also explore the factors blocking recovery (such as poverty, lack of education, lack of job training, and/or a history of sexual or physical abuse).
- Programs should be culturally sensitive and staffed by individuals who are representative of the population the program serves.
- Programs for pregnant or parenting women should include training in parenting and good nutrition. Treatment should build into the program skills in navigating the complex health and human services network.
- Programs must recognize that chemical dependency is a family affair, not an individual illness.
- Programs must recognize that relapse is a part of recovery. Relapse prevention should be part of the process of alcohol and other drug treatment. Because those providing treatment must expect relapse, successful programs should offer pre-discharge planning, supportive services, and resources to protect children and prevent relapse during the early recovery phase.
- Treatment programs should meet professional practice standards. Local or state agencies that govern their funding and operations should certify the programs. The state director for alcohol and drug abuse is a good source for specific information.
- The program providing treatment should be licensed.

**Substance Abuse: Working with Families
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Phases of Treatment

Getting Clean and Sober

Stabilization

Follow-up Support and Post-Permanency

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SIX STAGES OF CHANGE

Stage 1: Pre-contemplation

Description	Indicators
<p>This is the entry point of a person into the change process. The individual has not even considered the prospect of change. The individual is unlikely to perceive a need for change. It is usually someone else who perceives a problem. At this stage, a person is not likely to respond positively to anyone (family or professional) being confrontational or demanding change.</p>	<ul style="list-style-type: none"> ◆ Total resistance to doing anything ◆ No willingness to meet, talk to a professional, or get assessed ◆ Angry at any indication from another that there is a drug or alcohol problem ◆ Blaming others ◆ "Everything is okay" statements ◆ Willingness to work on other things, but not drugs or alcohol ◆ Refuse to let a professional in and work with him/her ◆ Lack of awareness ◆ Uses drugs, and believes there is no connection to problems

Stage 2: Contemplation

Description	Indicators
<p>Once the person has some awareness of the problem, then the person enters the stage called Contemplation. It is an ambivalent state where the individual both considers change and rejects it. If allowed to just talk about it, the person goes back and forth about the need to change without justification for change.</p>	<ul style="list-style-type: none"> ◆ Saying one thing, doing another ◆ Rationalizing, minimizing ◆ Anxiety rises while trying some things that do not work ◆ Both talking about change and arguing against it

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Stage 3: Preparation

Description	Indicators
<p>The person is ready to change. This is a window of opportunity when the person resolved the ambivalence enough to look at making change.</p>	<ul style="list-style-type: none"> ◆ Admitting the need for change ◆ Accepting negative ramifications of their use behavior ◆ Asking for help ◆ Starting to look at alternatives

Stage 4: Action

Description	Indicators
<p>The person engages in particular actions that intend to bring about change</p>	<ul style="list-style-type: none"> ◆ Starting to work out a plan ◆ Making changes in use behavior ◆ Asking for professional help, or using professional help to make their plan more successful

Stage 5: Maintenance

Description	Indicators
<p>The person identifies and implements strategies to maintain progress, and to reduce the likelihood of slips or full relapse into old behaviors.</p>	<ul style="list-style-type: none"> ◆ Making the long-term life changes needed to "actualize" the changes made in the action stage ◆ Focusing less on not using and more on a "recovery" lifestyle

Stage 6: Relapse

Description	Indicators
<p>The person has a slip, or returns to using at a level higher than acceptable to either the person or family. At times, the person might slip and not regard it as serious enough to be concerned, yet someone may be at risk. A professional needs to help the person holistically look at the situation.</p>	<ul style="list-style-type: none"> ◆ Using alcohol or the drug they try not to use ◆ Increasing their use beyond the amount to which they reduced their original use ◆ Beginning using a new drug; seeing such use as a failure

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	1. Avoidance: “I’ll talk about anything but my real problems!”
	2. Absolute Denial: “No, not me! I don’t have a problem!”
	3. Minimizing: “My problems aren’t that bad!”
	4. Rationalizing: “If I can find good enough reasons for my problems, I won’t have to deal with them!”
	5. Blaming: “If I can prove that my problems are not my fault, I won’t have to deal with them!”
	6. Comparing: “Showing that others are worse than me, proves that I don’t have serious problems!”
	7. Compliance: “I’ll pretend to do what you want, if you’ll leave me alone!”

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	8. Compliance: "I'll pretend to do what you want, if you'll leave me alone!"
	9. Manipulating: "I'll only admit that I have problems, if you agree to solve them for me!"
	10. Flight into Health: "Feeling better means that I'm cured!"
	11. Recovery by Fear: "Being scared of my problems will make them go away!"
	13. Strategic Hopelessness: "Since nothing works, I don't have to try."
	14. The Democratic Disease State: "I have the right to destroy myself and no one has the right to stop me!"

Developed by Terence Gorski N.C.A.C II, C.S.A.C and the CENAPS Corporation with regard to Denial Management Counseling®.

Resource: Gorski, T.T. "Denial Management Counseling," *Paradigm magazine*, Vol. 6(3) and Vol. 5(2);pgs. 20-21 (Summer 2001). Retrieved November 14, 2005 from the World Wide Web at http://www.onlineparadigm.com/archives/164-S01_PT.GI.pdf Used with permission of Paradigm magazine, P.O. Box 793768, Dallas, TX 75379 (972) 250-1110

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Abstinence: What It Is and What It Isn't

What It Is

Stopping and remaining free of any further drug or alcohol use.

What It Isn't

Not recovery!!!



**Substance Abuse: Working with Families
During Case Planning and Relapse**

Recovery Process

Pretreatment

Stabilization

Early Recovery

Middle recovery

Late recovery

Maintenance

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Relapse: What It Is and What It Isn't

What It Is:

- Relapse is a process

What It Isn't

- Relapse is not the person using one time
 - Relapse is not just a “slip”
 - Relapse is not a sign of failure
- A lot of times it is a part of the recovery process



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37 Relapse Warning Signs

Phase 1: The Return of Denial: Becomes unable to recognize and honestly tell others what he/she is thinking or feeling.

Warning signs include:

1. Concern About Well-Being
2. Denial

Phase 2: Avoidance and Defensive Behavior: Doesn't want to think about anything that will cause the painful and uncomfortable feelings to come back. Begins to avoid anything or anybody that will force and honest look at self. When asked direct questions about well being, he/she tends to become defensive.

Warning signs include:

3. Believing "I'll never drink again"
4. Worrying About Others Instead of Self
5. Defensiveness
6. Compulsive Behavior
7. Impulsive Behavior
8. Tendencies Towards Loneliness

Phase 3: Crisis Building: Begins experiencing a sequence of life problems that are caused by denying personal feelings, isolating self and neglecting the recovery program. Even though he/she wants to solve these problems and works hard at it, two new problems pop up to replace every problem that is solved.

Warning Signs include:

9. Tunnel Vision
10. Minor Depression
11. Loss of Constructive Planning
12. Plans Begin to Fail

Phase 4: Immobilization: Unable to initiate action. He/she goes through the motions of living, but is controlled by life rather than controlling life.

Warning signs include:

13. Daydreaming And Wishful thinking
14. Feeling That Nothing Can Be Solved
15. Immature Wish To Be Happy

Phase 5: Confusion and Overreaction: Can't think clearly. Becomes upset with self and others, becomes irritable and over reacts to small things.

16. Period of Confusion
17. Irritation With Friends
18. Easily Angered

Phase 6: Depression: Becomes so depressed that he/she has difficulty keeping to normal routines. At times there may be thoughts of suicide, drinking or drug use as a way to end the

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depression. The depression is severe and persistent and cannot be easily ignored or hidden from others.

Warning signs include:

19. Irregular Eating Habits
20. Lack of Desire to Take Action
21. Irregular Sleeping Habits
22. Progressive Loss Of Daily Structure
23. Periods of Deep Depression

Phase 7: Behavioral Loss of Control: Becomes unable to control or regulate personal behavior and a daily schedule. Heavy denial and no full awareness of being out of control. Life becomes chaotic and many problems are created in all areas of life and recovery.

Warning signs include:

24. Irregular Attendance At Treatment Meetings
25. Development of An "I Don't Care" Attitude
26. Open Rejection Of Help
27. Dissatisfaction With Life
28. Feelings Of Powerlessness And Helplessness Self-Pity

Phase 8: Recognition of Loss of Control: Denial breaks and suddenly he/she recognizes how severe the problems are, how unmanageable life has become, and how little power and control he/she has to solve any of the problems. This awareness is extremely painful and frightening. By this time he/she has become so isolated that there is no one to turn to for help

Warning Signs Include:

29. Self-Pity
30. Thoughts Of Social Drinking
31. Conscious Lying
32. Complete Loss Of Self-Confidence

Phase 9: Option reduction: Feels trapped by the pain and inability to manage his/her life. There seem to be only 3 ways out, insanity, suicide or drug use. He/she no longer believes that anyone or anything can help

Warning Signs include:

33. Unreasonable Resentments
34. Discontinuing All Treatment
35. Overwhelming Loneliness, Frustration, Anger And Tension

Phase 10: Acute Relapse Episode: Becomes totally unable to function normally. He/she may use alcohol or drugs or may become disabled with other conditions that make it impossible to function

Warning signs include:

36. Loss of Behavior Control
37. Acute Relapse Episode
 - Degeneration of all life areas

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- Alcohol or drug Use
- Emotional Collapse
- Physical Exhaustion
- Stress Related Illnesses
- Psychiatric Illness
- Suicide
- Accident Proneness
- Disruption of Social Structure

[Roleplay](#)

Substance Abuse: Working with Families During Case Planning and Relapse

Relapsing Client Case Study

Jonah is a 22-year-old male who has been in the recovery process for 14 months. You have had his case since he was 19, when he neglected his newborn baby by leaving him alone for the evening to go get high.

As a juvenile he was in foster care due to physical abuse in his home by his alcohol abusing parents. Jonah had been involved in heavy drug and alcohol use. He had used marijuana, cocaine, and alcohol up until the time he quit 14 months ago.

