Substance Use Disorder (SUD) Protocol

(Revised 01/08/2019)

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Introduction

Purpose

This Protocol assists CWS staff with the investigation, case-planning and management of cases where substance use contributes to the harm and danger to the child(ren). When children are unsafe due to parental substance use, the SW needs to engage the parents and their support system in developing a short- and long-term safety plan for the children. These engagement efforts start from the very first interaction with the family and should continue throughout the life of the case/referral.

For purposes of this Protocol, the term "parents" includes the child's mother and/or the child's father and/or any custodial caregiver of the child.

CWS intervention

CWS intervenes in the following situations when a child has been harmed or is in danger due to parental substance use:

- The parent is under the influence of alcohol and/or drugs when an accident and/or injury occurs to the child.
- The parent's substance use interferes with his/her ability to meet a child's physical and emotional needs.
- The parent's substance use interferes with his/her ability to meet the medical needs of the child who is determined to be medically fragile.
- The mother gives birth to a drug-exposed infant with additional risk factors like withdrawals, birth weight, prematurity, failure to thrive, SIDS, FAS, etc.

Substance use in and of itself does not warrant intervention by CWS. Each family where substance use has been identified must be assessed based on the impact of the parent's substance use on the child.

When the parent or child's substance use is assessed to have contributed to harm or danger to the child, referrals for Substance Use Disorder (SUD) treatment can be provided at any point in a CWS referral/case.

SDM

The **SDM Safety Assessment** tool is used in assessing the present harm or danger to a child as part of a referral investigation and whenever additional information becomes available or circumstances change. Substance use can contribute to most of the safety threats on the SDM safety assessment including physical abuse, neglect, domestic violence, sexual abuse and failure to protect and is listed as a complicating behavior as "Substance abuse."

The **SDM Risk Assessment** helps in determining whether a CWS referral needs to be opened for ongoing services. The "Primary Caregiver Has/Had an Alcohol and/or Drug Problem" factor in the neglect index is a critical part of determining the overall risk score.

Overview of SUD

DSM-V definitions

The DSM-V describes SUD as:
"...a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance related problems…an important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders (pg. 483)."

The DSM-V bases its diagnosis on "pathological pattern of behaviors related to use of the substance" that is grouped into the following major criterion:

1. *Impaired control* – for example, taking the substance in larger amounts over a longer period of time than originally intended, multiple unsuccessful efforts to decrease or discontinue use, spending a great deal of time obtaining, using and then recovering from the use. Craving or intense desire to use, usually triggered by specific environmental conditioning rewards (pg.483).

2. *Social Impairment* – for example, failure to fulfill obligations at work, school, or home, continual use despite recurrent interpersonal and social problems caused or accentuated by substance use, withdrawal from family activities to use substances, and important social and recreational activities may be given up or reduced to the substance use (pg.483).

3. *Risky use* – for example, recurrent substance use in situations which may be physically hazardous, continued use of the substance despite a persistent physical or psychological problem that may have been caused by the use in the first place, or "failure to abstain from using the substance despite the problems it may be causing" (pg.483).

4. *Pharmacological criteria* – for example, markedly increased tolerance of the substance dose required to achieve the desired effect/high, or the markedly reduced effect when the usual dose of the substance is consumed. Withdrawal symptoms after prolonged, heavy use of the substance with the individual likely using again to relieve the symptoms (pg.484).

Substance classes

The DSM-V categorizes substances into the following classes:

- Alcohol
- Caffeine
- Cannabis
- Phencyclidine
- Hallucinogens
- Other hallucinogens
- Inhalants
- Opioids
- Sedatives, hypnotics/anxiolytics
- Stimulants
- Tobacco
- Other (or unknown)

NOTE: Click here for a quick reference to commonly used drugs.

Marijuana

With the passage of Proposition 64 in 2016, marijuana is legal to consume recreationally in the State of California for adults 21 years and older.

Marijuana cases are to be treated the same as cases that have alcohol as the primary substance of choice when it comes to abuse or addiction. **The CWS SW must be able to document the impact of the Marijuana use on the child(ren) in the case where its use is an issue.**

Additionally, each treatment provider may have their individual policy regarding how they tolerate marijuana use in treating SUD in their programs. Due to cross-addictions, they may have a no-tolerance policy towards marijuana use or choose to address it the same as the abuse of or addiction to prescription medications.

MAT

Medication Assisted Treatment (MAT) is the use of medications in combination with counseling to provide a client centered approach to the treatment of SUD. The medication is used to overcome opioid and alcohol addiction and is supervised in a safe and controlled setting.

MAT is **not** a protective issue **unless** you can tie how the client's use impacts the child's safety. Clients in a MAT program can reunify with the child if found to be in the best interest of that child and for the client to sustain recovery.

NOTE: See MAT policy for more information.

