

## OVERVIEW

Goal—The goal of Module 6 is to provide child welfare workers with an in-depth understanding of the various ways in which children are impacted by their parents' substance use and/or mental disorders, including co-occurring disorders—from prenatal exposure through childhood and adolescent development. It will cover the possibility that children may be experiencing their own personal alcohol and drug or mental disorders. In addition, this module discusses the importance of screening and assessment for children's own alcohol and drug and mental disorders that may or may not be a result of their parent's personal issues. It will support the increased screening and identification of affected children so that referrals can be made to professionals trained in assessment and intervention with these children.

Methods: PowerPoint presentations (or overhead/transparencies); large group and small group discussions.

Training Aids: Projector and computer, disk with PowerPoint file (or overhead and transparencies); flip chart with markers; participant notebook.

Time: 2 hours, 55 minutes

Learning Objectives—After completing Module 6, child welfare professionals will have an understanding of the following topics:

- Impact of parental substance use on children
  - Prenatal
  - Postnatal
  - Special impact in homes where methamphetamine is produced
- Impact of parental mental disorders on children
  - Prenatal
  - Postnatal
- Children's personal substance use and/or mental disorders (either related to or separate from parental issues)
  - Alcohol and drug exploration, use, abuse, dependence
  - Mental disorders
    - Special focus on acts of self-harm, including suicide
- Screening and assessment of children
- Treatment strategies, systems of care, trauma, youth support (peer to peer, children of substance abuser groups, Alanon, Alateen, etc.).
- Referral resources

**Prior to start**                    **Meet and greet, registration**

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***Purpose is to give participants access to the space. Each will prepare differently, arrive at different times. Conduct registration and distribute materials. Trainers get ready.***

**0 – 15 minutes**                    **Introductions; Purpose; Ground Rules**                    **15 min.**

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***Trainer introduces him or herself and invites participants to briefly introduce themselves (e.g., name, unit, office location, years in the system, etc.). If this same group has been together for other modules in this series, you might substitute asking them how they used information learned in previous sessions in place of introductions. If group is smaller than 12-15 people, trainer could invite them also to briefly describe their interest in this training. If group is larger than 40-50 people, individual introductions are likely to take too much time.***

***Describe the purpose of Module 6. Language for this overview is provided below. Emphasize that child welfare professionals often work with families where one or more adults are experiencing substance use and/or mental disorders and this training is intended to prepare them to better help such adults access and use appropriate resources to recover from the effects of their disorder and function appropriately as parent or caregiver, while keeping their child(ren) safe. The language provided also describes four simple ground rules for the training session. After presenting them, the trainer may ask the group if there are any other ground rules important to them.***

**[Slide VI-1] Substance Use Disorders, Mental Disorders and Co-Occurring Disorders Training. Module 6: Understanding the Needs of Children of Parents with Substance Abuse or Mental Disorders**

Good morning! (afternoon; evening) I want to thank you for being here today. This training curriculum has been designed specifically for you, child welfare professionals, and will provide you with relevant information and opportunities to practice skills that will be useful to your work. In particular, this Module is designed to educate you about the effects of parental or primary caregiver substance use or mental disorders on their children, how to recognize those effects and what to do about them on the child's behalf.

We all know that parents with substance use and/or mental disorders can receive successful treatment, and the same is true for their children, regardless of the reasons behind the disorder. This curriculum is designed to help you better help both parents and their children succeed in this type of treatment.

Today's session is going to include several informational presentations, as well as several opportunities to talk, in small groups and as a whole, about this information and how it relates to your work. In our time together, there are just a few ground rules. I ask that we: 1) treat each other with respect; 2) talk only one at a time; 3) give each person the opportunity to participate; and 4) think about how to take new learning back to your job responsibilities.

## PRESENTATION 18

15 – 40 minutes      ***Presentation 18: Understanding the needs of children; impact of prenatal drug or alcohol use on children***      ***25 min.***

***Deliver scripted presentation about identifying and responding appropriately to needs that children might present that might, or might not, result from a parent's substance use or mental disorder. Slides VI-2 through VI-20. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on to the following discussion. Keep answers brief. Trainer should only answer questions to which you know the answer.***

Not all children of substance-abusing parents have been abused or neglected. Not all children of parents with mental disorders or co-occurring disorders have been abused or neglected. Most parents in treatment for these disorders are not involved in the child welfare system. However, for those parents with substance use and/or mental disorders who are involved in the child welfare system, protecting children from harm often involves more than assuring their physical safety. It also includes attending to the child's need to understand their parent's disorder and how they can protect themselves from harmful effects. Working with substance using parents can be challenging but rewarding. It requires understanding the goals and processes of both the child welfare and treatment systems.

### **[Slide VI-2] Role of the Child Welfare Worker**

Let's start with the role of the child welfare worker. Child welfare professionals are in a unique position to contribute to the health, the safety, the well-being, and the permanency of children and families—in critical ways. In fact, there are many important areas where you can make a difference on behalf of children and families.

One area where you can make a difference is in identifying consequences that the children may be experiencing. Parental substance use and/or mental disorders are often associated with risk to the well-being of the children. You are in a position to identify poor outcomes developmentally, the need for mental health services, inadequate medical care, ineffective educational supports, and other issues in the children's lives.

The second area is addressing the child's needs. While the child is in the custody of or under the protection of the State, the child's needs related to the parent's substance use or mental disorder become the responsibility of the child welfare agency. Child welfare professionals must take appropriate measures to meet these needs.

A third area is providing the Minimum Sufficient Level of Care for children. The concept of "minimum sufficient level of care" is a basic practice guide for child welfare and child protection workers. It applies to all children and is important because it helps prevent the child welfare system from not overly intruding in families' lives. It is intended to stop workers from imposing subjective or rigid standards. It is also intended to recognize that a top priority in child "well-being" is the relationship with the parent.

The removal of a child from a parent by the State is the greatest possible intrusion into a family's life and civil liberties, next to incarceration. For this reason, it cannot be done without due process, which includes a judicial finding regarding the minimum sufficient level of care for a

child. In fact, many States allow families to become involved with the child protection system on a voluntary basis, as parents seek to do the best they can for their children. The voluntary or involuntary basis of the family's involvement is one factor to be considered by the worker in determining the plan of care for an individual child.

**[Slide VI-3] Adoption and Safe Families Act Timetables**

A fourth area where you can really make a difference is in adhering to key Adoption and Safe Families Act (ASFA) timetables. ASFA child welfare requirements are organized around a series of timetables that come into play as decisions are made about children who are moving along the child welfare continuum into situations of greater risk.

For each step in the timetable, the child welfare system provides services that reflect reasonable efforts to prevent the placement of a child or to promote the return of a child to the home as soon as possible after a necessary removal. Abused or neglected children of substance-using parents often end up in foster care placement. So, here are the key steps and timetables:

Time-limited family reunification services are those provided to a child and family where the child has been removed and placed in foster care. Family reunification services must be provided in the first 15 months from the date the child enters foster care, with just a few exceptions. Each child must have a case plan that places the child in a safe environment using the most family-like (least restrictive) setting available and in proximity to the parents' home, consistent with the best interests of the child.

For children of parents with substance use or mental disorders, concurrent case planning must also take place, which includes direct input from the treatment professionals involved with the parents. A case review is conducted on the status of each child in foster care no less than once every 6 months, either by a court or by the child welfare agency. The case review will determine: the safety of the child, the continuing necessity for placement, the extent to which the parents have complied with the case plan, progress toward alleviating the circumstances that required placement, and projection of a likely date for reunification.

In addition, each child must have a permanency hearing, usually held in a family or juvenile court, no later than 12 months after the child enters foster care and not less than every 12 months thereafter as long as they are in foster care, depending on the State statute. This hearing determines the permanency plan for the child.

**[Slide VI-4] ASFA Timetables (cont.)**

When a child has been in foster care for 15 of the most recent 22 months, the State must request a petition to terminate parental rights, unless one of the following three conditions applies: (1) a relative is caring for the child, (2) there is a compelling reason that termination would not be in the best interests of the child, or (3) the State has not provided the family the needed services within the required deadlines. A State agency can document in the case plan a *compelling reason* for determining that filing such a petition would not be in the best interest of the child.