Since his involvement with you, he has been attending outpatient drug and alcohol counseling, attending Alcoholic's Anonymous (AA) meetings, and seeing a mental health representative. Recently you have begun to think about working towards reunification for Jonah and his child since he has been doing so well.

Up until the past month, his mental health representative has noticed a substantial amount of positive change in his attitudes, beliefs, and behavior. However over the past month, Jonah seems to be more withdrawn. He is still sporadically attending AA meetings, but he has not been open about discussing it, which was not the norm over the first 13 months of his recovery. His outpatient counselor has called you with the concern that he is beginning to reschedule his appointments, and always has an excuse.

His sponsor with AA has also noticed that he has begun to hang around with a different crowd, and his AA friends do not come over as often, if at all. Jonah has not acted too different when he has come in to the office for appointments, but he does at times seem to be in a hurry. You are concerned that he may again begin using drugs and alcohol. He has voluntarily submitted to drug testing and claims that he is not using, although he states that sometimes he was better off when he was using.

Jonah states that he wants to do well but things just do not work out for him and he thinks he will fail. He is concerned that he will be "no good" and turn out to be abusive like his father.

His work performance has begun to suffer and he is starting to show up late more often and call in sick more regularly. His employer states that, at times, he seems unfocused and that he does not work as hard as he used to. Jonah states that the boss is making a big deal out of nothing. He feels that it is not his fault if they do not know how to evaluate his work. He does not know why he needs to go listen to them all the time anyway. Jonah sees himself as one day working with children, but doesn't think he will get there because of what has happened to him. He feels that he would be better off if people would just leave him alone.

Jonah used to be more active in his AA meetings. However, as of late he thinks that he can do it on his own, and if he only uses occasionally, he could probably handle it. He does feel that if he could use occasionally it might help him to feel "normal again."

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Relapsing Client Case Study Evaluation

1. What are Jonah's problem areas?
2. What are the indicators of those problem areas?
3. What relapse triggers do you see facing Jonah?
4. What behaviors is Jonah showing that may indicate he is nearing or in a relapse episode?

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Community Resources with Relapse Prevention Planning

Stabilization

Assessment

Patient Education

Warning Signs Identification

Warning Sign Management

Recovery Planning

Inventory Training

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Family Involvement

.

Follow up

Roleplay

Originally Published In: Alcoholism & Addiction Magazine: Relapse - Issues and Answers: Column 3: How To Develop A Relapse Prevention Plan: By Terence T. Gorski, September 25, 1989; 708-799-5000, www.cenaps.com.

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Support Groups

Alcoholics Anonymous(AA) – Alcohol twelve step self-help program, free meetings, widely accessible

<http://www.aa.org>

Narcotics Anonymous(NA) – Same as AA but focuses on other drug problems <http://www.na.org>

Al-Anon/Alateen Family Groups – Self-help program for those who have been affected by a love ones drug and alcohol problem, AA model based. <http://www.al-anon.alateen.org>

Nar-Anon Family Groups – Drug counterpart to Al-Anon <http://nar-anon.org/index.html>

Adult Children of Alcoholics (ACA/AcoA) – Self-help group for those who grew up in families with alcoholism <http://www.adultchildren.org>

Rational Recovery Systems – Alternate self-help group based on Rational Emotive Therapy concepts

<http://www.rational.org>

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AA/NA 12 Steps

1. We admitted we were powerless over alcohol and that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of our higher power as we understood it.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to our higher power, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have our higher power remove all these defects of character.
7. Humbly asked our higher power to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with our higher power as we understood it for knowledge of our higher power's will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of those steps we tried to carry this message to others, and to practice these principles in all our affairs.

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Practical Skills for Interviewing a Relapsing Client

1.

Helping Traits

- ◆ . Empathy
- ◆ . Genuineness
- ◆ . Respect
- ◆ . Self-disclosure
- ◆ . Warmth
- ◆ . Immediacy
- ◆ . Concreteness
- ◆ . Confrontation

Active Listening Skills

- ◆ . Clear Listening
- ◆ . Reflecting
- ◆ . Ask Open Ended Questions
- ◆ . Use Effective Body Language
- ◆ . Watch for non-verbal cues

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Important Components of a Relapse Prevention Plan

Professional Monitoring

Are you involved in drug and alcohol treatment? With whom?

Self-Help Group Involvement

What self-help groups do you attend? How often?

Daily Inventories

What are your daily priorities? How do you track them? How do you deal with triggers that come up during the day?

Trigger Identification and Planning

What are your major triggers? How do you deal with them?

Personal Supports

Who do you have close to you that is supportive? Will they help you in crisis? How?

Physical Care

Do you exercise? Eat right?

Prompt Problem Solving

How do you problem solve? What is your plan to deal with daily life problems? Give examples...

Relaxation

What do you do for fun or leisure? How do you relax?

Spiritual Development

How do you meet your spiritual needs (not necessarily religious, meditation, relaxation, etc)

Balance Living

How do you define healthy relationships? How do you review if your plan is working?

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Client Role Play

Role Play #1

A 20 year old male client who has been in the recovery process for 3 months.

He is concerned because he is starting to have problems with his wife again and he relapsed last weekend while his wife was out by breaking into her medicine cabinet and taking her prescription sedatives. He does not want to continue the use. He has three children temporarily placed due to his drug use.

Role Play #2

A 26 year-old single mother of 3 who started hanging out with a negative peer group again.

She has been attending outpatient counseling, but just experienced a recent relapse by using marijuana.

She does not see it as that big of a deal, but can be convinced.

[Stabalization](#) Community Resources

[Phase 1: 37 Relapse Signs](#)

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Client Based Checklist To Assess Recovery Efforts And Prevent Relapse.

Please check the questions asked and indicate any comments applicable..
(page 1)

Check if applies	Question	Comments
	What changes have you made in your life? (Activities, church, friends, places you go or hang out?)	
	Have you been encountering triggers? Please explain.	
	What do you think about AA/NA?	
	Do you have a sponsor? Tell me about your sponsor.	
	When is your next A & D appointment?	
	Are you taking any medications? Prescription? Over the counter?	
	What is your normal daily schedule now?	
	How are you taking care of yourself?	
	What is your work schedule?	
	What have you learned about how your drinking/drug use has affected your children? How do you feel about that?	
	Has anything happened lately that made you depressed/sad? Please explain. What did you do about it?	
	What do you consider triggers? How are you dealing with them?	
	When is the last time you attended AA/NA?	
	How do you feel about AA/NA?	
	Are you attending 12-step meetings? What step are you on now? How many chips have you gotten? (Praise the chip level when appropriate)	
	When is the last time you went to a doctor? What did he prescribe?	
	What is the most important thing you have	

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<i>Check if applies</i>	<i>Question</i>	<i>Comments</i>
	learned in AA/NA?	
	Tell me about how you are eating and sleeping.	
	Who in your family is supporting/helping you? Who is helping/supporting you? How is your support system helping you?	
	Have you missed work lately? Please explain.	
	Have you made any new friends? Tell me about your friends.	
	What do you and your children do for fun?	
	Has anything happened lately that made you angry? Please explain. What did you do about it?	
	How has AA/NA helped you stay clean?	

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Questions to Ask Children/Teens

Check if applicable	Question	Comments
	How has AA/NA helped you stay clean?	
	What do you do when you get home from school?	
	Is your mom home at night?	
	What does your mom fix for you to eat?	
	What did your mom cook for dinner last night?	
	How is it going since your mom quit drinking (using)?	
	What time do you go to bed? Where do you sleep?	
	What have you done for fun lately with your mom?	
	Where have you gone for fun lately with your mom?	
	What family/friends do you and your mom have contact with?	
	What does your mom do when you misbehave?	
	How does your mom discipline you now?	
	Tell me about school. Have you missed school lately? How many days?	
	Have you been offered drugs/alcohol by anyone? Please explain.	
	Has anything happened in the last week/month that made you afraid? Please explain.	
	Who stays with you when your mom goes to AA/NA meetings?	
	What do you do when your mom goes to AA/NA?	
	How is your mom different since she started getting help for her drinking/drugs?	
	Have you been worried that your mom might start drinking/using again? (Explore reasons)	
	Is anything worrying you now? (Explore)	

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Constructing a Personalized Warning Sign List

1. Check three to five warning signs from the 37 Warning Signs List that apply to you.
2. In your own words, rewrite the summary title of the warning sign that you have checked. The summary title is the word or short phrase at the beginning of each warning sign.
3. Write a brief paragraph that describes in your own words each of the warning signs that you have selected.
4. Read your warning signs (as you have written them) to an addictions counselor, your A.A. sponsor, or a friend, and ask for feedback.
5. Rewrite the warning signs if they are unable to understand clearly what you mean.
6. Review the list every morning and every evening to remind yourself to look for the presence of these warning signs.
7. Discuss the list with your friends and family and ask them to tell you if they see any of the warning signs appearing in your life.
8. If you notice a warning sign, evaluate your need to get help.

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Daily Inventory Worksheet

(Use the daily inventory to review your relapse prevention plan and look at relapse warning signs you experienced during the day, and how you handled them)

1. What high-risk situations did you have today?
2. How did you handle them?
3. What warning signs did you have for today?
4. How did you handle them?
5. I need to talk to _____ to help me deal with these.
6. What did I learn about myself today?
7. What do I need to do differently tomorrow to make things better?

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Self-Blackmail Letter Example

(This letter is written and then given to a positive support person to give to the person's sponsor, counselor, caseworker or probation officer in the case that the recovering person has a relapse episode and needs help.)

Dear Sponsor, Counselor, Caseworker or Probation Officer,

If you are reading this letter then I am in a relapse episode and need help. Please assist me by any means possible in stopping my active use, because I am at risk to harm myself, my loved ones, or others. I am writing this letter of my free will and give you consent to help me, even if it means legal sanctions for myself, including being incarcerated, placed in detox or placement.

Thank you for this help. I may not like the results at first, but it is for my own good.