Dual Diagnosis	The parent may have a dual diagnosis consisting of co-occurring SUD and severe mental illness. A parent's behavior or appearance, often associated with substance use, may be the result of a medical or mental health condition. Documentation of this information may be available in the parent's medical records; however, a medical or mental health condition alone does not eliminate the possibility that a substance use problem exists. When psychiatric and SUD coexist, both should be thought of as primary and utilize integrated dual diagnosis specific treatment interventions. (Kenneth Minkoff, M.D., CCISC Model). Drug treatment sites will make referrals to the appropriate level of mental health treatment. Most programs can utilize onsite Mental Health Clinicians for referral evaluations. When needed, based on case assessment, the SW can make appropriate recommendations in court reports to have the Juvenile Court order Psychological/Psychiatric evaluations through the County TERM team providers.

Assessing SUD

Challenges	Gathering substance use information can be very difficult, even for a SUD professional. The first source of information about a parent's substance use is the parent's self-report. The parent may deny substance use problems. Although the SW may have knowledge of, or strongly suspect that a SUD problem exists, the SW's primary focus will be the child's safety. It may take several months before a parent reveals a substance use problems, if ever. The SW must gather information from all sources to assess the parent's substance use. **NOTE:** The parent may have a medical or mental health condition that appears to be SUD, or a co-occurring disorder consisting of both a medical or mental health condition and SUD. Therefore focus on the safety of the child is essential.

Features

The following is a list of features that **may** be exhibited by a SUD parent:

- Lack of adequate supervision and/or failure to protect children
- History of physical, sexual or emotional abuse, or neglect
- Failure to provide necessary medical care and/or lack of prenatal care
- Failure to model appropriate adult and parental roles
- Domestic violence
- Current/recent involvement with law enforcement agencies and the courts
- Unemployment or underemployment
- Inability to maintain stable living arrangements
- Social isolation
- Increased incidence of sexually transmitted infections, including HIV and AIDS
- Unsafe and/or unsanitary physical environment
- Poor general health and nutrition
- History of and/or current mental health problems.

NOTE: The existence of one or more of the above does not **prove** that a parent is using alcohol or drugs. The intent of this list is to describe common features found in many (but not all) substance-using people.

Effects on children

The following factors **may** affect children as a result of a parent's SUD:

- Positive drug test due to exposure to drugs
- Drug exposed infant experiencing withdrawals and/or birth complications
- Child using alcohol and/or other drugs
- School problems
- Delayed development
- Parentified behavior
- Unkempt appearance, poor hygiene and/or inappropriate dress
- Lack of supervision
- Mood disturbance/anxiety
- Poor nutrition
- Lack of basic medical/dental care
- Social isolation
- Intense focus on basic needs.

Additional factors

The level of danger to the child and ability of the parent to protect and care for the child must be assessed in conjunction with the following factors:

- Age of the child
- History of violence or child abuse related to substance use
- Severity and duration of substance use
- Detriment to the child
- Parent's willingness to engage in treatment/previous treatment history
- Availability of support system/safety network.

Appearance and behavior

A critical assessment tool for evaluating a parent's substance use is appearance and/or observable behaviors of the parent. The SW should be aware of the following indicators, which may assist in the documentation of substance use.

NOTE: Some of these factors may be due to physical or mental health issues and do not necessarily indicate substance use.

Appearance	Behavior
• Burned fingertips or lips • Drug symbols and/or paraphernalia • Extremely thin • Needle marks or tracks • Profuse sweating, chills • Ulcers • Sores around the nose or on other body parts • Alcohol breath • Bloodshot eyes • Poor physical/dental hygiene • Erratic eye movement • Enlarged pupils • Pinpointed pupils • Watery eyes • Acne and/or sores • Broken blood vessels on the nose • Runny nose and/or sniffing • Wearing sunglasses indoors	• Belligerent and/or abusive • Blank stare, stupor/non-responsive • Distracted and/or poor concentration • Hyperactivity and/or agitated • Anxious and/or agitated • Lethargic • Nodding off • Paranoia • Scratching • Strong thirst/dry mouth • Tremors and/or shaking; e.g., hands • Unusual behavior • Rapid/excessive talking or slurred speech • Mumbling and/or rambling • Unstable balance and/or coordination

Additional sources of information

The SW will consider any of the following when assessing for SUD:

- Observation by child of the parent using alcohol and/or other drugs
- The parent not taking their prescription medication as prescribed and/or mixing street drugs with prescription medications
- Evidence of drug use and/or manufacturing in the home by law enforcement/DEA
- Reliable information from other service professionals (e.g., probation officer, Cal WORKs/Human Services Specialist) that the parent is using alcohol or other drugs
- Reports from the parent's significant other, family members, neighbors, and/or friends that the parent is using alcohol or other drugs
- Law enforcement records indicating the parent's arrest for driving under the influence (DUI) and/or drug related offenses
- Hospital records indicating the parent's drug related hospitalizations and/or frequent emergency room activity
- Medical records from the parent's physician to rule out any prior physical/medical (or organic) conditions
- CWS records indicating the parent has prior SUD related referrals
- Positive toxicology/drug test results.

