Substance Use Disorders and Child Welfare

Part 1 of a 3-part series addressing Substance Use Disorders, the opioid epidemic, child welfare and a family-centered approach

February 19, 2020

Sarah Fox
Program Associate
NCSACW Presenter
LEARNING OBJECTIVES

By participating in this training, you will:

• Become more familiar with substance abuse as a disorder
• Gain knowledge around the history of the disorder and the opioid epidemic
• Begin to learn about the road to treatment and recovery
A THANK YOU TO OUR SPONSORS

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The content provided by this resource is made possible through participation in the Office for Victims of Crime (OVC) and Bureau of Justice Assistance (BJA) National Stakeholder Partnership (NSP).

This Partnership, comprised of seven national organizations, leverages expertise on child and youth impacted and victimized by the nation’s opioid and broader substance use crisis, with an emphasis on multidisciplinary collaborations, research, and promotion of training and education.

Members of the NSP dedicate time and resources to inform the planning, development, and implementation of OVC and BJA initiatives designed to respond to, treat, and support those impacted by the opioid epidemic, specifically young victims. In addition, members participate in informative, national conversations regarding children and youth impact and best-practice models that focus on innovative strategies and force-multiplying partnerships.

The overarching goals of this work are to advance awareness and knowledge to help mitigate the traumatization of children and youth and to advance dissemination of innovative practices throughout the field.
NCSACW PRESENTER

SARAH FOX, MA
PROGRAM ASSOCIATE
A program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration for Children and Families (ACF), Children’s Bureau
• Substance Use Disorder (SUD) myths
• Language considerations to combat stigma
• History of SUD and the opioid epidemic
• SUD terminology
UNDERSTANDING THE CHALLENGE
THE NECESSITY OF COLLABORATION

Substance use and child maltreatment are often multi-generational problems that can only be addressed through a coordinated approach across multiple systems to address needs of both parents and children.

(Boles, et al., 2012; Dennis, et al., 2015; Drabble, 2010)
Meaningful collaboration across systems that includes agreement on **common values**, enhanced **communication** and **information sharing**, blended funding and data collection for **shared outcomes**...

...results in improved outcomes for families including **increased engagement and retention** of parents in substance use treatment, **fewer children removed** from parental custody, **increased family reunification** post-removal and **fewer children reentering** the child welfare system and foster care.

(Boles, et al., 2012; Dennis, et al., 2015; Drabble, 2010)
STIGMA AND PERCEPTIONS OF PARENTS WITH SUBSTANCE USE DISORDERS

“Once an addict, always and addict.”
“They don’t really want to change.”
“They lie.”
“They must love their drug more than their child.”
“They need to get to rock bottom, before…”
“They made a choice when they picked up to use/drink in the first place.”
STIGMA

- Affects the attitudes of…
  - Medical and healthcare professionals
  - Social service agencies and workers
  - Families and friends

- Creates barriers to treatment and impedes access to programs
- Influences policies
COMBATING STIGMA

- Are you using person-first language?
- Are you using technical language with a single, clear meaning instead of colloquialisms or words with inconsistent definitions?
- Are you conflating substance use and a substance use disorder?
- Are you using sensational or fear-based language?
- Are you unintentionally perpetuating drug-related moral panic?

(Center for Substance Abuse Treatment, 2008)
<table>
<thead>
<tr>
<th><strong>Instead of:</strong></th>
<th><strong>Try:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Addict</td>
<td>Person with a substance use disorder</td>
</tr>
<tr>
<td></td>
<td>Person with a serious substance use disorder</td>
</tr>
<tr>
<td>Addicted to X</td>
<td>Has an X use disorder</td>
</tr>
<tr>
<td></td>
<td>Has a serious X use disorder</td>
</tr>
<tr>
<td></td>
<td>Has a substance use disorder involving X (if more than one substance is involved)</td>
</tr>
<tr>
<td>Addiction</td>
<td>Substance use disorder</td>
</tr>
<tr>
<td></td>
<td>Serious substance use disorder</td>
</tr>
</tbody>
</table>

**Note:**

- “Addiction” is appropriate when quoting findings or research that used the term or if it appears in a proper name of an organization.
- “Addiction” is appropriate when speaking of the disease process that leads to someone developing a substance use disorder that includes compulsive use (for example, “the field of addiction medicine,” and “the science of addiction”).
- It is appropriate to refer to scheduled drugs as “additive.”