With hope for sobriety,

XXXXXXXXXXXX

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Eight Steps to Lowering Risks

1. Admit when you are wrong.
2. Be aware of what you are doing.
3. Change what you are doing if it puts you at risk.
4. Acknowledge, apologize, and make amends for problems you have caused.
5. Identify problems.
6. Clarify problems.
7. Think out the alternatives.
8. Make a decision and follow through on the action.

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Brainstorm Worksheet

(Feel free to go wild. Brainstorm any other ideas that you feel will help a person who is relapsing.)

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VISITATION WITH SUBSTANCE ABUSING PARENTS

General Rules for Visits with Parents Who Are Addicted

- Substance abuse, by itself, is not child abuse or neglect. It is the impact the substance abuse has on the parents abilities that may result in abuse or neglect.
- Denial of **any** type of visit or contact should only occur in extreme situations.
- It is *highly* recommended that the substance abuse treatment professional be a part of the case planning team to ensure case and visitation plans are based on accurate knowledge related to parent's specific form of addiction(s).
- The vast majority of children removed from substance abusing parents are removed for neglect. These parents are not likely to physically or sexually abuse their child during a visit.
- Visits are NOT to be used as a reward or punishment for either the parent or child.
- Generally, the parent should be in substance abuse treatment before the level of supervision is lowered from supervised to observed or unsupervised.
- There should be a **safety plan** for the child and a **relapse plan** for the parent, shared with all parties, which will ensure that the child will be safe even after a parent appears to be maintaining sobriety.
- Most of these children will be reunited with their parents. There is never a guarantee that an addicted person will never relapse. Progressive visitation planning allows us to assess if the safety and relapse plan will work.

Urine analysis

What UAs do NOT tell us:

- The level of intoxication – some drugs will test positive days and weeks after the last use.
- The ability of the parent to behave in a safe manner during the visit.
- Whether a parent with a clean UA is able to be safe or appropriate during a visit.
 - Dual diagnosed patients may be more unsafe when not self-medicating.
- Whether or not the person is actually drug free.
 - There are many ways to cheat the test.
 - Even medical doctors often fail at performing the test correctly.
 - Whether or not the person took the drug after the test but before or during the visit.
 - The person may have taken a drug not covered by that test, i.e., legal drugs.

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How to Have a Safe Visit with Addicted Parents

- Have a **visitation plan** that specifically addresses what is allowed and not allowed during the visit.
- List behaviors that are unsafe or not allowed – be specific.
- Just saying, “do not be drunk or high” is NOT clear or specific.
- List indicators that parent is high during the visit – get expert opinion.
- State the process of what will occur if a parent violates visitation rules.
- Usually, the first violation leads to discussion between case manager and parent outside the room – teaching parent what to do.
- Multiple violations can lead to premature end of the visit. Parent is asked to go back to child to explain why the visit must stop and to say goodbye.
- When there are behaviors that place anyone in danger, the visit stops *immediately*, and the child may not have a chance to say goodbye. The child should be told why the visit had to be terminated.
- Safety plan: Have a method for the parent to ask for help or ask questions that do not embarrass the parent in front of the child. This plan would include the following:
 - ◆ Resources for the addicted parent to call for help at any time
 - ◆ Resources for an older child to call for help if the parent is not providing safe care
 - ◆ Family and community members who regularly check on the well-being of the parent and child
- Work with the substance abuse specialist
 - ◆ Get a copy of the client’s relapse plan. This should include identification of the following:
 - Triggers – internal or external events (not always observable to others)
 - Warning signs – Observable: thoughts, speeches and behaviors
 - Who is in position to notice these signs (family, therapist, case manager, co-workers) – All of these people should be a part of the relapse plan
 - Aftercare Service Plan
 - Communication plan for the child welfare and drug treatment professionals to give parents clear consistent messages
 - A support network to include self-help sponsors and peer counseling
 - A personal recovery plan including coping skills for those situations which are problematic, e.g. holidays
 - ◆ Coordination of child’s permanency plan and parent’s substance abuse treatment plan:
Divorce order, domestic violence order, and treatment plans may also be necessary
- Meet with parent before the visit starts:
 - ◆ Use time to discuss case plan and progress.
 - ◆ Assess parent’s ability to interact safely with his/her child.
 - ◆ Remind parent of rules and purpose of the visit.

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- ◆ Reassure parent that visits can be difficult for them but the main purpose of the visit is to meet the child's needs – give parent exemplars of what to do.
- During visits:
 - ◆ Supervisor/observer must be able and willing to ensure safety.
 - ◆ Everyone involved in the visit must know the rules including caregivers and others whose involvement may be limited to driving the child.
 - ◆ Supervisor of visit must have clear guidelines and document the visit so that the case manager can adequately assess the parent's progress.
 - ◆ Case manager should observe a visit at least once a month.
- Debrief after visits:
 - ◆ Meet with the parent and provide strengths-based feedback.
 - ◆ Address any problems NOW while they are small.
 - ◆ Case manager *talks* to person who supervised the visit.
- Location of the Visit:
 - ◆ Have the visit in a safe environment that is the most homelike as possible.
 - ◆ It is best to have the visits where the child is comfortable: foster home, school, home of a relative, parent's home. The child is more likely to notice unusual behaviors in these locations
 - ◆ Before the visit, check the location for safety and drugs, if needed.
 - ◆ Eventually, most children of addicted parents do go home to the parent. Having supervised visits in the parents home is ESSENTIAL before unsupervised visits can occur.
- Visits are a **progressive process**
- State the connection between the addiction and the child abuse and neglect.
 - ◆ In a clear, non-judgmental manner, make sure the parent and others know how the two behaviors are connect. (Ms. Jones, when you used meth, your child was harmed when you...)
 - ◆ Case plans should clarify this connection and state what behaviors will indicate safe parenting.
 - Do not *only* measure attendance in treatment and clean UAs.
 - Measure changed behaviors and ability to maintain safe parenting even while under stress.
- Identify people in the parent's support system who can do the following:
 - ◆ Watch for triggers and report concerns to case manager or SA therapist.
 - ◆ Support the parent in maintaining sobriety and healthy life changes
 - ◆ Be available, if needed, to help with relapse crisis or provide safety for the child. (Someone who is available after-hours and whom all parties can trust.)
- Maintain highly supervised visits until these items occur:
 - ◆ The Substance Abuse therapist states that a parent is maintaining sobriety and is in real recovery, **and**
 - ◆ During supervised visits the parent demonstrates safe parenting and good interactions with the child, **and**

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- ◆ During supervised visits “normal” daily stresses have occurred, especially ones that may be triggers, and the parent has reacted appropriately.
- ◆ ***The level of supervision is related to safety and NOT to the progress of drug treatment!!***

Parents who are sober and have completed drug treatment but who cannot maintain safe parenting during visits should NOT be allowed to have their visits progress towards reunification.

- Children should...
 - ◆ Be told about their parent’s addiction in an age-appropriate way.
 - ◆ Be told about the warning signs and know adults to whom they can report any concerns.
 - ◆ Have a safety plan – even for supervised visits.
 - Signal to supervisor of visit that the child wants a break.
 - The child has a phone number and method of contacting a safe person if the visit is unsupervised.
 - ◆ Always talk to the child after the visit to evaluate for any problems or concerns.

Permanency Goals

Reunification

Adoption

Guardianship

Fit and Will Relative

**Another Planned Permanent
Living Arrangement (APPLA)**

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THE STAGES OF CHANGE: CASE MANAGER TASKS AND SKILLS

PRE-CONTEMPLATION	CONTEMPLATION	PREPARATION	ACTION	MAINTENANCE	RELAPSE
<ul style="list-style-type: none"> • Engage the person • Diffuse the crisis • Assess safety concerns • Show empathy and caring • Provide needed services in areas besides SA • Assess strengths and values • Build a relationship • Affirm the individual's strengths and capacity to the point he or she feels competent to change if he or she wishes to do so • Provide information and feedback on the possible risks of behavior to raise the awareness of the possibility of change • Listen for windows of opportunity where the person talks about problems, concerns and need to change • Provide specific information to the person. 	<ul style="list-style-type: none"> • Help tip the balance to favor change • Evoke reasons to change and risks of not changing • Continue to strengthen the client's self-efficacy • Strategically use open-ended questions, affirmations, and summarizing • Have the person voice the problem, concern, and intention to change • Have the person self assess values, strengths, and needs. 	<ul style="list-style-type: none"> • Facilitate the development of a vision for their future • Provide information on all available options • Explore all available options, and the benefits and consequences of each. • Help the person set specific goal(s). • Help the person develop the plan. • Help the person choose strategies to use, resources needed, and potential barriers to the plan. 	<ul style="list-style-type: none"> • Introduce and practice coping strategies to avoid, change, replace, or change a client's reactions to triggers and conditions leading to use • Suggest methods, provide support in trying them out, and help evaluate the effectiveness of those methods. • Keep steps small and incremental • Teach skills. • Access resources for the person's use. • Reward small steps of progress. • Assess success. • Make necessary changes in the Permanency Plan as the person continues to progress. 	<ul style="list-style-type: none"> • Assist in sustaining changes accomplished by the previous actions. • Help the person to develop the skills and self-efficacy to build a new life. • Build relapse roadmaps. • Prepare crisis plans for when a relapse might happen • Review warning signs of a possible slip or relapse • Help the person connect to other support systems for a healthier lifestyle 	<ul style="list-style-type: none"> • Assist in processing the emotions resulting from the slip. • Help the person understand what happened to lead to another slip • Help the person process the experience and use the slip as a learning experience • Review the Permanency Plan and commitment to continue • Adjust the plan as needed. • Implement the plan (as adjusted)

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Case Scenario: Jose

Megan is 22 years old and has just given birth to her son, Jose, who tested positive for methamphetamine and cocaine. Megan offered to hospital staff that she has been actively using and is concerned about the health of her child. Megan is not married to Jose's father, Juan, but he is at the hospital and signs an acknowledgement of paternity.

Megan's parental rights were terminated voluntarily to another child three years ago after that child was born testing positive for cocaine and Megan had not been successful in completing a drug treatment program. Megan's sister, Anne, has adopted that child but isn't certain about how involved she wants to be with Jose.