One situation that might suggest that termination of parental rights and adoption are not appropriate goals for the child is if a parent is attending a substance use disorder treatment program. A compelling reason might be a favorable prognosis for completing treatment based on clear evidence that the parent is making substantial progress in both abstinence and parenting, suggesting that the child is likely to be able to return home safely within the next six

months. Unless there are justified extenuating circumstances, this factor should not be invoked more than once (Center for the Study of Social Policy, 2005).

- To learn more, review *Criteria and Procedures for Determining a “Compelling Reason” Not to File a TPR* written by the Center for the Study of Social Policy. The link is provided on your resource list.

For more information on the ASFA timetables, you can refer to two handouts in your packets: *Summary of Key ASFA Timetables* and *Exceptions to ASFA Requirements*

#### **[Slide VI-5] Indian Child Welfare Act Protection**

As part of the screening and assessment process, child welfare services workers need to determine if the Indian Child Welfare Act (ICWA) applies to the family. ICWA provides safeguards to protect the interests of Indian families and addresses the removal of Indian children from their families and the considerations that must take place in doing so. The ICWA applies to unmarried Indian children and youth under 18 years of age who are either: (1) a member of a Federally recognized Indian tribe or (2) the biological child of a member of an Indian tribe and eligible for membership in a tribe.

#### **[Slide VI-6] Indian Child Welfare Act Protection (cont.)**

The two most common violations of ICWA are: (1) the failure to identify Indian children, and (2) the failure to inform the tribe once children are identified. To carry out the intent of ICWA, the State child welfare agency and other service providers must participate fully in these provisions and make active efforts to contact the appropriate tribes, involve the tribes in decisions about the family, and allow the tribe to take over the responsibility if it wishes to do so. If you refer to the Handout entitled *Will ICWA Apply?* you'll find a description of the decisions that determine whether ICWA applies and the results of those decisions.

#### **[Slide VI-7] ICWA: Strict Requirements**

Let's look at some of the ICWA requirements.

The ICWA provides *specific and stricter safeguards* for Indian families for removing a child from the family. For example, the court may not issue an order affecting a foster care placement of an Indian child unless clear and convincing evidence is presented, including the testimony of one or more qualified expert witnesses—and this evidence must demonstrate that, if the child's stays in the custody of the parents or Indian custodian, they are likely to receive serious emotional or physical damage (Bureau of Indian Affairs, 1979).

For example, evidence that only shows the existence of community or family poverty, crowded or inadequate housing, alcohol abuse, or nonconforming social behavior does not constitute clear and convincing evidence. Instead, the evidence must show the existence of *specific conditions* in the home that are likely to result in serious emotional or physical damage to the child. It must also show the causal relationship between the conditions that exist and the damage that is likely to result (Bureau of Indian Affairs, 1979).

In other words, a child may not be removed simply because there is someone else willing to raise the child who is likely to do a better job or if it would be "in the best interests of the child" for him or her to live with someone else. Also, a placement or termination of parental rights cannot be ordered simply based on a determination that the parents or custodians are "unfit parents." It must be shown that it is dangerous for the child to remain with his or her present custodians. Evidence for removal must meet the legal standard of "*clear and convincing.*"

Evidence for termination of parental rights must also be "beyond a reasonable doubt" (Bureau of Indian Affairs, 1979).

- To learn more, review the *Bureau of Indian Affairs Guidelines for State Courts; Indian Child Custody Proceedings*. The link is provided on your resource list.

### **[Slide VI-8] Impact of parental alcohol and drug use on children: Considerations**

We want to discuss in detail the ways that children are impacted by their parents' alcohol and drug use. Later, we will talk about the impact of parental mental disturbances. For now, to help guide our understanding of the importance of the impact of these types of parental disturbances on children, keep three things in mind:

The first issue is the potential for *disrupted child development*. Each child is on an individual development path. But children of parents with substance use and/or mental disorders may not progress through normal child developmental milestones. Their family experiences can interfere with typical physical, emotional, and educational development, and may make it more difficult for them to integrate difficult developmental experiences—which is necessary for them to move forward to the next developmental task (Johnson and Leff, 1999; Petterson and Albers, 2001; Karr-Morse and Wiley, 1997). This is not entirely predictable, but we will talk later about some common impacts among such children.

The second issue is the importance of understanding *the child's needs* while a parent is in treatment. Child welfare workers understand the importance of providing assistance and support to children and youth. You know to address children's developmental needs in the context of potential separation and loss of parents, abuse or neglect, and potential experiences with trauma. However, when parents are in substance abuse and/or mental health treatment, you must also work in a close partnership with treatment professionals so that you can ensure the ongoing safety and well-being of the children and so that you can motivate parents to carry out the responsibilities that will enable them to meet the requirements of the dependency court. The child welfare professional may be the key person in touch with and responding to the child's needs.

The third issue is *educating children* about substance use and mental disorders. Child welfare workers must help children develop a foundational understanding about substance abuse and mental illness in terms that are nonjudgmental and supportive. Information must be conveyed in a way that defines the disorder, not the person, and that leads to the child's hopefulness about the possibilities for recovery. It helps children most if the information they receive is appropriate to their developmental stage and age.

And now, to illustrate these concepts, please take out and read the Module 6 Vignette, concerning Lora, Michael and their three children, Freddie, Rita and James.

***[Note to Trainer: Ask the group "What would you say about each of the issues delineated on this slide as each applies to the children in this family?" The group should be able to come up with several suggestions for each item under disrupted child development, child's needs and educating children. You can also ask participants "Where is this family on the ASFA timeline?"]***

### **[Slide VI-9] Childhood Experiences of Parental Substance Abuse**

Now we're going to talk about common childhood experiences of parental substance abuse. Please refer to Handout *Modes of Exposure of Children to Alcohol and Other Drugs*. Generally,

the experiences of children whose parents have substance use disorders can be grouped initially into *prenatal exposure* or *postnatal family environments* (Malanga and Kosofsky, 2003; Chiriboga, 2003; Lester, Andreozzi and Appiah, 2004; Kronstadt, 1991; Mathis, 1998).

Children may have experienced prenatal exposure to alcohol or other drugs, which can impact their normal growth and development (Riley and McGee, 2005; Chasnoff, 1997). Prenatal alcohol exposure can lead to changes in brain structure and have long-term consequences for the children as well as societal costs (Riley & McGee, 2005). Children may also have experienced postnatal environmental risk factors, such as inadequate parenting skills and support, violence, living in poverty, and parental mental illness. These have all been shown to result in or exacerbate developmental and behavioral problems in children (Carta, Atwater, Greenwood, McConnell, McEvoy and Williams, 2001; Ondresma, Simpson, Brestan and Ward, 2000; Kronstadt, 1991).

Let's talk first about prenatal exposure—and then we'll talk about postnatal exposure.

**[Slide VI-10] Substance Use by Pregnant Women by Length of Gestation and Number of Infants Exposed**

Children in your caseload may have experienced prenatal exposure to alcohol and/or other drugs that has impacted their normal growth and development (Riley and McGee, 2005; Chasnoff, 1997).

The latest Federal data available from the National Survey on Drug Use and Health (NSDUH) report on 2003 to 2004 annual averages of substance use by pregnant women. As you can see from this table, the NSDUH found that 4.6% of pregnant women aged 15 to 44 used illicit drugs in the past month. Rates varied by length of gestation, however, with 8% of first trimester women, 3.8% of second trimester women, and 2.4% of third trimester women reporting past month illicit drug use.

Alcohol use was reported by 11.2% of pregnant women, with 22.2% of women in their first trimester reporting alcohol use and the rates then declining to 7% and 4.9% in the second and third trimesters, respectively. Binge drinking, five or more drinks on the same occasion, was reported by 4.5% of pregnant women. Again, rates varied by length of gestation, with 10.6% of first trimester women, 1.9% of second trimester women, and 1.1% of third trimester women reporting binge drinking (Substance Abuse and Mental Health Services Administration [SAMHSA], 2005). Refer to Handout *Effects of Alcohol on a Fetus*.

If we project these percentages to the approximately 4 million infants born each year, we get a wide range of estimated substance-exposed infants depending on substance and trimester of use.

***[Note to Trainer: You can make these numbers applicable to your State, County or Region. Find the data for your State, County or Region's number of births for the latest year available. Then apply the percentages for substance use by trimester to that number of births.]***

It is important to note that these estimates of alcohol and drug use during pregnancy and the number of substance-exposed infants are likely to be lower than what actually occurs, due to individuals underreporting substance use and limited screening and testing done by physicians and hospitals. In one large-scale study of newborns in a high-risk urban obstetric population,

44% tested positive for illegal drugs, while only 11% of mothers admitted to illegal drug use (Ostrea, Brady, Gause, Raymundo, & Stevens, 1992).