(White House Office of National Drug Control Policy, 2015)
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic</td>
<td>Person with an alcohol use disorder</td>
</tr>
<tr>
<td></td>
<td>Person with a serious alcohol use disorder</td>
</tr>
<tr>
<td>Alcoholics Anonymous / Narcotics Anonymous / etc.</td>
<td><strong>Note:</strong> When using these terms, take care to avoid divulging an individual's participation in a named 12-step program.</td>
</tr>
<tr>
<td>Clean</td>
<td>Abstinent</td>
</tr>
<tr>
<td>Clean Screen</td>
<td>Substance-free</td>
</tr>
<tr>
<td></td>
<td>Testing negative for substance use</td>
</tr>
<tr>
<td>Dirty</td>
<td>Actively using</td>
</tr>
<tr>
<td></td>
<td>Positive for substance use</td>
</tr>
<tr>
<td>Dirty Screen</td>
<td>Testing positive for substance use</td>
</tr>
<tr>
<td>Drug habit</td>
<td>Substance use disorder</td>
</tr>
<tr>
<td></td>
<td>Compulsive or regular substance use</td>
</tr>
</tbody>
</table>

(White House Office of National Drug Control Policy, 2015)
<table>
<thead>
<tr>
<th>Drug/Substance Abuser</th>
<th>Person with a substance use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Person who uses drugs (if not qualified as a disorder)</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> When feasible, “Drug/Substance Abuse” can be replaced with “Substance Use Disorder.”</td>
</tr>
<tr>
<td>Former/reformed Addict/Alcoholic</td>
<td>Person in recovery</td>
</tr>
<tr>
<td></td>
<td>Person in long-term recovery</td>
</tr>
<tr>
<td>Opioid Replacement or Methadone Maintenance</td>
<td>Medication assisted treatment</td>
</tr>
<tr>
<td></td>
<td>Medication-assisted recovery</td>
</tr>
<tr>
<td>Recreational, Casual, or Experimental Users (as opposed to those with a use disorder)</td>
<td>People who use drugs for non-medical reasons</td>
</tr>
<tr>
<td></td>
<td>People starting to use drugs</td>
</tr>
<tr>
<td></td>
<td>People who are new to drug use</td>
</tr>
<tr>
<td></td>
<td>Initiates</td>
</tr>
</tbody>
</table>

(White House Office of National Drug Control Policy, 2015)
DRUG EPIDEMICS OF THE DECADES

1970s

1980s–1990s

2000s

2010s
## DRUG CLASSIFICATIONS

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stimulants</strong></td>
<td>Medications that increase alertness, attention, energy, blood pressure, heart rate, and breathing rate</td>
</tr>
<tr>
<td></td>
<td>• Short-term effects: Increased alertness, attention, energy; increased blood pressure and heart rate</td>
</tr>
<tr>
<td></td>
<td>• Long-term effects: Heart problems, psychosis, anger, paranoia</td>
</tr>
<tr>
<td><strong>Central Nervous System Depressants</strong></td>
<td>Medications that slow brain activity, which makes them useful for treating anxiety and sleep problems</td>
</tr>
<tr>
<td></td>
<td>• Short-term effects: Drowsiness, slurred speech, poor concentration, confusion, dizziness, problems with movement and memory, lowered blood pressure, slowed breathing</td>
</tr>
<tr>
<td></td>
<td>• Long-term effects: Unknown</td>
</tr>
<tr>
<td><strong>Hallucinogens</strong></td>
<td>Substances that distort the perception of reality</td>
</tr>
<tr>
<td></td>
<td>• Short-term effects: Increased heart rate, nausea, intensified feelings and sensory experiences, changes in sense of time</td>
</tr>
<tr>
<td></td>
<td>• Long-term effects: Speech problems, memory loss, weight loss, anxiety, depression and suicidal thoughts</td>
</tr>
</tbody>
</table>

(National Institute on Drug Abuse, 2018a; National Institute on Drug Abuse, 2016)
COMMON SUBSTANCES OF USE

**Alcohol**
A depressant, which means it slows the function of the central nervous system
- Short-term effects: Reduced inhibitions, slurred speech, motor impairment, confusion, memory problems, concentration problems
- Long-term effects: Development of an alcohol use disorder, health problems, increased risk for certain cancers