Juan has a four year old son with another woman. He does not see his son often, maybe once or twice a year. He is upset by that arrangement, stating the child's mother does not allow him more frequent access.

Megan was involved with social services as an adolescent, having run away from home a number of times. A number of assessments speculate that Megan may have fetal alcohol spectrum disorder but no official testing was completed.

Juan is currently employed full-time at a local factory. He is living in an apartment with two other men. He has a history of marijuana use and states that he continues to use marijuana and doesn't think that should be an issue. He states he would like to live with Megan and Jose as a family and that he will do whatever is needed for that to happen.

Megan has two other siblings, one of which is a minor. The other one, her brother, is 30 years old. He is married and has two children and states he would be a placement resource, both short-term and long-term. He has a felony level drug conviction on his criminal record that is ten years old. He has no other legal issues. Megan is living with her brother. Megan's mother also lives in the home.

Jose seems to be going through withdrawal. He is irritable most of the time. Many times during the day his body becomes stiff, he shakes and he cries inconsolably. Nothing seems to soothe him. He eats only small amounts and vomits at almost every feeding.

From this point, in your group, make up the scenario

- Identify who should participate in writing the plan at the FTM (formal supports, informal supports, including paternal family)
- Identify functional strengths of the family
- Identify risk and safety concerns to ensure they are addressed in the plan
- Identify goals case manager would support
- Identify possible steps you would suggest at the FTM
- Identify what aspects of concurrent planning could be included during the "assess what could go wrong" stage of the FTM
- Project a possible outcome for the scenario

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Considerations while Writing the Plan

- Who you invite to the table to write the plan; and, how?
- Family strengths and needs
- Educational level to which you write the plan
- What are the risk and safety concerns?
- Identify goals to support
- Suggest steps
- What aspects of concurrent planning could be included?
- What services and timeframes will you (and hopefully the family) use to try to ensure Jose's reunification and/or safety, permanency, and well-being in his alternate placement?
- Why will you suggest certain services?
- How will you try to ensure that the services link to the permanency goals?
- Formal or informal resources planned for use
- For treatment services, what considerations must you make before asking family members to attend treatment sessions?
- Visitation
- Will ASFA mandates play a role in any of your decisions?
- How will you develop the plan considering relapse and the stages of change?

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Transfer of Learning

What are two concepts you learned that you might apply immediately to your casework?

What are three concepts you plan to share with your supervisor?

When applicable, which resources/handouts from your training do you plan to share with co-workers?

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Additional Resources

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INDICATORS FOR PROGRESS IN THE SUBSTANCE ABUSE RECOVERY PROCESS: ZERO TO THREE MONTHS				
0-3 Months	Poor Progress	Some Progress	Moderate Progress	Substantial Progress
Substance Abuse Treatment	Parent remains in denial of substance abuse/addiction and has not completed substance abuse screen	Reduction of initial resistance and defensiveness ↓ Completed Adult Substance Abuse Screen ↓ Parent has completed substance abuse assessment and has accepted treatment referral ↓ Parent has entered substance abuse treatment ↓ Sporadic attendance in substance abuse treatment	Attendance in substance abuse treatment becomes more consistent. Improvements in personal hygiene	Regular attendance in substance abuse treatment ↓ Parent has accepted the negative consequences of substance abuse ↓ Parent is thinking more clearly and is able to verbalize consequences of continued substance abuse ↓ If applicable, parent has participated in a planning meeting with case manager and substance abuse treatment provided If parent is ready for discharge: Parent has developed relapse prevention plan. Parent has developed aftercare plans. If parent has been discharged: Parent is attending after care services at a treatment facility and or attending self-help or community support groups
Substance Abuse Education	Parent remains in denial of substance abuse and has not entered treatment/substance abuse education classes.	Parent has recently entered substance abuse treatment and substance abuse education classes.	Attending substance abuse education classes on addiction and recovery. Acknowledges need for insight into personal addiction	Parent is receiving or has completed substance abuse education classes. Has gained insight into personal addiction. Parent is able to discuss the impact of substance abuse on parenting behaviors.
Participation in Recovery Support System	No current participation	Has received education on 12 Step/Recovery Support Group meetings	Has mapped out 12 Step (AA/CA/NA) or community recovery support group	Has attended a 12 Step/support group at the treatment program <ul style="list-style-type: none"> • All clients are not ready to participate in 12 Step/support groups during the early months of treatment/recover

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INDICATORS FOR PROGRESS IN THE SUBSTANCE ABUSE RECOVERY PROCESS: ZERO TO THREE MONTHS				
0-3 Months	Poor Progress	Some Progress	Moderate Progress	Substantial Progress
Abstinence	Actively abusing drugs	Parent has decreased substance abuse Parent is able to self report relapse	Fewer episodes of relapse and is able to discuss triggers.	Parent has developed a specific relapse prevention plan. Parent may have achieved abstinence.
Other Service Plan Provision Compliance	Parent is non-compliant with service plan: Visiting with workers Other assessments	Parent is inconsistent in meeting service plan conditions	Parent is consistently working on service plan conditions.	Parent is currently in compliance with service plan conditions
Visiting	Parent does not visit child(ren).	Parent inconsistently visits child(ren)	Parent consistently visits child(ren)	Parent consistently visits child(ren)
Parental Skills/ Parental Functioning	A parent who retains custody of the child must follow a child safety plan but may not acknowledge the impact of substance abuse on parenting			Parent may begin to identify the impact of substance abuse on parenting

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INDICATORS FOR PROGRESS IN THE SUBSTANCE ABUSE RECOVERY PROCESS: THREE TO SIX MONTHS				
3-6 Months	Poor Progress	Some Progress	Moderate Progress	Substantial Progress
Substance Abuse Treatment	<p>No current participation in substance abuse treatment.</p> <p>Parent may have initially engaged in treatment but left against staff advice.</p>	<p>Parent is inconsistent in attending substance abuse treatment.</p> <p style="text-align: center;">↓</p> <p>Within this time frame the parent could become more consistent.</p> <p>Improvements in personal hygiene.</p>	<p>Parent's continued progress is demonstrated in:</p> <ul style="list-style-type: none"> • Consistent attendance • Ability to identify triggers • Self report of drug free time, meeting attendance, and certificates of achievements • Improvement in personal hygiene and self esteem • Greater insight into substance abuse / addiction • Developed a specific relapse prevention plan 	<p>Parent's attendance in substance abuse treatment is consistent and has demonstrated compliance with treatment plan and is preparing for discharge. Developing and discussing aftercare plans with treatment provider (may occur at this time due to extended length of stay or residential treatment).</p> <p><i>If parent has been discharged:</i> Parent is consistently participating in after care services and working with a specific relapse prevention plan.</p>
Participation in Recovery Support System	<p>No current participation in recovery support groups</p>	<p>Attends initial recovery support meeting (AA/CA/NA meetings or support group meetings).</p>	<p>Increased attendance in AA/CA/NA meetings or support group meetings.</p> <p>Working on Stages 1 and 2 of the 12 Steps of AA/NA; parent is able to discuss the process of recovery</p> <p>Parent is letting go of relationships with substance abusers and developing sober friendships</p>	<p>Regular attendance in self help meetings</p> <p>Developing relationships with recovering role models/mentors</p> <p>Parent has chosen 12 Step Sponsor or community support person</p> <p>Increasing involvement in drug free activities, recovery support systems, sober relationships and/or community activities.</p>
Abstinence	<p>Parent is currently abusing drugs.</p>	<p>Parent is able to self report relapse. Fewer episodes of relapse and the parent is able to discuss triggers.</p>	<p>Parent has recently achieved abstinence. (At least 30 days)</p>	<p>Parent has achieved a sustained period of abstinence.</p>
Service Plan Compliance	<p>Parent is noncompliant with service plan:</p> <ul style="list-style-type: none"> • Visiting with worker • Other 	<p>Parent is inconsistent in meeting service plan conditions.</p>	<p>Parent is consistently working on service plan conditions</p>	<p>Parent is currently in compliance with service plan conditions</p>

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INDICATORS FOR PROGRESS IN THE SUBSTANCE ABUSE RECOVERY PROCESS: THREE TO SIX MONTHS				
3-6 Months	Poor Progress	Some Progress	Moderate Progress	Substantial Progress
	assessments			
Visiting	Parent inconsistently visits with child(ren)	Parent is consistent in visits with child(ren)	Parent demonstrates increased parenting responsibility during visits	Parent demonstrates increased parenting responsibility during visits
Parental Skills/ Parental Functioning	Parent is unwilling or unable to acknowledge impact of drug use on parenting	Parent begins to acknowledge the impact of drug use on parenting	Parent acknowledges impact of drug use on parenting and identifying parenting deficits.	Parent is able to identify parenting deficits and strengths. Parent is developing parenting goals

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INDICATORS FOR PROGRESS IN THE SUBSTANCE ABUSE RECOVERY PROCESS: SIX TO NINE MONTHS				
6-9 Months	Poor Progress	Some Progress	Moderate Progress	Substantial Progress
Substance Abuse Treatment	Currently not participating in substance abuse treatment (parent left treatment).	Parent is more consistent in attendance. Parent is able to identify triggers. Self report of drug free time, meeting attendance, and certificates of achievements. Continued improvement in personal hygiene and self-esteem. Parent has gained greater insight into substance abuse/addiction.	Consistent attendance in substance abuse treatment; has demonstrated compliance with treatment plan. Verbalizes a greater awareness of intense emotions and triggers. Uses new coping skills learned in substance abuse treatment or 12 Step support groups. Has developed a specific relapse prevention plan. Developing/discussing aftercare plans with treatment provider (may occur at this time due to extended length of stay or residential treatment).	Regular attendance in formal substance abuse treatment. Parent has entered after care services. Parent consistent in follow through with after care services. Parent is consistently working on relapse prevention plans.
Participation in Recovery Support System	No current participation in recovery support groups.	Attends 12 Step recovery support meeting or community support groups. ↓ Has increased participation in self help meetings or community recovery support groups. ↓ Has chosen sponsor	Consistently working on the 12 Steps program with sponsor /consistently attending community support. Actively working on relapse prevention with after care provider, sponsor or recovery support person Parent is working on parenting goals.	Parent is consistently working 12 Step program, attending self help meetings, and maintaining contact with sponsor. ↓ Parent is applying Steps 1-3 in daily life (AA/CA/NA). ↓ Parent is discussing long term goals and setting time frames with support persons.
Abstinence	Parent is currently abusing drugs	Parent has decreased substance abuse and self reports relapse. Has fewer episodes of relapse and has developed a specific relapse prevention plan.	Parent has recently achieved abstinence. Parent has sustained periods of abstinence	Parent continues to maintain abstinence
Service Plan Compliance	Parent is noncompliant with service plan.	Is inconsistent in meeting service plan conditions.	Is consistently working on service plan conditions.	Parent is currently in compliance with service plan conditions.
Visiting	Parent inconsistently visits child(ren).	Parent consistent in visits with child(ren).	Consistently visiting child(ren) and demonstrating increased parenting responsibility during visits (if applies).	Parent consistently visiting child and demonstrating increased parenting responsibility during visits (if applicable).