For many years child welfare agencies have been working with mothers, their infants and the families affected by prenatal stimulant exposure and can draw on those experiences to create the programs and services needed to address the needs of families affected by prenatal methamphetamine exposure as well.

**[Slide VI-11] Role of Child Welfare Worker: Substance Use by Pregnant Women by Length of Gestation and Number of Infants Exposed**

Child welfare workers must explore as much information as possible about the substance use of the mother and the condition of the child at birth. Children under age 3 should be seen by a pediatrician and referred to the community's provider of services under the Individuals with Disabilities Education Act (IDEA) Part C, Early Intervention Services (the local school district will be able to refer you to the Early Intervention Service Provider in the child's neighborhood). The Early Intervention Service Provider will be experienced in the assessment and treatment of children who were prenatally exposed to alcohol and/or other drugs and will make a determination of the child's eligibility for services based on the type and severity of any existing developmental delay. Older children should also be seen by a pediatrician and may qualify for specialized pre-school programs and interventions provided by the local school district through IDEA Part B services. Making a referral to a school district should include information that the social worker is requesting a determination whether the pre-school or school-aged child qualifies for services under Part B.

- To learn more, review *Information and Infant and Children's Special Education Services*. The link is provided on your resource list.

***[Note to Trainer: As an additional discussion, you can ask participants "What indications do you see in the vignette that any of these children may have been substance exposed at birth?"]***

**[Slide VI-12] 2003 Reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA)**

The Federal Government has recently passed new legal requirements for serving substance-exposed infants. Specifically, the 2003 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) has new requirements for responding when an infant who is prenatally exposed to illegal drugs is identified. Refer to Handout *About CAPTA: A Legislative History*.

These amendments to CAPTA assure that children who have been exposed *in utero* (in the mother's womb) and their parents have access to appropriate treatment and intervention services that they might need in a timely manner.

CAPTA allows for variations in State practice and does not mandate a child abuse or neglect report, only notification of child protective services when a child is identified as substance-exposed. It is the responsibility of each State child welfare authority to decide how to incorporate this required notification into its system and how to ensure that a plan of safe care for these infants is developed. While the amendment does not include identification of infants prenatally exposed to alcohol, it does not keep a State from identifying such infants to ensure that they are referred to appropriate services.

**[Slide VI-13] Prenatal Exposure: CPS Responses**

So, what are the key State requirements for responding to reports of substance-exposed infants? Every State must operate a statewide program for child abuse and neglect that has two components: *policies and procedures*, and a *plan of safe care*.

States must develop *policies and procedures* (including appropriate referrals to CPS systems and for other appropriate services) to address the needs of infants who are identified at birth as affected by illegal substance abuse or who have withdrawal symptoms resulting from prenatal drug exposure. These policies and procedures must require health care providers involved in the delivery or care of these infants to notify the CPS system about these infants (although not in the form of a child abuse or neglect report, or to prosecute). States must also develop a plan of safe care for any infant born and identified as being affected by illegal substance abuse or withdrawal symptoms.

By ensuring that infants who are identified as substance affected are referred to child welfare for a *plan of safe care*, the goals of the CAPTA amendments to address their needs and ensure their safety are met. These referrals don't assume child abuse or neglect, but they may indicate a potential problem. Screening and developmental assessments will determine if individual children need medical and developmental interventions in addition to assurance of their safety.

Child welfare workers must know how their own State responds to these requirements. You must know what provisions have been made for developing a plan of safe care for newborn infants who have been prenatally exposed. Some States have developed responses involving more than just the referral of a drug-exposed infant to CPS. These State responses coordinate with other agencies, such as maternal and child health, developmental disabilities, children's mental health, and child care.

***[Note to Trainer: As an additional discussion, you can ask participants "What do you know about policies and procedures in your own state for safe care of infants identified as having been substance-exposed at birth?"]***

#### **[Slide VI-14] Prenatal Exposure: CPS Responses**

Notifying CPS can mean simply that a routine report has been received and filed. It may also mean that priority treatment is given, with a specific time limit for response, using a screening instrument that reviews safety and risk issues in depth. Some States and localities use decision-making tools to assess risk and safety factors that help workers make informed decisions about appropriate safety responses.

Some States have implemented a "dual-track" or differential system for substance-exposed infants. In this approach, CPS may assess reports of substance-exposed births without a traditional investigation. Hospital referrals of substance-exposed births would lead to a CPS family assessment for services, and investigations would be used only in families in which it is believed the child is at risk of child abuse or neglect.

***[Note to Trainer: If time allows, ask the group: "How are substance-exposed infants identified in your State or county?" "How are substance-exposed infants referred to your child welfare agency?" "What kind of services are available for substance-exposed infants and their families in your State or county?"]***

#### **[Slide VI-15] Prenatal Exposure: Promising Practices**

There are many promising practices developing in different States to respond to infants prenatally exposed to substances and to their families. Let's look briefly at four.

First are coordinated treatment and safety plans. In some States, the birth of a substance-exposed infant triggers several events that are designed to ensure the child's safety and the mother's recovery. One of these events is the development of a substance use treatment plan that is linked with a formal safety plan through an interagency protocol that includes at least the child protection system and the mental health and substance abuse treatment systems.

Second are the interagency protocols. In some States, an interagency protocol governs the information that CPS, treatment, and other agencies can share about the family's history, once a prenatally exposed child is identified. Information covered by the protocols can include such things as prior births of drug-exposed children to the same mother; information on prenatal care; and prior CPS reports for abuse or neglect.

Third are in home services. Once a substance-exposed child has been identified, some States immediately begin voluntary or involuntary home visiting services, using trained nurses, paraprofessionals, or other personnel. These visits can be used to help develop mother-child attachment and parenting skills, explain the benefits of quality child development services, educate parents about good nutrition, and provide information about the full array of family income support programs available for parents of children with special needs. These skilled persons can also help families identify emerging needs of their children as they develop.

Fourth are automatic referrals for developmental screening. In some States, a referral for a developmental screening and assessment is made for all children known to be born drug-exposed, and eligibility for certain services is based on the prenatal exposure rather than the type and severity of the developmental delay.

#### **[Slide VI-16] Postnatal Effects of Substance Abuse - 1**

Now let's discuss possible postnatal effects of parental substance abuse. As I mentioned earlier, children may have lived in family environments that don't have adequate resources to meet their needs. Relationships with, or support from, their parents may be inconsistent. They may not have the steady presence of care-giving persons. The following are examples of typical experiences of children whose primary caregiver abused substances (Substance Abuse and Mental Health Services Administration [SAMHSA], 2004):

- The home life may be chaotic and unpredictable.
- There may be inconsistent parenting and a lack of appropriate supervision.
- Substance-abusing adults may provide inconsistent emotional responses to children, or they may provide inconsistent care, especially to younger children.
- Parents may have abandoned children physically and emotionally.
- Parents may emphasize secrecy about home life.
- Parental behavior may make the child feel guilt, shame, or self-blame.
- Parental behavior may frighten children and may result in physical harm.

#### **[Slide VI-17] Postnatal Effects of Substance Abuse – 2**

Because of their life experiences, children may develop certain feelings, such as:

- Anxiety about the future and constantly preoccupied or worried.
- Believing they have to be perfect.
- Believing they have to become the parent to the parent.
- Difficulty trusting others.
- Difficulty maintaining a sense of attachment.

- Difficulty achieving a sustaining self-esteem.
- Difficulty achieving self-autonomy.
- Feelings of extreme shyness or aggressiveness.

Each individual child will react to life experiences in unique ways, but these are common experiences observed in, or reported by, children growing up in homes with parental substance abuse. Child welfare professionals need to be aware of these possibilities and, in working with each child, be keenly aware of evidence suggesting that any of these responses have taken place.

- To learn more, visit the National Association for Children of Alcoholics (NACOA) website. The link is provided on your resource list. They also have age-appropriate videos for children.

### **[Slide VI-18] Three Key Responsibilities**

So far we have described a host of ways in which children might be affected by the substance abuse of their caretaking parents, but what actions can social workers take to finding evidence for such effects? First, child welfare professionals have three overarching responsibilities for children of parents who are in the child welfare system: ensuring their safety, developing a permanency plan, and providing for their well-being—and those responsibilities apply to children of substance-abusing parents as well.