**Cocaine**
A powerfully addictive stimulant drug made from the leaves of the coca plant native to South America
- Short-term effects: Narrowed blood vessels, enlarged pupils, increased body temperature, heart rate, and blood pressure, headache, abdominal pain and nausea, euphoria
- Long-term effects: Loss of sense of smell, nosebleeds, nasal damage and trouble swallowing from snorting, infection and death of bowel tissue from decreased blood flow

**Heroin**
An opioid drug made from morphine, a natural substance extracted from the seed pod of various opium poppy plants
- Short-term effects: Euphoria, dry mouth, itching, nausea, vomiting, analgesia, slowed breathing and heart rate
- Long-term effects: Collapsed veins, abscesses (swollen tissue with pus), infection of the lining and valves in the heart, constipation and stomach cramps, liver or kidney disease, pneumonia

(National Institute on Alcohol Abuse and Alcoholism; National Institute on Drug Abuse, 2018a)
# COMMON SUBSTANCES OF USE

<table>
<thead>
<tr>
<th>Substance</th>
<th>Description</th>
<th>Short-term effects</th>
<th>Long-term effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methamphetamine</td>
<td>A stimulant drug chemically related to amphetamine but with stronger effects on the central nervous system</td>
<td>- Increased wakefulness and physical activity, decreased appetite, increased breathing, heart rate, blood pressure, temperature, irregular heartbeat</td>
<td>- Anxiety, confusion, insomnia, mood problems, violent behavior, paranoia, hallucinations, delusions, weight loss</td>
</tr>
<tr>
<td>Marijuana</td>
<td>Made from the hemp plant, <em>cannabis sativa</em>. The main psychoactive (mind-altering) chemical in marijuana is delta-9-tetrahydrocannabinol, or THC.</td>
<td>- Enhanced sensory perception and euphoria followed by drowsiness/relaxation; slowed reaction time; problems with balance and coordination</td>
<td>- Mental health problems, chronic cough, frequent respiratory infections</td>
</tr>
<tr>
<td>Opioids</td>
<td>Pain relievers with an origin similar to that of heroin. Opioids can cause euphoria and are often used non-medically, leading to overdose deaths.</td>
<td>- Pain relief, drowsiness, nausea, constipation, euphoria, slowed breathing, death</td>
<td>- Increased risk of overdose or addiction if misused</td>
</tr>
</tbody>
</table>
THE OPIOID EPIDEMIC

OPIOID CRISIS, US DEPARTMENT OF HEALTH AND HUMAN SERVICES, 2018
The opioid epidemic by the numbers

4.4%
Of the population, or 11.5 million people, have an opioid use disorder.

170
People die from drug overdoses a day—116 are opioid-related.

13%
Increase in overdose deaths 2016–2017

(U.S. Department of Health and Human Services, 2018)
The crisis in context

Opioid overdose deaths at historically high levels

(U.S. Health and Human Services Department, 2018)
- Roughly 21%–29% of patients who are prescribed opioids for chronic pain misuse them; between 8% and 12% of these patients will develop an opioid use disorder.

- An estimated 4%–6% of people who misuse prescription opioids transition to heroin.

- About 80% of people who use heroin misused prescription opioids prior to using heroin.

- Opioid overdoses increased 30% from July 2016 through September 2017 in 52 areas in 45 states.


(The Crisis in Context Continued) (National Institute on Drug Abuse, 2018a; Rudd et al., 2016)
3 out of 4 people who used heroin in the past year misused prescription opioids first

(U.S. Department of Health and Human Services, 2018; Jones, 2013)
OPIOIDS

Derived fully or partially from opium:

- Heroin
- Codeine
- Hydromorphone (Dilaudid)
- Oxycodone (OxyContin, Roxicodone, Percodan, Percocet)
- Hydrocodone (Vicodin or Lortab)
- Pentazocine
- Morphine
- Fentanyl (Duragesic, Actiq, Sublimaze)
- Meperidine
- Propoxyphene
EFFECTS OF OPIOID USE

- All opioids are chemically related and interact with opioid receptors on nerve cells in the body and brain.

- Prescribed opioid pain relievers are generally safe when taken for a short time and as prescribed by a doctor, but because they produce euphoria in addition to pain relief, they can be misused.

- Regular use—even as prescribed by a doctor—can lead to dependence and, when misused, opioid pain relievers can lead to addiction, overdose incidents, and death.

(National Institute on Drug Abuse, n.d.)
EFFECTS OF OPPIOIDS ON THE BODY

Opioids act on many places in the brain and nervous system, including:

- **Limbic system**: Controls emotions
  - Opioids create feelings of pleasure, relaxation, and contentment.