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INDICATORS FOR PROGRESS IN THE SUBSTANCE ABUSE RECOVERY PROCESS: SIX TO NINE MONTHS				
6-9 Months	Poor Progress	Some Progress	Moderate Progress	Substantial Progress
Parental Skills/ Parental Functioning	Parent is unwilling or unable to acknowledge impact of drug use on parenting.	Parent begins to acknowledge the impact of drug use on parenting. ↓ Acknowledges impact of drug use on parenting.	Parent identifies parenting deficits and strengths and sets parenting goals Parent is working on parenting goals.	Parent is working on parenting goals. ↓ Parent is achieving one or more parenting goal.

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INDICATORS FOR PROGRESS IN THE SUBSTANCE ABUSE RECOVERY PROCESS: NINE TO TWELVE MONTHS			
9-12 Months	Poor Progress	Some to Moderate Progress	Substantial Progress
Participation in Recovery Support System	<p>Parent does not currently participate in mutual help/ recovery support groups.</p> <p>Parent is not actively engaged with a sponsor</p>	<p>Parent has increased participation in mutual help/ recovery support groups.</p> <p style="text-align: center;">↓</p> <p>Has chosen sponsor.</p> <p style="text-align: center;">↓</p> <p>Has made more consistent contact with sponsor.</p> <p style="text-align: center;">↓</p> <p>Works on the 12 Steps program with sponsor.</p> <p style="text-align: center;">↓</p> <p>Actively works on relapse prevention with after care provider, sponsor or recovery support person.</p>	<p>Parent consistently participates in mutual help meetings/ recovery support groups.</p> <p style="text-align: center;">↓</p> <p>Consistently working on the 12 Step program with sponsor or with a community support person.</p> <p style="text-align: center;">↓</p> <p>Parent is engaged in sober relationships and activities.</p> <p style="text-align: center;">↓</p> <p>Has accepted the maintenance phase of recovery is a lifelong responsibility.</p>
Abstinence	<p>Parent is currently abusing drugs.</p>	<p>Fewer episodes of relapse and the parent has developed a specific relapse plan.</p> <p style="text-align: center;">↓</p> <p>Parent has recently achieved abstinence.</p>	<p>Parent has sustained periods of abstinence.</p> <p style="text-align: center;">↓</p> <p>Parent continues to maintain abstinence.</p>
Service Plan Compliance	<p>Parent is non-compliant with service plan.</p>	<p>Parent is inconsistent in meeting service plan conditions. (i.e. Attending parent training, counseling, keeping assessment appointments.)</p>	<p>Parent is consistently working on service plan conditions.</p>
Visiting	<p>Parent inconsistently visits child(ren).</p>	<p>Parent consistently visits child</p>	<p>Parent demonstrates increased parenting responsibility during visits (if applicable).</p>
Parental Skills/ Parental Functioning	<p>Parent is unwilling or unable to acknowledge impact of drug use on parenting.</p> <p>Parent beginning to acknowledge the impact of drug use on parenting.</p>	<p>Parent acknowledges impact of drug use on parenting.</p> <p style="text-align: center;">↓</p> <p>Parent identifies parenting deficits and strengths and sets parenting goals.</p> <p style="text-align: center;">↓</p> <p>Parent is working on parenting goals.</p> <p style="text-align: center;">↓</p> <p>Parent is demonstrating improved parental functioning.</p>	<p>Parent maintains improved parenting functioning and continuing to work on parenting goals.</p>
Interpersonal Relationships	<p>No attempts to address interpersonal conflicts with family members</p>	<p>Minimal attempts to address interpersonal conflicts with family members.</p>	<p>Parent is actively addressing interpersonal conflicts with family members.</p>
Skill Building	<p>No participation in skill building training.</p>	<p>Parent has entered skill building training.</p>	<p>Parent consistently participates in skill building training.</p>

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An Introduction to Mutual Support Groups for Alcohol and Drug Abuse

Center for Substance Abuse Treatment. (2008). An Introduction to Mutual Support Groups for Alcohol and Drug Abuse. *Substance Abuse in Brief Fact Sheet*, Volume 5, Issue 1. Rockville, MD: Substance Abuse and Mental Health Services Administration. DHHS Publication No. (SMA) 08-4336 Printed 2008

Mutual support (also called self-help) groups are an important part of recovery from substance use disorders (SUDs). Mutual support groups exist both for persons with an SUD and for their families or significant others and are one of the choices an individual has during the recovery process. This issue of *Substance Abuse in Brief Fact Sheet* will help healthcare and social service providers understand the effect of mutual support groups on recovery, become familiar with the different types of mutual support groups available, and make informed referrals to such groups.

Mutual Support Groups

Mutual support groups are nonprofessional groups comprising members who share the same problem and voluntarily support one another in the recovery from that problem. Although mutual support groups do not provide formal treatment, they are one part of a recovery-oriented systems-of-care approach to substance abuse recovery. By providing social, emotional, and informational support for persons throughout the recovery process, mutual support groups help individuals take responsibility for their alcohol and drug problems and for their sustained health, wellness, and recovery. The most widely available mutual support groups are 12-Step groups, such as Alcoholics Anonymous (AA), but other mutual support groups such as Women for Sobriety (WFS), SMART Recovery® (Self-Management and Recovery Training), and Secular Organizations for Sobriety/Save Our Selves (SOS) are also available.

12-Step Groups

Twelve-Step groups emphasize abstinence and have 12 core developmental “steps” to recovering from dependence. Other elements of 12-Step groups include taking responsibility for recovery, sharing personal narratives, helping others, and recognizing and incorporating into daily life the existence of a higher power. Participants often maintain a close relationship with a sponsor, an experienced member with long-term abstinence, and lifetime participation is expected.

AA is the oldest and best known 12-Step mutual support group. There are more than 100,000 AA groups worldwide and nearly 2 million members. The AA model has been adapted for people with dependence on drugs and for their family members. Some groups, such as Narcotics Anonymous (NA) and Chemically Dependent Anonymous, focus on any type of drug use. Other groups, such as Cocaine Anonymous and Crystal Meth Anonymous, focus on abuse of specific drugs. Groups for persons with co-occurring substance use and mental disorders also exist (e.g., Double Trouble in Recovery; Dual Recovery Anonymous). Other 12-Step groups—Families Anonymous, Al-Anon/Alateen, Nar-Anon, and Co-Anon—provide support to significant others, families, and friends of persons with SUDs. Twelve-Step meetings are held in locations such as churches and public buildings. Metropolitan areas usually have specialized groups, based on such member characteristics as gender, length of time in recovery, age, sexual orientation, profession, ethnicity, and language spoken.⁴ Attendance and membership are free, although people usually give a small donation when they attend a meeting.

Meetings can be “open” or “closed”—that is, anyone can attend an open meeting, but attendance at closed meetings is limited to people who want to stop drinking or using drugs. Although meeting formats vary somewhat, most 12-Step meetings have an opening and a closing that are the same at every meeting, such as a 12-Step reading or prayer. The main part of the meeting usually consists of (1) members sharing their

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stories of dependence, its effect on their lives, and what they are doing to stay abstinent, (2) the study of a particular step or other doctrine of the group, or (3) a guest speaker.

Twelve-Step groups are not necessarily for everyone. Some people are uncomfortable with the spiritual emphasis and prefer a more secular approach. Others may not agree with the 12-Step philosophy that addiction is a chronic disease, thinking that this belief can be a self-fulfilling prophecy that weakens the ability to remain abstinent. Still others may prefer gender specific groups.

Mutual support groups that are not based on the 12-Step model typically do not advocate sponsors or lifetime membership. These support groups offer an alternative to traditional 12-Step groups, but the availability of in-person meetings is more limited than that of 12-Step programs (see individual group descriptions below). However, many offer literature, discussion boards, and online meetings.

Women for Sobriety

WFS is the first national self-help group solely for women wishing to stop using alcohol and drugs. The program is based on Thirteen Statements that encourage emotional and spiritual growth, with abstinence as the only acceptable goal. Although daily meditation is encouraged, WFS does not otherwise emphasize God or a higher power. The nearly 300 meetings held weekly are led by experienced, abstinent WFS members and follow a structured format, which includes reading the Thirteen Statements, an introduction of members, and a moderated discussion.

SMART Recovery

SMART Recovery helps individuals become free from dependence on any substance. Dependence is viewed as a learned behavior that can be modified using cognitive behavioral approaches. Its four principles are to (1) enhance and maintain motivation to abstain, (2) cope with urges, (3) manage thoughts, feelings, and behaviors, and (4) balance momentary and enduring satisfactions. At the approximately 300 weekly group meetings held worldwide, attendees discuss personal experiences and real-world applications of these SMART Recovery principles. SMART Recovery has online meetings and a message board discussion group on its Web site.