*Safety* is the core responsibility of the child welfare worker. When investigating allegations of child abuse or neglect, the worker must determine whether, and to what extent, a child is being maltreated and ensure the child's safety. Determining the impact of a substance use or mental disorder on a child and how it is related to child safety issues is a primary function for child welfare. As noted in other modules, the child welfare worker needs to establish a partnership with treatment professionals so that they can work together to ensure that children remain safe.

Developing a *permanency plan* for the family is also a core responsibility for a child welfare worker. Successfully implementing the permanency plan has life-long consequences for children and parents. When children have been removed, or are under consideration for removal, the child welfare professional must work with the parents, treatment systems, and the dependency courts to determine what is going to best protect the children and help them heal from the effects of parental substance use and/or mental disorders.

The permanency plan becomes the statutory framework of requirements for these activities. The permanency plan must describe specific services and supports that will be provided for children and parents. Careful attention to substance use or mental disorder issues can help ensure that reunification of parents and children goes smoothly or can better prepare children for other permanency options, depending on the plan. If these issues are not addressed, youth may repeat their parents' behavior patterns as adults.

Providing for a child's *well-being* is something that is more difficult to define. The Child and Family Service Review (CFSR) standards define well-being as "meeting the child's educational, health and mental health needs." Given what is known about the intergenerational aspects of substance use and mental disorders (whether through genetic predisposition, prenatal or environmental exposure), ensuring children's well-being should also mean meeting children's needs for substance use and mental disorder prevention. Child welfare professionals need to include a plan to address these needs in the child's case plan and they need to consult with treatment professionals about the most effective strategies for educating children about

protecting themselves from developing disorders, especially adolescents at risk for abusing substances themselves.

### **[Slide VI-19] Children of Parents Who Use or Produce Methamphetamine – 1**

***[Note to Trainer: If time allows, ask the group: “What experiences have you had with families who are making or using methamphetamine?” “What did you learn about the children’s experiences?”]***

Special considerations are needed for children whose parents use, sell, or produce methamphetamine. Children of methamphetamine users experience many of the same risks as other children of drug users. However, if children live with parents who are manufacturing methamphetamine in the home, these children face additional risks. It is important to understand the different ways children can be affected by environmental exposure to methamphetamine and the risks to their safety and well-being that are associated with that exposure.

Children are particularly vulnerable when living in a home where methamphetamine is being produced. Children can be affected in many different ways—including exposure to dangerous chemicals and risks to their safety and well-being. For this reason, they are likely to need medical assessment and intervention. These children can also be separated from their parents if the parents are incarcerated.

And so it is particularly important for child welfare to understand the types of parental methamphetamine use that affect children. These are the primary ways that children are affected by their parent’s involvement in methamphetamine (Young, 2006):

- The parent uses or abuses methamphetamine (episodic use)
- The parent is chemically dependent on methamphetamine
- The mother uses methamphetamine while pregnant with the child
- The parent “cooks” methamphetamine in the home
- The parent sells, transports, or distributes methamphetamine (traffickers)
- The parent manufactures large quantities of methamphetamine (super labs)

Each situation poses different risks and requires different responses. However, the greatest numbers of children are exposed through a parent who uses, abuses or is dependent on the drug.

**[Note to trainer: To make this information more specific to your State or county, look at the SAMHSA TEDS data for people that entered treatment in the most recent data available. The data are usually 2 years behind the current year. Refer to Module 1, Presentation 1 for more information.]**

Parents who sell, transport, or distribute methamphetamine expose their children to an increased risk of violence and abuse because of drug trafficking. Weapons are one problem: there may be weapons in the home or the parent’s associates or customers may carry weapons, putting the children at risk for violence. These children are also at increased risk of physical and sexual abuse by those who visit the home (Hampton, Senatore and Gullota, 1998; Shillington, Hohman and Jones, 2001; Rosas, 2003a; Rosas, 2003b).

Another way that children are affected by methamphetamine is through prenatal exposure. Since the crack epidemic of the late 1980s, researchers have become aware that a pregnant

mother's stimulant use can have both direct and indirect effects on her fetus (Lester, LaGasse, Freier and Brunner, 1996). This is because the fetus is directly affected by the cocaine that enters its system and indirectly affected by a decrease in the mother's blood flow that is caused by the cocaine use. Many of the effects of prenatal exposure to methamphetamine are similar to those in infants who were exposed to other substances, particularly cocaine/crack (Arria et al., 2006).

***[Note to Trainer: Many studies compare methamphetamine-exposed infants to infants who have not had this exposure without also comparing them to infants who have been exposed to cocaine or other stimulants. Thus it is difficult to determine whether the effects on the infants are associated with methamphetamine in particular or with all stimulants.]***

Prenatal substance exposure to stimulants can cause birth defects, fetal death, growth retardation, premature birth, low birth weight, developmental disorders, difficulty sucking and swallowing, and hypersensitivity to touch after birth (Anglin, Burke, Perrochet, Stamper and Dawud-Noursi, 2000; Oro and Dixon, 1987; Rawson and Anglin, 1999). Methamphetamine exposure during pregnancy can jeopardize the development of the fetal brain and other organs. An echoencephalographic study of newborns who were exposed prenatally to methamphetamine or cocaine showed higher rates of bleeding, decay, and lesions in the brain (Dixon and Bejar, 1989). A high dose of methamphetamine taken during pregnancy can cause a rapid rise in temperature and blood pressure in the brain of the fetus, which can lead to stroke or brain hemorrhage.

Infants who were exposed to methamphetamine before birth are significantly smaller for their gestational age than infants who have not been exposed, and methamphetamine-exposed infants whose mothers also smoked tobacco had significantly were smaller, compared with infants exposed to methamphetamine alone (Smith, Yonekura, Wallace, Berman, Kuo and Berkowitz, 2003).

Earlier studies have shown similar problems in infants exposed prenatally to cocaine, methamphetamine, or both (Oro and Dixon, 1987). All three groups had altered neonatal behavioral patterns—which included things such as abnormal sleep patterns, poor feeding, tremors, and hypertonia, which is another word for excessive muscle tension. All three groups were more likely to be born premature and to have had intrauterine growth retardation and smaller head circumferences, compared to drug-free infants (Oro and Dixon, 1987). Of the three groups that were studied, infants exposed prenatally to methamphetamine were more likely to have feeding problems due to difficulty in sucking and swallowing. Shah (2006) also found that 34.4% of methamphetamine exposed infants had feeding problems compared to 9.4% of infants prenatally exposed to cocaine. These difficulties suggest that infants prenatally exposed to methamphetamine may fail to thrive.

The long-term effects of prenatal methamphetamine exposure may be similar to the effects from other substances. Children 18 months to 5 years who were exposed to methamphetamine prenatally have less focused attention, are more easily distracted, have poor anger management, and have aggressive outbursts (Shah, 2006). Older children who were exposed before they were born also show cognitive deficits, learning disabilities, and poor social adjustment (Anglin, Burke, Perrochet, Stamper and Dawud-Noursi, 2000; Rawson and Anglin, 1999). Over-stimulation and self-regulation difficulties have also been seen with cocaine-exposed children (Chasnoff, Griffith, Freier and Murray, 1992) and with children exposed to other stimulants. One study showed alterations of brain chemistry in children that may be

related to other findings that some cocaine-exposed children are more impulsive and easily distracted than their children who have not been exposed (National Institute on Drug Abuse, 2001). But we need more research to see if the same effects are found in methamphetamine-exposed children.

Children who have been exposed to stimulants may also be affected by other substances used by the mother and by other risk factors such as the mother's nutritional and health status. Recent surveys indicate that 12-14% of all pregnant women consume alcohol and two-thirds of female smokers continue to smoke during pregnancy (Chasnoff, Landress, and Barrett, 1990). Among pregnant women who use meth, one study showed that nicotine use is nearly universal while 60% of these meth users also use marijuana and alcohol (Arria, Derauf, Lagasse, Grant, Shah, et al, 2006). When you put the multiple substances alongside the environmental risks, you get a situation that can cause significant adverse effects on a newborn (Zuckerman, 1991).