- **Brain stem**: Controls things your body does automatically, like breathing
  - Opioids can slow breathing, stop coughing, and reduce feelings of pain.

- **Spinal cord**: Receives sensations from the body before sending them to the brain
  - Opioids decrease feelings of pain, even after serious injuries.

(National Institute on Drug Abuse, 2018c)
SIGNS OF OPIOID USE: PHYSICAL

- Evident elation/euphoria
- Sedation/drowsiness
- Misperception
- Decelerated breathing
- Intermittent nodding off, or loss of consciousness
- Dry mouth
- Warm flushing of the skin
- Heavy feeling in the arms and legs
- Digestive problems such as nausea, vomiting, diarrhea, or constipation
- Weight loss
- Poor hygiene
- Severe itching
- Clouded mental functioning
- Scabs, sores, or puncture wounds suggestive of IV drug use

If these signs are present, it does not necessarily mean that the person is using opioids or other drugs.

(National Institute on Drug Abuse, n.d.)
SIGNS OF OPIOID USE: BEHAVIORAL

- Doctor shopping (making appointments with multiple doctors to receive multiple prescriptions for opioids)
- Poor performance in school or work
- Unexplained periods of absence
- Failure to fulfill personal responsibilities
- Social isolation
- Restlessness
- Lethargy
- Stealing medications from friends and family

If these signs are present, it does not necessarily mean that the person is using opioids or other drugs.

(National Institute on Drug Abuse, n.d.)
SIGNS OF OPIOID USE: PSYCHOSOCIAL

- Mood swings
- Outbursts
- Irritability
- Depression
- Paranoia
- Delusions
- Forgetfulness
- Increased symptoms of mental illness

If these signs are present, it does not necessarily mean that the person is using opioids or other drugs.

(National Institute on Drug Abuse, n.d.)
1. Substance taken in larger amounts over a longer period than was indicated
2. Persistent desire or unsuccessful efforts to cut down or control use
3. Great deal of time spent in activities obtaining substance
4. Craving, or strong desire/urge for substance
5. Failure to fulfill major role obligations at work, school, or home
6. Continued use despite having recurrent social or interpersonal problems
7. Important social, occupational, or recreational activities are given up or reduced
8. Recurrent use in situations that are physically hazardous
9. Continued use despite knowledge of having a problem that is likely caused or exacerbated by the substance
10. Tolerance*
11. Withdrawal*

* Not to be met for those taking a substance solely under appropriate medical supervision

(Diagnostic and Statistical Manual of Mental Disorders, 5th ed)
“Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic disease.”

(American Society of Addiction Medicine, 2019)
Brain imaging studies show physical changes in areas of the brain when a drug is ingested that are critical to:

- Judgment
- Decision making
- Learning and memory
- Behavior control

These changes alter the way the brain works and help explain the compulsion and continued use despite negative consequences.

(National Institute on Drug Abuse, 2018b)
ADDITIONAL STRESSORS

- Co-occurring substance use and mental health disorders
- Limited educational and vocational opportunities
- Limited fiscal resources
- Criminal involvement
- Physical illnesses
- Difficult and traumatic life experiences

(Center for Behavioral Health Statistics and Quality, 2015)
ADDITIONAL RESOURCES ON COLLABORATION

**Web-Based Resource Directory**
- Includes research, training materials, webinars and videos, site examples and other resources
- Topics include substance use disorders and treatment, medication-assisted treatment, infants with prenatal substance exposure, and supporting families with opioid use disorders

**Technical Assistance**
- Identifying values and principles of collaborative practice to address differences and develop agency values’, missions and mandates
- Examples of effective collaborative practice between substance use providers, child welfare and the courts

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CONTACT US

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### UPCOMING WEBINARS

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
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<tbody>
<tr>
<td>March 17, 2020</td>
<td>Advocating for Indian Children: ICWA and the Role of CASA/GALs</td>
</tr>
<tr>
<td>April 22, 2020</td>
<td>Substance Abuse Disorders and Child Welfare, Part 2</td>
</tr>
<tr>
<td>June 24, 2020</td>
<td>Substance Abuse Disorders and Child Welfare, Part 3</td>
</tr>
<tr>
<td>TBD</td>
<td>Substance Abuse Disorders and CASA/GALs: A Local Program Perspective</td>
</tr>
</tbody>
</table>

All are open to CASA/GAL staff and volunteer advocates.