Secular Organization for Sobriety/Save Our Selves

SOS considers recovery from alcohol and drugs an individual responsibility separate from spirituality and emphasizes a cognitive approach to maintaining lifelong abstinence. Meetings typically begin with a reading of the SOS Guidelines for Sobriety and introductions, followed by an open discussion of a topic deemed appropriate by the members. However, because each of the approximately 500 SOS groups is autonomous, the meeting format may differ from group to group. SOS also has online support groups, such as the SOS International E-Support Group (<http://health.groups.yahoo.com/group/sossaveourselves>) and the SOS Women E-Support Group (<http://groups.yahoo.com/group/SOSWomen>).

LifeRing Secular Recovery

Originally part of SOS, LifeRing is now a separate organization for people who want to stop using alcohol and drugs. The principles of LifeRing are sobriety, secularity, and self-help. LifeRing encourages participants to develop a unique path to abstinence according to their needs and to use the group meetings to facilitate their personal recovery plan. LifeRing meetings are relatively unstructured; attendees discuss what has happened to them in the past week, but some meetings focus on helping members create a personal recovery plan. Although there are fewer than 100 meetings worldwide, LifeRing has a chat room, e-mail lists, and an online forum that provide additional support to its members.

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The Effectiveness of Mutual Support Groups

Research on mutual support groups indicates that active participation in any type of mutual support group significantly increases the likelihood of maintaining abstinence.⁶ Previous research has shown that participating in 12-Step or other mutual support groups is related to abstinence from alcohol and drug use. An important finding is that these abstinence rates increase with greater group participation. Persons who attend mutual support groups have also been found to have lower levels of alcohol- and drug-related problems. Another benefit of mutual support group participation is that “helping helps the helper.” Helping others by sharing experiences and providing support increases involvement in 12-Step groups, which in turn increases abstinence and lowers binge drinking rates among those who have not achieved abstinence.

Facilitating Mutual Support Group Participation

If a healthcare or social service provider suspects that a patient or client has an SUD, the provider should ensure that the client receives formal treatment. Once the client receives formal treatment—or if he or she refuses or cannot afford treatment—the provider’s next step is to facilitate involvement in a mutual support group. Matching clients to treatment based solely on gender, motivation, cognitive impairment, or other such characteristics has not been proved to be effective. Clients who are “philosophically well matched” to a mutual support group are more likely to actively participate in that group.⁶ Thus, the best way to help a client benefit from mutual support groups is to encourage increased participation in his or her chosen group.

Providers can increase their knowledge of mutual support groups, and thus their ability to make informed referrals, by doing the following:

- ◆ Become familiar with the different types of support groups and their philosophies. Most groups’ Web sites describe their philosophies and have online publications (see list of mutual support group Web sites at the end of the article).
- ◆ Determine which groups are active locally. Most groups’ Web sites have meeting locator services.
- ◆ Find out about the different types of meetings available within local mutual support groups (e.g. which meetings are for women only).
- ◆ Establish contacts in local mutual support groups. AA and NA in particular have committees whose members work with healthcare and social service providers to get clients to meetings and to provide information to providers.
- ◆ Attend open meetings to expand knowledge of mutual support groups and how local meetings are conducted.

Understanding the needs and beliefs of clients with SUDs helps providers make informed referrals. Providers should find out clients’ experiences with mutual support groups, their concerns and misconceptions about mutual support groups, and their personal beliefs. Persons who agree with the group’s belief system are more likely to participate and, thus, more likely to have better outcomes.⁶ For example, having strong religious beliefs is related to greater participation in the spiritually based 12-Step programs and WFS. In contrast, religiosity was less effective in increasing participation in SMART Recovery groups and decreased participation in SOS. Whether the client is participating in medication assisted treatment (MAT) is another consideration when making a referral to a mutual support group, because some groups may be more supportive of MAT than others. For example, individuals being treated with methadone for opioid dependence may be more comfortable attending a meeting of Methadone Anonymous, whose members understand the benefits of opioid pharmacotherapy.

To improve the client’s chances of attending a meeting, providers can:

- ◆ Present more than one choice when making referrals and encourage clients to attend several meetings before making any judgments about the groups. Clients should be encouraged to attend different groups until they find one in which they are comfortable.

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- ◆ Initiate the first conversation between a client and a support group contact person. Having a mutual support group member speak to a client by phone during the office visit may increase the likelihood that the client will attend the support group meeting.
- ◆ Refer family members or others who may be affected by the client's substance use. Their involvement may encourage participation by providing social support (see list of mutual support group Web sites for families, friends, and significant others at the end of the article.)

Once clients are attending a group they are comfortable with, the provider should actively encourage the clients' support group experiences by scheduling follow-up visits to talk about their experiences and providing positive feedback. Clients should be asked about details—how many meetings are they attending, do they have a sponsor, are they abstinent. Gentle, positive encouragement will likely increase participation. Providers should watch for signs of an impending relapse, such as a reluctance to discuss group participation or periods of extreme stress. By offering knowledgeable advice and informed referrals and taking an ongoing, active interest in clients' support group experiences, providers can make a difference in their clients' recovery.

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RESOURCES

For People Who Have a Substance Use Disorder

Alcoholics Anonymous: <http://www.alcoholics-anonymous.org>

Chemically Dependent Anonymous: <http://www.cdaweb.org>

Cocaine Anonymous: <http://www.ca.org>

Crystal Meth Anonymous: <http://www.crystalmeth.org>

Heroin Anonymous: <http://www.heroin-anonymous.org>

LifeRing Secular Recovery: <http://www.unhooked.com>

Marijuana Anonymous: <http://www.marijuana-anonymous.org>

Methadone Anonymous: <http://www.methadone-anonymous.org>

Narcotics Anonymous: <http://www.na.org>

Secular Organizations for Sobriety/SaveOur Selves: <http://www.sossobriety.org>

SMART Recovery: <http://www.smartrecovery.org>

Women for Sobriety: <http://www.womenforsobriety.org>

For People With Co-Occurring Disorders

Double Trouble in Recovery: [http:// www.doubletroubleinrecovery.org](http://www.doubletroubleinrecovery.org)

Dual Recovery Anonymous: <http://www.dualrecovery.org>

For Families, Friends, and Significant Others

Al-Anon/Alateen: <http://www.al-anon.alateen.org>

Co-Anon: <http://www.co-anon.org>

Families Anonymous: <http://www.familiesanonymous.org>

Nar-Anon: <http://nar-anon.org>

More Online Resources

Faces and Voices of Recovery: http://www.facesandvoicesofrecovery.org/resources/support_home.php

Mutual Support Groups: What Everyone Needs to Know (webcast):

<http://ncadistore.samhsa.gov/catalog/mediaDetails.aspx?ID=266>

Recovery Community Services Program: <http://www.rcsp.samhsa.gov>

Self-Help Group Sourcebook Online: <http://mentalhelp.net/selfhelp>

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Substance Abuse: Working with Families During Case Planning and Relapse

Substance Abuse and Child Maltreatment

The Scope of the Problem

Substance abuse has a major impact on the child welfare system. It is estimated that 9 percent of children in this country (6 million) live with at least one parent who abuses alcohol or other drugs (Office of Applied Studies, 2003). Research has demonstrated that children of substance abusing parents are more likely to experience abuse—physical, sexual, or emotional—or neglect than children in non-substance abusing households (DeBellis, Broussard, Herring, Wexler, Moritz, & Benitez, 2001; Dube, Anda, Felitti, Croft, Edwards, & Giles, 2001; Chaffin, Kelleher, & Hollenberg, 1996; Kelleher, Chaffin, Hollenberg, & Fischer, 1994).

Parents who abuse substances are less likely to be able to function effectively in a parental role. This can be due to:

- Impairments (both physical and mental) that occur while under the influence of alcohol or other drugs.
- Expenditure of often limited household resources on purchasing alcohol or other drugs.
- Time spent seeking out drugs.
- Time spent using alcohol or other drugs.

The basic needs of children, including nutrition, supervision, and nurturing, often go unmet due to parental substance abuse, resulting in neglect. Additionally, families in which one or both parents abuse substances, and particularly families with an addicted parent, often experience a number of other problems including mental illness, unemployment, high levels of stress, and impaired family functioning, all of which can put children at risk for abuse.

The statistics vary, but studies have shown that between one-third and two-thirds of child maltreatment cases involve substance abuse (U.S. Department of Health and Human Services, 1999). In a recent survey by the National Center on Child Abuse Prevention Research, 85 percent of States reported substance abuse was one of the two major problems exhibited by families in which maltreatment was suspected (National Center on Child Abuse Prevention Research, 2001).

Impact of Parental Substance Abuse on Children

Maltreated children of substance abusing parents are more likely to have poorer physical, intellectual, social, and emotional outcomes and are at greater risk of developing substance abuse problems themselves (U.S. Department of Health and Human Services, 1999). Data indicate that abused or neglected children from substance abusing families are more likely to be placed in foster care and are more likely to remain there longer than maltreated children from non-substance abusing families (U.S. Department of Health and Human Services, 1999).

Because of the severity of problems experienced by maltreated children of substance abusing parents, and the fact that they are often in the foster care system longer than maltreated children from non-substance abusing families, expenditures related to substance abuse among families in the child welfare system are significant. One study estimates that of the more than \$24 billion States spend to address different aspects of substance abuse, \$5.3 billion (slightly more than 20 percent) goes to child welfare costs related to substance abuse (National Center on Addiction and Substance Abuse at Columbia University, 2001).

Service Delivery Issues

Along with the high cost of serving these families, child welfare agencies often face a number of service barriers, such as:

- Inadequate treatment resources to meet existing needs.
- Lack of training for child welfare workers on substance abuse issues.
- Conflicts in the time required for sufficient progress in substance abuse recovery to develop adequate parenting potential, legislative requirements regarding child permanency, and the developmental needs of children (Young & Gardner, 2003).

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Agencies are faced with strict timeframes imposed by the Adoption and Safe Families Act of 1997 (ASFA) that do not necessarily coincide with the realities of substance abuse treatment. For example, despite a Federal mandate that pregnant and parenting women receive priority for accessing substance abuse treatment services, States report it is often difficult for these parents to access an open treatment slot quickly (GAO, 2003). Once a slot is available, treatment itself may take many months (some residential treatment programs can be as long as 12 months). Also, if the parent has custody of the child(ren) and requires residential treatment, there may be an additional barrier since many of these programs do not allow children to live in the facility. Although ASFA requires that parental rights be terminated if a child has been in foster care for 15 of the past 22 months, many States cannot adhere to this timeframe due to problems accessing substance abuse services in a timely manner, resulting in delayed permanency decisions for children in the foster care system (GAO, 2003).