**[Slide VI-20] Children of Parents Who Use or Produce Methamphetamine – 2**

Children who are living in a home where methamphetamine or other drugs are being manufactured may need to go through a decontamination process facilitated by law enforcement, emergency medical services or other public health agency staff. Law enforcement officials should be on-site and should assess the need for medical interventions for children based on their knowledge of the extent of contamination in the home. Workers need to be aware of the child's clothing, toys, blankets and other personal items that may not be safe for the child to take to his/her placement outside of the home (US Department of Justice, 2003).

In all cases, the children should be assessed by a physician for any immediate health or safety concerns. The physician should screen for drug and chemical exposure so that necessary treatment can be delivered. This screening may include but is not limited to getting a urine sample within 2 to 4 hours, taking the children's vital signs, and conducting liver and kidney functioning tests, baseline blood tests and a pediatric physical exam (Denver Family Crisis Center).

The children may not need to be decontaminated if they have been out of the home for 72 hours, but they will need to be examined by their physician. If the children are at school, the risk that they may have contaminated other children or school personnel is minimal because most of the chemicals dissipate in the air once the child is out of the area where the manufacturing is conducted (Denver Family Crisis Center).

***[Note to Trainer: Refer to Module 1, Presentation 2 for more information on worker safety issues related to methamphetamine.]***

***[Note to Trainer: It is important to note here, however, that there is a difference between the manufacture of methamphetamine and the use of methamphetamine. The use of methamphetamine in the house can lead to similar risks factors for children as any other substance of abuse, including alcohol, cocaine, marijuana, etc. Similarly, the dangers of selling, transporting, or distributing methamphetamine will be the same regardless of the specific illegal substance with respect to the risk of arrest, incarceration, and exposure to dangerous individuals. When substance use is the issue, what may be of greater concern for child welfare professionals is the pattern of substance use, rather than the nature of the substance itself. You may want to refer participants back to Module 2 information on substance use, abuse and dependence, and discuss the effects and patterns of use of other substances in comparison to methamphetamine.]***

- To learn more, review the Denver Family Crisis Center *Medical Protocols for Children Found at Methamphetamine Labs*. The link is provided on your resources link.
- To learn more about worker safety issues, review Webber, R. *Working with Methamphetamine Abusers: Personal Safety Recommendations and Procedures*. The link is provided on your resources list.
- To learn more, review Otero, C., Boles, S., Young, N., and Dennis, K., *Methamphetamine Addiction, Treatment, and Outcomes: Implications for Child Welfare Workers*. The link is provided on your resources list.

**40 – 60 minutes      *Facilitated Group Discussion*      20 min.**

Once questions have been addressed, move the whole group into a discussion about prenatal exposure to alcohol or other drugs. Begin the discussion by asking,

**"What is your experience with children affected by prenatal substance use by the mother? What physical or behavioral differences did you notice if you have seen such children?"**

If additional questions are needed to stimulate discussion, you might ask any of the following questions:

**"What kind of services and supports might these children need?"**

**"What kinds of school experience did these children have?"**

**"What kind of social experiences with peers?"**

The GOAL of this discussion is to help participants learn from each other about the real world effects of prenatal drug or alcohol use on developing children. Try not to let one participant dominate the discussion; draw in others to the discussion.

To bring closure to this discussion, emphasize that treatment of children for effects of prenatal substance use by the mother is a specialized field, but a great deal can be learned by observation of such children. Child welfare professionals may be the first to recognize the effects a child has experienced and help such a child access necessary assessments and interventions.

**PRESENTATION 19**

**60 – 80 minutes      *Presentation 19: Impact of parental mental disorders on children; child substance abuse & mental health issues*      20 min.**

***Deliver scripted presentation on the impact of parental mental disorders on their children and covering some types of substance use or mental disorders children may face. Slides VI-21 through VI-28. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on. Keep answers brief. Trainer should only answer questions to which you know the answer.***

**[Slide VI-21]    Mental Disorders: Impact on Children**

One purpose of this module is to help you better understand some of the issues around children who have substance use or mental disorders themselves. Sometimes such disorders reflect parental influence, through genetics, general health, or prenatal behaviors that somehow impact fetal development. And sometimes being the child of a parent with a substance use or mental disorder leads to life experiences that are different than those of other children. In this presentation we're going to focus on mental health issues in children.

It is easiest to talk about the prenatal impact of parental mental disorders on their children by looking at them in terms of three types: 1) genetics; 2) prenatal physical development; and, 3) perinatal trauma.

### **[Slide VI-22] Prenatal Impact**

It is known that certain *genes*, passed from parent to child, increase the chances that a parent with certain mental disorders may pass the predisposition for such disorders to some or all of their children. Not all children of parents with mental disorders receive such genes, and not all with those genes manifest mental disorders. We have not yet figured out how to study the genes of an individual and identify or "fix" inherited predispositions towards mental disorders. But the chances increase, so it makes sense to learn about parental disorders.

*Prenatal physical development* is in great part dependent on the health and behaviors of the mother carrying the developing child. Her nutrition, use of drugs or alcohol, physical activity, and emotional states may all impact the developing fetus, especially the development of the nervous system. For example, untreated prenatal depression is associated with poor birth outcomes, including low birthweight, premature birth, and obstetric complications (Neggers, Goldenberg, Cliver and Hauth, 2006).

The *perinatal or birth experience* itself may have traumatic consequences on the child's development, from such experiences as prolonged or premature labor, head injury, medications for the mother, and others.

None of this means we blame mothers or fathers for their children's special needs, but it does mean that we have to find out if there were significant genetic, prenatal or perinatal conditions. If a child shows signs of a mental disorder, it may reflect the influence of parent health or genetic contribution, but it also may not. It is important to both look for influences as a means to understand how to help the child and families and not to assume such influences.

### **[Slide VI-23] Child Development Impact**

After birth the impact of parental mental disorders on the developing child becomes much more complex, since each family is unique, but some impact from such disorders is unavoidable. The disorder is part of who the parent is. The impact is not always negative, but children born to persons with mental disorders are at a somewhat higher risk of mental disorders than other children.

Consider that most infants experience exclusively the environment around their primary caretaker, and in their earliest learning experiences they will assume whatever is around them is "normal." When a mom has a mental disorder and behaves in ways others might label strange, her children are likely to view that as "just mom," especially younger children. Children not only accept this as "normal" but also generally love their parents very much and are absolutely devastated if they are removed from the home, no matter the degree of abuse or neglect (this reaction can vary depending on the age of the child, type of abuse, etc).

Much research has been conducted to identify the impact of maternal depression on children. The timing, severity, and the length of time a child is exposed to maternal depression can lead to varying degrees of impact (Campbell, Cohn, Meyers, 1995). The effects can be exacerbated by poverty and other social risk factors, (Sameroff, Seifer, Baldwin and Baldwin, 1993).

Maternal depression can lead to various negative consequences for children's cognitive, social, and emotional development. Maternal depression during infancy has a more significant impact on a child's development than later exposure, having been linked to more internalizing behaviors (such as depression and anxiety) and externalizing behaviors (such as oppositional defiant, conduct problems, and overt aggression) (Essex, Klein, Miech and Smider, 2001). Mothers with depression often fail to talk, play, and nurture their children (Huang and Freed, 2006). Depressed mothers were less likely to set limits on their children and to follow through if they did set limits (Kochanska, Kuczynski, Radke-Yarrow and Welsh, 1987). Children of depressed mothers appeared more passively noncompliant, with less mature expressions of age-appropriate autonomy (Kuczynski and Kochanska, 1990).

#### **[Slide VI-24] Assessing Impact**

A developing child's primary needs are security, safety, stability, health, nourishment, someone who cares about them – all the things parents work constantly to provide for their children. When those needs are inadequately met, for whatever reason, the developing child can be affected, often in ways that last a lifetime. And sometimes the reason is the impact of a mental disorder. As children mature and move out into the world to interact with other adults and families, they may begin to see differences – some major – between their life experience and that of others. They may seek more experiences like those at home, or they may withdraw from the outside world to remain safe at home.

Children sometimes take on the caregiver role during a parent's experience of a mental disorder, with significant developmental consequences that may or may not represent a safety risk. The care of children is often or occasionally stressful, even in the "best" of homes. Mental disorders may be triggered or exaggerated by stress. Therefore, a parent or caregiver's mental illness will impact a child with whom they have any contact, but that impact is going to be unique to each parent-child relationship and reflect the unique expression of mental illness in that adult. As said before, the impact will not necessarily lead to a mental disorder in the child, although research shows that such children are at a somewhat higher risk for mental disorder from the combination of genetics and life experience.