Because so many maltreatment cases involve substance abuse, agencies are developing strategies to address the issue more effectively. All of these strategies require collaboration among the various systems within which affected families are involved (e.g., child welfare, substance abuse, public assistance, and dependency court). Examples of innovative approaches include:

Practice Implications

- Stationing addiction counselors in child welfare offices.
- Giving mothers involved in the child welfare system priority access to substance abuse treatment slots.
- Developing or modifying dependency drug courts to ensure treatment access and therapeutic monitoring of compliance with court orders.
- Developing cross-system partnerships to ensure coordinated services (e.g., formal linkages between child welfare and other community agencies to address each family's needs).
- Conducting cross-system training.
- Developing creative approaches to fund these efforts (e.g., using State or local funds to maximize child welfare funding for substance abuse-related services or using Temporary Assistance to Needy Families [TANF] funds to purchase substance abuse treatment) (Young and Gardner, 2002).

Not all of the above approaches are appropriate in all instances. Agencies should focus on the specific needs of the families they serve when selecting among these (and other) approaches.

Implications

Parental substance abuse continues to be a serious issue in the child welfare system. Maltreated children of substance abusing parents often remain in the child welfare system longer and experience poorer outcomes. Additionally, since the passage of ASFA, these children may be less likely to reunify with parents and are subject to alternative permanency decisions in greater numbers than children from non-substance abusing families. Moreover, scarce resources and lack of coordination among various service systems often make it difficult to address the multiple needs of these children and families. The inability of residential programs to accommodate children can result in an additional barrier. Some agencies have developed innovative approaches for addressing child maltreatment and substance abuse, but many have not. Given the prevalence of substance use disorders among the child welfare population, several approaches have been initiated to address this issue:

- **Focus on early identification of at-risk families in substance abuse programs.** Such preventive efforts can reduce the number of maltreated children and help families obtain needed services (U.S. Department of Health and Human Services, 1999).
- **Improve communication between the child welfare system and the substance abuse treatment system.** Communication, understanding, and active collaboration between service systems are vital to ensuring that child welfare-involved parents in need of substance abuse treatment are accurately identified and receive appropriate treatment in a timely manner (Child Welfare League of America, 2001; U.S. Department of Health and Human Services, 1999).

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- **Close the gap between treatment need and available treatment slots.** Even with strong working relationships among systems, more treatment slots, particularly in the more intensive levels of care and providing gender-specific comprehensive services, need to be developed to meet the need for all parents. Creative financing and resource development need to be priorities for administrators and policymakers (U.S. Department of Health and Human Services, 1999).

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Resources for Further Information

Web Sites

Child Welfare League of America (www.cwla.org/programs/bhd/aod.htm)

The Child Welfare League of America (CWLA) is the Nation's oldest and largest membership-based child welfare organization. CWLA addresses all aspect of child welfare, one component of which is the relationship between child welfare and substance abuse.

Child Welfare Training Resources Online Network (www.childwelfaretraining.org/index.cfm)

The Network is designed to enable State trainers, practitioners, social work educators, and other stakeholders to locate the most current training information and materials for the child welfare workforce. Information on training related to substance abuse issues is available.

National Center on Substance Abuse and Child Welfare (www.ncsacw.samhsa.gov)

NCSACW was formed to improve systems and practice for families with substance use disorders who are involved in the child welfare and family judicial systems by assisting local, State, and Tribal agencies.

National Institute on Drug Abuse, Child and Adolescent Workgroup
(www.drugabuse.gov/about/organization/ICAW/ICAWInterest.html)

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One component of NIDA's Child and Adolescent Workgroup is Prenatal Drug Exposure and Drug-Abusing Environments. This group examines the impact of prenatal drug exposure on physical and developmental outcomes, as well as interventions to address adverse consequences of prenatal drug exposure.

National Organization on Fetal Alcohol Syndrome (www.nofas.org)

NOFAS works to raise public awareness of Fetal Alcohol Syndrome (FAS) and to develop and implement innovative ideas in prevention, intervention, education, and advocacy in communities throughout the nation.

Substance Abuse and Mental Health Services Administration (www.samhsa.gov)

SAMHSA is the Federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

Additional Publications

Administration for Children and Families. (1994). *Protecting children in substance-abusing families*. Washington, D.C.: U.S. Dept. of Health and Human Services. (<http://nccanch.acf.hhs.gov/pubs/usermanuals/subabuse/index.cfm>)

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Resource: Substance Abuse and Child Maltreatment <http://nccanch.acf.hhs.gov> December 2003

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Risk in Families with Substance Abuse Concerns

- 1. Alcohol and drugs increasingly serve as a factor in child abuse and neglect cases.**
 - *Link between AOD abuse and child abuse and neglect is not new.*
 - *What changed with the advent of crack cocaine is the staggering number of chemically dependent women with children.*
 - *The lure of drugs, especially crack, can override even the ability of a well-meaning caregiver with substance abuse concerns to address the needs of a child.*
 - *Parental alcohol and other drug abuse is increasingly a factor in reported CPS cases. An estimated 50 to 75 percent of all child abuse and neglect cases substantiated by CPS involve some degree of parental abuse of drugs or alcohol.*
- 2. Chemically involved parents are more likely to abuse children over age ten than younger children.**
 - *Studies show that abuse or neglect of very young children is particularly associated with parental drug use.*
- 3. Fewer children enter out-of-home care because of parental substance use.**
 - *Number of children in out-of-home care increases every year. This growth parallels the advent of crack cocaine and the widespread use of drugs by pregnant and parenting youth.*
 - *Fastest growing group of children entering foster care is children under age 6; an increasing number of those children have parents involved with some chemical.*
- 4. Caregivers with substance abuse concerns are more likely to physically abuse their children than neglect them.**
 - *When comparing physical abuse and neglect, individuals neglect children more than they physically abuse children; however, individuals also harm, in a number of other ways, many children in chemically dependent families.*
 - *Use of alcohol and drugs affects parents' mental functioning, lowers their inhibitions, and impairs their judgment, resulting in increased risk of both abuse and neglect of children.*
 - *Drug "high" or experience of withdrawal might cause parents to become unaware of their children's needs. Examples:*
 - *Parent might leave children with caregivers for days at a time, caregivers who might not be prepared or able to meet the children's needs or ensure the child's safety.*
 - *Parents with chemical dependency might spend money on drugs that they instead should use for food, housing, and medical care.*
 - *Children might not receive adequate nourishment, necessary health care, and neglect their child's educational needs.*
 - *Mothers with chemical dependence often prenatally expose the children to drugs or alcohol. The child can develop a range of health and developmental problems that require special care. Parents who use might not be able to meet the special needs of these children.*
 - *Children are at increased risk for physical abuse because the parent's use of alcohol or other drugs might lower inhibitions and result in poor impulse control and inappropriate behaviors.*
 - *Sexual abuse might result when alcohol or drug abuse lowers inhibition and affects judgment. Alcohol or drug abuse might also affect a parent's ability to protect the child from sexual assault by paramours, relatives, or others with access to the child.*

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- *Criminal activity associated with manufacturing, using, and selling drugs might place children at risk of harm.*
- 5. **Experiencing abuse or neglect as a child causes one to become chemically dependent later in life.**
 - *Little data exists to support the theory that there exists a causal relationship between alcohol or drug abuse and child abuse and/or neglect, or that, as a child, experiencing abuse causes one to abuse alcohol or drugs later in life.*
 - *However, numerous studies and anecdotal information establish a strong connection between caregiver substance abuse, physical abuse and/or neglect, and victim substance abuse later in life.*
 - *Research indicates that alcohol is involved in 30 to 40 percent of cases of sexual abuse. Some studies show that substance abuse can lead to lowered inhibitions and thereby lower the parent's threshold for to use violence.*
 - *Other research found that the preoccupation with drugs or alcohol that results from dependency could cause the parent physically and emotionally to withdraw from the child, resulting in child neglect.*
 - *Adults, whom someone physically, sexually, or emotionally abused as children, are more likely than others are to abuse alcohol and drugs.*
 - *Studies focusing on individuals with chemical involvement report rates of childhood sexual abuse between 30 and 44 percent.*
 - *In one study regarding parents with chemical involvement, 42 percent reported that their parents physically or sexually abused them during childhood.*
 - *Although the relationship is extremely complex, research reveals that alcohol or drug involvement in a family relates to child abuse and neglect.*
- 6. **Children of substance abusers share many characteristics with abused children.**
 - *One of the most prevalent shared dynamics of families with chemical involvement and those with child abuse and neglect problems is **secrecy**.*
 - *Because of the stigma associated with chemical involvement, relatives are more likely to "protect" from exposure the family members addicted to drugs or alcohol and are less likely to encourage family members to seek help.*
 - *Abused children also keep secrets if someone threatened them or if they think that information disclosed/revealed might hurt someone they love. Fear, blame, and shame can pressure the child to maintain the secret, or to recant a disclosure.*
 - *Another dynamic shared by children of substance abusers and abused children is **denial**.*
 - *Alcoholics, for example, deny that they have a drinking problem because they believe that their drinking does not hurt anyone else.*
 - *Parents who abuse their children might deny or minimize their actions or harm to the child.*
 - *Children also use denial for a number of reasons. For example, they might have fear of what will happen to them if they admit the problem. They might feel shame and embarrassment; or they might feel guilt.*
 - *Families with tendencies toward chemical involvement, abusiveness, and neglectfulness tend to **isolate** themselves geographically and socially from others.*

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- *Other dynamics identified in families with chemical involvement and families where child abuse and neglect exist, include **marital conflict, poor communication, blurred boundaries, rigid roles, absence of trust, and impaired problem-solving ability.***
- 7. Individuals can safely maintain children in homes where chemical dependency is a factor.**
- *Risk refers to the likelihood that abuse will occur in the future and safety refers to a determination as to whether the child is in imminent danger.*
 - *If you determine that there exists a risk of abuse, regardless of the level, your next decision is whether you and other individuals (preferably in the family) can ensure the child's safety in the child's own home. A child can be at risk of abuse and still be safe in his/her own home.*
 - *In conjunction with the family, we develop a safety plan and a family service plan to the family to assure the child's safety and to reduce the risk of harm.*
 - *To assess the child's risk of harm and safety, you must **identify the factors that threaten the child** both imminently and in the future.*
 - *Example: The parent's daily use of a drug and the frequency, pattern, and type of drug or alcohol used by the parent).*
 - *You must also **identify the effect of the substance use** on the parent's ability to:*
 - *provide the child safety*
 - *control the risks in the family*
 - *the likelihood that the abuse again might occur*
 - *the severity of the physical and emotional consequences to the child*
 - *the availability of supports and resources for the family.*
 - *Assessing the risk of future harm and determining whether a child can safely remain in the home of parents with chemical involvement requires an **understanding of the differential effects of the used substance(s) and the combinations of various substances on the caregivers' ability to care for the child(ren).***
 - *Case Managers should never use the use of drugs or alcohol as the sole cause for separating the child from the family. Case Managers should **base the decision to remove a child on the safety and risk of harm to the child and the ability of the caregiver to protect the child.***
- 8. We appropriately can use drug testing to help ensure the safety of children in their homes.**
- *If there is an indication of substance abuse in the case, you may decide to request a random drug screen. Some cases have court orders which require random drug screens to monitor drug use.*
 - *Case Managers must not rely solely on drug screening in making critical casework decisions.*
 - *A drug screen cannot distinguish drug use patterns (occasional use in low amounts, periodic binges, habitual use); nor can it determine whether an individual is capable of parenting a child. Patterns of use and drugs of choice have dramatically different effects on each individual parent's ability to care for a child. Consequently, there is great danger in using the results of drug tests to draw conclusions about parenting ability.*
 - *Screening should be used as **one means of monitoring** substance use. Drug testing can be useful as a tool to indicate the necessity for increasing the level of intervention.*

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- *You should help parents understand why the agency chose to use tests and should inform parents of any consequences of a positive screen (such as temporary placement of the child out-of-home until such a time as the parent's screening comes back negative).*
- 9. **Families in which chemical dependence plays a part are more difficult to work with than abusive (or neglectful) families.**
- *Parents who are chemically involved often:*
 - *are unstable*
 - *move frequently*
 - *lack telephones*
 - *fail to keep appointment*
 - *drop out of sight*
 - *remain supported by family and friends in their denial and flight.*
 - *These characteristics are **similar to many non-SA involved parents**. It is **true** that parents addicted to drugs often have a **primary commitment to chemicals, not to their children**.*
- *Parents tend to deny and resist treatment because of fear –fear of loss of self-esteem, loss of control, loss of their children, or punitive action.*
- *Strategies you normally use to engage non-SA involved parents are relevant for this population as well.*
 - *Demonstrate genuine respect for the client when you directly confront the substance abuse concern behaviors*
 - *Educate family members and friends about the addiction process and their role in enabling the person with chemical involvement*
 - *Help family members recognize their role in supporting the addiction; they then might be able to help you address the denial of the individual with the substance abuse concern.*
- *Caseworkers might believe that chemically dependent parents are more difficult to engage. In fact, this may be due primarily to the worker's lack of preparation rather than to the family's characteristics.*
- 10. **The prognosis for chemically involved families is better than that for abusive or neglectful families.**

The good news is that there exists means of treating both chemical dependency and child abuse. Still, a number of factors, some we addressed previously, might work against successful intervention. These factors include:

- *Drugs used today are more highly addictive and inexpensive than in the past.*
- *Lack of appropriate, accessible, and affordable treatment resources.*
- *Although individuals now strive to develop model programs designed to address the mother with chemical dependence in relation to her children, few currently exist.*
- *Lack knowledge about what constitutes effective drug treatment for different populations. Studies show that even after completing treatment, only 25 percent of individuals dependent on crack remain drug free six months after discharge.*
- *High child welfare caseloads might hinder workers from making the type of response needed to assist these families in a timely way. We often cannot provide prevention and early intervention services, which can be the most effective strategies with families with chemical dependency,*

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because of the crisis nature of the cases and the high caseloads for which workers have responsibility.

- *Case Managers may not have the specialized training they need to assess, plan, and intervene effectively and to make accurate case decisions.*
- *Communities often lack coordination among service providers; and, in most cases, individuals do not clearly define the role of each service provider.*

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CONFIDENTIALITY OF PATIENT RECORDS FOR ALCOHOL AND OTHER DRUG TREATMENT

Where are the federal regulations related to confidentiality located?

Regulations are set out in Title 42, part 2, Code of Federal Regulations

What is the primary purpose of the law?

The Federal drug and alcohol confidentiality laws are predicated on the public health view that people with alcohol or other drug problems are likelier to seek (and succeed at) treatment if they are assured that their need for treatment will not be disclosed unnecessarily to others. The confidentiality regulations grew out of a concern that the social stigma and potential discrimination would deter people with alcohol and other drug problems from entering treatment. Every patient and former patient must be assured that his or her right to privacy will be protected.

What is the scope of the law?

The Federal alcohol and drug confidentiality regulations restrict the disclosure and use of “patient identifying” information about individuals in alcohol and other drug treatment. Patient-identifying information is defined as information that reveals a person is receiving, has received, or has applied for alcohol and other drug treatment. Applicants are protected, even if they are not admitted to the program. However, someone who does not show up for an appointment arranged for by a third party would not be considered a client.

To whom does the law apply?

The law applies to any type of program that specializes in whole, or in part, in any type of treatment, assessment, referral, or counseling for clients with alcohol and other drug problems. A “prevention” program is not excused from adhering to the confidentiality rule because it is the type of services, rather than the label, that determines whether the program must comply. The law applies to programs that receive any federal assistance including federal funds (such as federal funds that are administered through local counties) or tax-exempt status. The regulations apply to holders, recipients, and seekers of patient-identifying information. An individual or program in possession of such information, may not release it except as authorized by the patient concerned.

What about conflicts with state laws?

State confidentiality law may be more restrictive than but may not override the Federal regulations. Where state law is less restrictive or in conflict with Federal regulations, State law must yield.

What is the general rule?

The general rule is that a federally-assisted drug or alcohol treatment program may not disclose, directly or indirectly, the identity of its former, current, or would-be patients. For example, programs may not permit an employee to testify about a patient’s treatment, allow a receptionist to confirm that a particular person is a patient of the program, or use stationery that suggests that the addressee may be one of its patients.

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What are the exceptions to the general rule?

Exceptions to the rule prohibiting disclosure about a client who seeks or receives alcohol and other drug treatment are described briefly below.

- ◆ **Internal Program Communications:** Patient-identifying information may be disclosed within a program or to an entity having direct administrative control over a program, if the recipient of the disclosure needs the information to provide substance abuse services to the patient. For example, the staff of a detox unit within a hospital may share information with one another--where such sharing of information is needed to provide the services to the patient. The program may also share information with the hospital's record-keeping or billing departments, since these units are integral to the program's functioning. These individuals must also adhere to the confidentiality regulations regarding redisclosure.

- ◆ **Consent:** A program may disclose information about a patient if the patient authorizes it by signing a valid consent form. To be valid, a consent form must specify the following:
 - ◆ Name of the program or person permitted to make the disclosure,
 - ◆ Name or title of the individual or organization to receive disclosure,
 - ◆ Name of patient/client,
 - ◆ Purpose or need for the disclosure,
 - ◆ The information to be released (described as exactly as possible),
 - ◆ Statement that the patient may revoke the consent at any time,
 - ◆ Date or condition upon which the consent expires, and
 - ◆ Signature of patient and date signed.

- ◆ **Disclosures That Do Not Reveal Client-Identifying Information**

Programs may disclose information about a client if the program reveals no client-identifying information, which identifies the client as a treatment recipient or as having an alcohol or drug problem. A program that provides only alcohol or other drug treatment services cannot disclose under this exception, because stating that a contact is from a treatment program by default would identify a client as a substance abuse treatment client.

 - ◆ **Research, Audit, and Evaluation**

Programs can disclose client-identifying information for research, audit, or evaluation purposes as long as certain safeguards are met.
 - ◆ **Qualified Service Organization**

Programs may disclose information to a person or agency that provides professional services (dosage preparation, lab analyses, medical etc.) that the program does not provide for itself. To become qualified, the service organization must enter into a written agreement with the program in which it acknowledges it is also bound by Federal confidentiality regulations.
 - ◆ **Crimes on Program Premises**

Programs may release information to the police where a patient commits or threatens to commit a crime on the premises or against program staff.

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- ◆ ***Medical Emergencies***

Information may be disclosed to certain persons in a medical emergency that poses an immediate threat to the health of an individual (need not be the patient) and requires immediate medical intervention.

- ◆ ***Mandated Reports of Child Abuse or Neglect***

Programs are required to report suspected child abuse, but it must still protect patient records from subsequent disclosures absent patient consent or court order to release the information.

- ◆ ***Disclosures Authorized by Court Order***

A court may authorize disclosure of “confidential communications” by a patient to the program only if the disclosure is (a) necessary to protect against a threat to life or of serious bodily injury, (b) is necessary to investigate or prosecute an extremely serious crime, (including child abuse), or (c) is in connection with a proceeding in which the patient has already presented evidence concerning confidential communications.

A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, standing alone, to require or even to permit a program to disclose information.

Source: Adapted from *Confidentiality of patient records for alcohol and other drug treatment* (Technical Assistance Publication #13; DHHS Publication No SMA 95-3018), US Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration (1994) and “Protecting clients privacy” in *Substance abuse treatment for persons with child abuse and neglect issues* (Treatment Improvement Protocol #36; DHHS Publication No SMA 00-3357, 2000).

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