Most children who have experienced child abuse or neglect need interventions to appropriately adjust to separation from their parents. Children may have mental health service needs related to traumatic experiences, including treatment for Post Traumatic Stress Disorder, depression and anxiety.

- To learn more, review information on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). The link is provided on your resource list.

***[Note to Trainer: If time permits, you can engage participants in a discussion that draws parallels between parental substance use disorders and mental health disorders. Regardless of the parental disorder, the effects of the behaviors on children may be very similar.]***

Now let's talk about child mental health issues, which may be related to or separate from parental issues around substance abuse or mental health.

### **[Slide VI-25] Children's Mental Health**

There are three reasons that child and adolescent mental disorders are addressed in a field of expertise that is separate from the adult mental health system:

- 1) *Children are still developing.* They begin life completely dependent on adults and (most) are gradually weaned from that dependence as they mature to adulthood. They are constantly and rapidly changing, reflecting growth and experience, but also reflecting naiveté and vulnerability – it is difficult in some children to separate common developmental issues from mental disorders. Childhood developmental processes are complex and challenging for anyone to understand, including professionals, and it is essential that we do understand them if our services are going to be successful.
- 2) *Children are raised in families.* That is what our culture believes, across multiple faith systems, countries of origin, and languages. The adults in families hold the legal rights and responsibilities for the children. Therefore, the families and caregivers of any child with needs must be primary decision makers and chief experts about the needs and care of their child, whenever the child's safety can be maintained in their care. When safety is assured, all efforts are made to keep children in their own families or in family-like settings, and parents always need to be included in care planning and service delivery, however possible. If birth parents are unable to safely care for their children, kinship care should be a primary consideration, again with the child's safety as the top priority. If kin-care is not possible, children still need to grow in family-like settings, however that is best achieved. It is obvious that professionals need to know how to interact effectively with families.
- 3) *Our publicly funded helping systems for children and families have been designed separately,* which means there is the potential for multiple agency and system involvement with any particular child and family, depending on the complexity and severity of their needs. Caring for children with mental disorders can require complex coordination of knowledge and care from multiple helpers and helping systems, and the quality of the coordination significantly impacts the outcomes experienced by the child and family. Child welfare professionals need to know how to work as part of multiple provider teams, advocating for needs and compromising when needed.

A child that grows up in an inconsistent or changing environment, or an environment that provides limited guidance, is at greater risk for growing up with difficulties interacting successfully in the community. Such difficulties may include resistance to rules or authority, experimentation or abuse of alcohol or other drugs, withdrawal and timidity, difficult relationships with peers and/or adults, and others. And such behaviors may be indicators of mental disorders, or may not.

### **[Slide VI-26] Child Mental Health Diagnoses**

As discussed in a previous module, there is a book (The Diagnostic and Statistical Manual of Mental Disorders - DSM-IV) that contains the diagnoses and the criteria for all recognized mental disorders. Some of the diagnoses described in the DSM-IV may occur in children, adolescents or adults, while others are child-only disorders. Generally, professionals with specialized training and experience working with children and/or adolescents are the best choice for assessment, diagnosis and treatment planning.

### **[Slide VI-27] Child & Youth Disorders Data**

Let's look at some of the data about disorders in youth:

- Approximately 9% of all children are considered to have mental disorders that significantly impact their functioning (New Freedom Commission on Mental Health, 2003), and 20% are reported to have diagnosable disorders (U. S. Surgeon General's Report, 1999);
- Children whose first use alcohol, marijuana, or other drugs before they turn 15 are half-again as likely to be substance dependent in adulthood as their peers who begin use after 18 (Dennis, 2006);
- Children who begin using before age 15 are likely to continue using twice as long as their peers who begin after 18 (32 years of use compared to 16 years; Dennis, 2006);
- Youth who enter treatment are likely to achieve sobriety twice as quickly as peers that enter treatment later (17 years before sobriety compared to 35 years; Dennis, 2006);
- Of youth assessed or treated for substance abuse problems, 84% were reported to be sexually active prior to treatment (Dennis, 2006);
- Of youth assessed or treated, 59% were reported to be past victims of physical, sexual or emotional abuse (Dennis, 2006);
- Of youth assessed or treated, 79% were diagnosed with co-occurring psychiatric problems (Dennis, 2006);
- Of youth assessed or treated, 25% had homicidal or suicidal thoughts in the past year, and 16% had actively self-mutilated in the past year (Dennis, 2006);
- Of youth assessed or treated, 84% reported any lifetime juvenile justice system involvement, and 68% reported current juvenile court involvement (Dennis, 2006);
- Fewer than 1 in 10 of these youth were receiving any treatment prior to the reported assessment or treatment (Dennis, 2006).

These data don't tell the whole story, but they begin to suggest how vulnerable our children are to substance use and mental disorders, even before you factor in their experiences growing up in homes with parents involved in the child welfare system. There are clear correlations between mental and substance use disorders, and there are high correlations with other risk factors, such as abuse, violence and juvenile court involvement. Most disturbing of all are the very low rates of reported treatment for any of these youth. Again, you, as a child welfare professional, may be the key person to help identify these needs for individual children and help them receive appropriate treatment.

#### **[Slide VI-28] Self-Harm in Children & Youth**

Let's look now at a specialized type of mental disturbance. Some children, for a host of unique and complex reasons, respond to their life experiences by hurting themselves, which might include self-mutilation or suicide attempts or gestures. Studies indicate that more than 90% of suicide victims have a mental or substance use disorder (Mckeon, 2005). In addition, the combination of childhood trauma, particularly childhood sexual abuse, and mental illness have been shown to increase suicide risk (Goldsmith, Pellmar, Kleinmann and Bunney, 2002). And some young people mutilate themselves. Self-mutilation can include cutting patterns into the skin, burning, scalding, chronic picking at scabs, self-tattoos, hitting parts of the body with fists, aggressive piercing and/or tattooing, battering the body into solid objects, etc. These acts generally indicate that the child is in need of help, but the causes and therefore the interventions will vary widely across such children.

In an extensive study of suicides in Utah, the agencies that victims had most frequently had contact with prior to their suicide were the juvenile justice and child protective services agencies, which led the researchers to the conclusion that suicide prevention efforts should focus on institutions, rather than individuals (Silverman and Felner, 1995). In this group, 63% of

the suicide victims had contact with the juvenile justice agency, and of those, 54% were substance-related. In 27% of completed suicide cases the individual or a family member had been referred to child protective services. Of the individuals referred, 83% were victims of abuse. Only 5% to 20% of suicide completers were in psychiatric treatment at the time of their deaths (Gray, Achilles, Keller, Tate, Haggard, et al, 2002).

Suicide attempts are not always intended to be final. The vast majority of child and adolescent suicide attempts (or gestures) are intended to call attention to pain or hurt the child has experienced, even though they might resist acknowledging or addressing those hurts. And children and adolescents do sometimes die from attempts to call attention. When any child dies from a suicide attempt the surviving family must become the immediate focus of care and concern.

As a group, those who have made one or more attempts are at an elevated risk for an additional attempt(s), but that does not mean each individual child will make more attempts. Where the suicide attempt reflected an underlying depression (diagnosed or not), it is likely that the depression will recur episodically or at a later age, although effective treatment can mitigate later emergence of the depression.

Therapeutic approaches exist, and more are being developed, to help individuals who engage in self-harm to help them develop new coping mechanisms to replace the self-harming behaviors. It is believed that once the self-harming behaviors can be stabilized, work can be done on the issues that underlie the self-harm. In addition, research into the use of medications that reduce depression or anxiety and stabilize mood for those who self-harm is being conducted.

It is important that you remember that not all children react to their hurts with acts as dramatic as suicide or self-mutilation. Other types of reactions are important to identify and treat, such as insecurities, empathy problems, learning difficulties, and struggles with impulse control.

- To learn more, visit the American Self-Harm Information Clearinghouse website. The link is provided on your resources list.

**80 – 100 minutes      *Facilitated Group Discussion*      20 min.**

***Once questions have been answered, begin a whole group discussion by asking,***

***“How do you feel about a parent with a serious mental disorder having and raising children? Are your feelings affected by the type of disorder a parent may have?”***

***To stimulate group discussion, you might ask the following:***

***“How are your feelings affected if a parent with a mental disorder chooses not to participate actively in treatment for their disorder?”***

***“How does the presence of a mental disorder impact their parental rights?”***

***“What about the child’s rights? How do you think they are affected?”***

***Ask: “What is your reaction to Michael as he leaves some of his issues unresolved? What are some red flags you see there?” “What about Lora?” “What is your reaction to her diagnosis and behavior?” Here you are searching for an understanding of the material in this module, as well as any additional comments about the diagnosis of***



physical capabilities and behaviors by a qualified assessor. Deviations may not immediately be labeled a mental disorder, but an assessment by an appropriately trained professional will help determine causes and identify potentially effective interventions.

### **[Slide VI-30] Assessment of Children**

Even though community mental health systems are predominantly focused on adults with serious and persistent mental illness, many communities do have specialized child mental health units. In any case, a professional with training and experience with children and adolescents should conduct assessments and/or treatment for a child or adolescent with possible mental health needs.

Primary caregivers are very important in the initial screening as well as any ongoing assessment of children's mental health needs because they can provide historic and contextual information, as well as expertise gained from providing care. This especially includes parents who may not currently have custody but for whom reunification is a case plan goal, and it may also include foster parents. Diagnosis and recommendations for care should be discussed with primary caregivers to determine the most effective plan of care for a child with needs. And as you prepare, be sure to include all activities that are necessary to help the child and the family receive the services they need from appropriate community agencies.

### **[Slide VI-31] Effective Care Strategies**

Now we are going to talk about a set of specific treatment strategies that you'll want to become familiar with to assure that children receive necessary and appropriate services.

*Meaningful family involvement* – A child's needs are better met when people that the child considers "family" participate in planning, delivering and evaluating services. But parents and other caregivers are not always well prepared to participate meaningfully in system processes. Sometimes you are going to need to focus your efforts on educating and encouraging parents to involve themselves productively in these activities. You can help parents to understand:

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

***[Note to Trainer: As an additional discussion, you can ask participants "How would you work with Michael, Joy and Lora to help meet the needs of the three children?"]***

*Close cooperation with other helpers* – Helpers and parents will need to work together to address the needs of children, and both may need to cooperate with other helpers to address a child's needs. A child welfare professional has an important role in cooperative practices and is likely to need help from others with different skills and knowledge if care of each child is to be successful. Teamwork takes time, but the attitude of wanting to work successfully with community partners is key to collaborative success.

***[Note to Trainer: As an additional discussion, you can ask participants "How do you develop an alliance with the three adults in the vignette?"]***

*Exploration through further assessment* – A main objective of this curriculum is to help child welfare professionals understand when and how to seek additional assessments for parents of children involved in the child protection system, but the same strategy is important for children with possible disorders. If the parents and child welfare professional are unsure about the existence of a disorder, it is always appropriate to ask for help from more specialized providers who have the right knowledge, skills, and licensure.

*Child specific teams* – For children and/or families with multiple or complex needs, you will have the best outcomes if you can work with a child-specific team, bringing together people who are important to the child, including informal family supports and professionals with specific, relevant expertise or responsibilities. If possible, a single, integrated plan should be created to address all system requirements. Without question, parents, primary caregivers, other family members and the children themselves should be included in such teams to the extent that they can express their own wishes and needs.

*Peer-to-peer strategies* – Current best practices recognize that peers can accomplish things a professional, paraprofessional, or family member can't. Someone who is "similar" or who can "speak the same language" can provide support to a person with a substance use or mental disorder that is unobtainable from anyone else. Children and parents alike may benefit from peer support. Peer-run service delivery organizations have been very successful in many states. In some communities, parents who have successfully resolved their families' child protection issues and have entered recovery are mentoring other parents currently involved in the system.

*Family advocacy* – Parents, caregivers and other family members benefit when they have advocacy—or support—that is available and accessible to them. Each person connected to a helping system can provide advocacy in many different ways. But for parents with substance use or mental disorders and also involved with the child welfare system, advocacy to help them understand their rights and their possibilities for successful help is especially beneficial, and that advocacy can come from anyone.

***[Note to Trainer: There are a variety of advocacy groups in all communities that provide trained advocates to support families. In advance of this session, you may research local advocacy organizations and share this information with participants. You can also use this opportunity to engage participants in an optional discussion of local advocacy groups.]***

### **[Slide VI-32] Developing Support Systems - 1**

When developing support systems for the children, child welfare workers need to do the following:

Ensure that the child receives a comprehensive assessment that will give insight into developmental progress, the neurodevelopmental effects of any prenatal substance exposure, learning disabilities, and health and mental health care needs. You can access these services through a service that is called the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service. EPSDT is a comprehensive and preventive child health program for individuals under the age of 21 who receive Medicaid benefits. It is designed to ensure periodic screening, vision, dental, and hearing services. It also requires that certain medically necessary health care services be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

- To learn more about EPSDT, visit the Centers for Medicare and Medicaid Services website. The link is provided on your resource list.

It is critical that children receive services to intervene and treat the effects of parental substance use or child abuse and neglect. These services are often delivered by a variety of agencies and disciplines through agreements with the child welfare agency. When you make the referrals to these agencies, be sure that they include information about the parent's status in treatment. This is particularly important for foster parents who may be responding to the special needs of foster children. In fact, foster parents may require special training regarding the neurodevelopmental effects of prenatal substance exposure or postnatal family environments, including exposure to violence, so that they can provide effective care giving.

***[Note to Trainer: As an additional discussion, you can ask participants “What sort of information would it be helpful to have about Freddie that we don’t have already? How could more thorough assessments be helpful?]***

### **[Slide VI-33] Developing Support Systems - 2**

An important part of your job is helping children develop an understanding of substance use and mental disorders that is supportive and nonjudgmental. This means that information about their parents' substance use or mental disorder must be conveyed in a way that defines the disorder, not the person, and is appropriate to the developmental stage and age of the child.

In addition, if it is appropriate to the permanency plan, try to develop an effective visitation program between parents and children that will help the children understand what is going on in their lives and that will give them an opportunity to maintain a relationship, safely and positively, with their parents.

### **[Slide VI-34] Talking With Children About a Parent’s Disorder**

How should child welfare professionals talk to children about their parents' substance use or mental disorder? First and foremost, these discussions must take the child's age and development into consideration. The child welfare professional can also help the foster parent or kinship care provider talk to the children in their home about the parent's substance use or dependence or mental disorders. That said, the four talking points on this slide can be used to help guide these discussions:

- First, addiction and mental disorders are largely based on physical disease processes. It is important that you explain to the child that their parent is not a bad person. She or he has a disease or an illness. You should also explain that the use of alcohol or other drugs may cause their parent to lose control. Be sure to tell them that when their parents drink or use drugs or are experiencing a mental disorder, they may behave in ways that do not keep the child safe or cared for.
- You can also tell the child, “You are not the reason your parent drinks or uses drugs or has a mental disorder. You did not cause this disease. You cannot stop or fix your parent's disorder.”
- It is important for children to realize that they are not alone. You can say, “There are a lot of children like you. In fact, there are millions of children whose parents are addicted to drugs or alcohol or have a mental disorder. Some are in your school. You are not alone.”
- And finally, help the child come up with a game plan. You can say, “Let’s think of people you might talk with about your concerns. You don’t have to feel scared or ashamed or

embarrassed. You can talk to your teacher, a close friend, or to an adult in your family that you trust.”

You might want to keep questions like this on a small card to remind yourself about these important points as you talk with the child.

### **[Slide VI-35] 7 C's of Addiction**

The National Association for Children of Alcoholics developed the 7 Cs of Addiction to help children understand that they are not responsible for another person's addiction to alcohol or other drugs. Please refer to Handout in your packet that is called “Remember the 7 Cs.” This exercise can help children understand that their parent’s drug or alcohol use is not their fault. The same message is here on this slide:

#### **Remember the 7 Cs**

Some children with moms and dads that drink too much think that it is their fault. Maybe you are one of those children. Well, it's not your fault and you can't control it. But, there are ways that you can deal with it. One important way is to remember the 7 Cs.

I didn't **Cause** it.

I can't **Cure** it.

I can't **Control** it.

I can **Care** for myself by

**Communicating** my feelings,

Making healthy **Choices**, and

By **Celebrating** myself.

Even though this exercise was developed for use with children of alcoholics and has not specifically been used with children of parents with mental disorders, the same concepts can be applied. In fact, when working with children whose parent has a mental disorder, mental health treatment professionals often tell these children “you didn’t cause it and you can’t fix it.” Using the 7 Cs with children of parents with substance use and/or mental disorders can increase their ability to cope with their experiences. The 7 Cs is a message that child welfare professionals can use repeatedly with children. Refer to Handouts *It's Not Your Fault* and *You Can Help: A Guide for Caring Adults Working With Young People Experiencing Addiction in the Family* for an additional resource you can use with children and youth.

- To learn more, visit the National Association for Children of Alcoholics website. The link is provided on your resource list. They also have age-appropriate videos for children.
- To learn more about strategies for working with children of alcoholics or drug-dependent parents, order the Children’s Program Kit. The link is provided on your resource list.

### **[Slide VI-36] Needs of Children with a Parent with a Substance Use or Mental Disorder**

So, what are the typical needs of children who come from homes where parents have substance use disorders and/or mental disorders?

- First of all, children need the opportunity to identify and express their feelings an adult who is safe and who they trust.
- Children also need information about substance use and mental disorders so that they know they are not to blame.
- These children need to be screened for developmental delays, medical conditions, mental disorders, and substance use disorders, and they need appropriate follow up.

- They may need to participate in counseling or peer support groups.
- And finally, they need consistent, ongoing support systems and caregivers who will keep them safe and help them recover over an extended period of time.

**[Slide VI-37] How Child Welfare Workers Can Help**

How can the needs of children be met by child welfare workers, in partnership with substance use treatment and mental health professionals? Child welfare and treatment services need to work together to address the entire family, rather than separately addressing the needs of children in the child welfare system and the needs of parents in the treatment system. Addressing family needs is an ongoing process. It begins with the initial screening and assessment for child abuse and neglect, and screening for substance use and mental disorders. And then it continues throughout the family's participation in the child welfare system. During this time:

- The parents are encouraged and supported to receive appropriate treatment,
- Child welfare staff and the dependency court monitor the progress of parents to meet their sobriety goals and to establish their capacity to take care of their children.
- During this time, parents should continue to relate to their children through regular visitation in appropriate settings.
- And, as I just explained, the child welfare worker and treatment professional need to partner together to meet the needs of parents and children to support a positive outcome.

**[Slide VI-38] Case Plans and Children's Needs - 1**

What are the key elements that you need to address in a child welfare case plan to ensure that the children's needs are met? There are a few steps that you need to follow if you are going to develop an effective plan:

- First, you will need to oversee the assessment of the child's health, mental health, educational, social, behavioral, and emotional needs.
- Second, be sure to arrange for interventions that address the assessed needs of the child.
- Third, you must determine the strengths and the limitations in the family's capacity to meet the child's needs, and you will need to determine which unmet needs require special services.
- In addition, the plan you develop should specify the services that are needed by parents, as they progress through treatment, which will enable them to best meet their children's needs.

**[Slide VI-39] Case Plans and Children's Needs – 2**

This slide lists three more steps that you need to take:

- You need to collaborate with school or childcare systems to best determine how to provide support.
- Whenever and however possible, depending on their age and where they are developmentally, involve children and youth in case planning/treatment planning -- gather their input, their needs, and information about their goals so that you can identify potential support systems.
- And finally, using this information, you should be prepared to supervise and monitor the progress of the children so that you can address improvements in their development and health that parallel the efforts that are being made by and for the parents in treatment.

**[Slide VI-40] Case Plans and Children's Needs – 3**

And finally, you can support children by including opportunities for them to develop skills and their ability to express themselves.

- In terms of promoting skills, it is especially important that the plan you develop include opportunities for children to participate in substance abuse prevention programs that will give them strategies and skills they can use to avoid repeating the substance-abusing behaviors of their parents.
- To help children learn to identify and express their feelings in healthy ways, it is also critical that you link them with safe and trusted adults who can help them learn to express themselves and who can provide age-appropriate messages about substance use and mental disorders.

#### **[Slide VI-41] Children's Safety Plan: Basic Elements**

You have an important role in developing a safety plan for these children too. The plan, which you should develop along with treatment professionals, will address the possibility of a parent's relapse or the re-emergence of a mental disorder. Let's go over some of the most important elements of this plan:

- First, the plan should include the names of people who will regularly check on the well-being of children. This could include family members or neighbors.
- The plan should also list people or locations, agreed to ahead of time, where the child can be placed if parents abandon them or are unable to provide a safe environment for them to live.
- The plan needs to include the trigger behaviors that treatment professionals will use to bring safety plans into play.
- Safe havens need to be identified where parents can send children if they feel they are going to start using substances or if symptoms of a mental disorder reoccur or if the parent relapses into inappropriate behavior around and toward children.
- Finally, respite opportunities, appropriate to the child and parents' needs and wishes, should also be included.

It is important here not to assign children an active role in their own safety plans, such as requiring them not to ride with a parent who has been drinking. This places the child at too great a risk due to the power difference between parent and child. Active participants in safety plans need to be adults.

#### **[Slide VI-41] Community Mental Health Resources**

Other resources may be available to you but these will be different in each community.

For example, some local school districts offer specialized, effective services for children and adolescents with substance use and/or mental disorders, but the majority do not, for a wide range of reasons. Caseworkers should work with local school staff responsible for pupil services to learn about capabilities at the local level. You may also want to contact the office that is responsible for special education.

Some local juvenile courts offer specialized, effective services for youth with behavioral health issues if they are prioritizing treatment over punishment, but the majority do not. You should work with local probationary and administrative managers to learn about local capabilities in this area.

On the other hand, virtually all communities have mental health service providers, and they may employ staff with expertise working with children and their families, but the quality and

effectiveness of such providers varies greatly. Some mental health service providers are non-profit, while some are for-profit. Mental health providers are generally licensed within each State (if they accept public funds or provide legally defined services), while some are certified by national or regional organizations (e.g., CARF). Caseworkers should work with mental health agency supervisors and managers to learn about local system capabilities.

***[Note to Trainer: There are a variety of mental health resources in all communities. In advance of this session, you may research local mental health organizations and share this information with participants. You can also use this opportunity to engage participants in an optional discussion of local resources.]***

#### **[Slide VI-43] Gather and Maintain Information - 1**

Another way child welfare professionals can support families is by gathering and maintaining information about community prevention, early intervention, and treatment services provided by the mental health and medical systems, the schools, child care programs, and community-based organizations. In particular, child welfare offices should have ready access to the services that are listed here:

- Individual counseling services for children with mental health or substance use problems.
- Substance abuse prevention and early intervention programs to help children and youth develop healthy lifestyles that do not include the use of alcohol and other substances.
- Support groups, such as those offered by Children of Alcoholics, Alateen, or Alanon, can assist children with the behavioral consequences of having substance-abusing parents, including self-blame, guilt, parenting the parent, etc.
- And medical screenings and care so that physical conditions associated with learning, development, and stress are addressed.

#### **[Slide VI-44] Gather and Maintain Information - 2**

Other information that child welfare offices need to gather includes:

- Ongoing, daily, quality childcare that addresses their developmental needs. This could be care from kin, foster care, or child care programs.
- Regular contacts with special education teachers and schools to ensure that children with learning disabilities are receiving the necessary special education services and to help prevent behavioral problems that arise from untreated medical or learning problems.
- And finally, the child welfare office should have on file resources available for counseling and other service referrals for children whose families are in recovery and who have returned home to ensure that they continue to have access to ongoing support.

#### **[Slide VI-45] Resources for Children with Disabilities**

Research links prenatal use of alcohol and illegal drugs with learning disabilities. There is a wide range of possible effects, both from prenatal drug exposure and from the impact of alcohol and drugs on the family environment. These may be severe, such as Fetal Alcohol Syndrome or alcohol-related neurodevelopmental effects. They may also be relatively mild experiences with learning problems or attention deficit disorder.

It is critical to supply all children with disabilities like these with resources provided by the Individuals with Disabilities Education Act (IDEA) as early as possible in their lives and to provide them with family and caretaker environments that can nurture and work with children with these needs. Special education services will be tailored to the needs of the child and may



***and apply to their work with families. Ask the group whether they have changed any personal attitudes as a result of this session. The GOAL of this brief discussion is to help participants think about what they will take away from the session. At the end, thank them all for participating.***