SOP with parent

The following table provides examples of specific topics and questions that can be utilized in an SOP assessment interview for a parent with SUD. These questions can also help provide a timeline of the parents substance use, periods of sobriety and relapse to identify strengths and needs. A version of these same questions can be used to talk with the non-offending parent to get his/her position on the issues and their ideas to build more safety for the child.

NOTE: If the interviewee identifies their drug of choice, the interviewer may directly identify the specific substance in the question.

Prompting Safety Actions	Sample Questions
What we are worried about:	• When do you use drugs/drink alcohol most often? What are some reasons you used drugs/abused alcohol? • What is your understanding of what people are worried about? • Do you think that I might be worried at all about this? What do you imagine I am worried about? • If your children were here right now and were able to speak about this, what would they say worries them about your substance use? • If X (family member who is seen as important) were here right now, what would he/she say worries him/her about your substance use and how you care for your child? • If Y (professional/therapist) were here right now, what would he/she say worries him/her about your substance use and how you care for your child? • Are you worried about the same thing? Why/why not? • How has your substance use impacted your child?

SOP with parent (cont.)

Prompting Safety Actions	Sample Questions
What is working well:	• Have you ever felt like using but didn't? When was that? Can you tell me what you did? How did you do it? • Has there ever been a time when you were using but you were somehow able to care for your child's needs and make sure they were safe? When was that? Can you tell me what you did? How did you do it? • What have you done in the past to keep your children safe when you were using? • How have you coped with your substance use? What has kept you going? • How do you think your children have coped with your drug/alcohol use? What has kept them going?
What needs to happen next:	• What type of relationship would you like to have with your child? What can you do to create that relationship? • If things keep going as they are, what do you imagine will be your child's story about this time in his/her life? Is that the story you want for him/her? What story would you hope for instead? • Imagine that it is six months from now and you have found a way to parent your children without using any drugs or alcohol. What would that be like for you? How do imagine you would have accomplished this? What would have been the very first step?
Scaling Questions (mostly related to "What needs to happen next")	• On a scale of 0 to 10, where 0 = your child has to struggle to get what he/she needs when you're using; and 10 = your child is never around when you're using and he is thriving and happy, where do you scale your child's current situation? What got you to that number? What would it take to move that number up just one point on the scale? • If your children were here, where would each of them scale the current situation? What would have gotten them to that number? What do you think they would say needs to happen to move the scale up just one point? • Where would your spouse/partner scale the situation? What would they say got it to that number? What would they say needs to happen to move it up just one? • Where do you think I (the social worker) would sit? What do you think would get me to that number? What do you think I would suggest moving that number up just one point? What number on the scale do you think the situation would need to be so that your children would not be affected by what is going on? What would be happening if things were at that number?

SOP with parent (cont.)

Prompting Safety Actions	Sample Questions
Prompts for Safety Networks	• Who in your life already knows about your case with us? • Who really "has your back"—who can you really trust? • Who knows you and your parenting at its best? • If you suddenly became sick, who would you trust the most with your children? • If your children were here right now, who would they say they trust the most? Who would they say they hope would be there for them? • If you had to pick one person to come to a meeting, to start talking and sharing about what's going on, who would you want it to be?

SOP with child

Including the voice of the child in every child abuse investigation is critical. Safety-Organized Practice provides a variety of tools that allow the child, in developmentally appropriate ways, to meaningfully contribute to both the assessment process and to safety planning.

Two tools that can help keep child's voice at the center of our work are:

Three Houses: This tool solicits the child's perspective on the three questions, "What are they worried about?" (House of Worries), "What's working well?" (House of Good Things), and "What needs to happen next?" (House of Dreams). Essentially this is a version of safety mapping for the child.

Safety House: This tool helps get the child's perspective on what needs to happen for them to feel safe in their home. It is particularly useful for reunification, but can also be used in ER, VS, FM, and PP cases.

Case Plan

Components

The CWS case plan is separate from the SUD treatment plan devised by the service provider. SW's will utilize the Child Adolescent Needs and Strengths (CANS) tool and CFT meetings during case planning to assess and identify the child and family's strengths and needs to create a case plan that will help the family achieve their safety goals. The CWS case plan will consist of culturally appropriate objectives, safety actions, and services that address the SUD issues. If the parent/caregiver is Court ordered to SUD treatment, the recommended case plan will become part of the court order.

The SW can identify the following services in the case plan:

- Enrollment in a SUD treatment program
- Participation and progress in a 12-Step Program (i.e., AA, NA, etc.)
- Drug testing
- Parenting classes that address substance abuse problems
- Ancillary services such as childcare, respite care, transportation, etc.
- Referrals for involved family members to Al-Anon, Nar-Anon, Alateen, etc.

The following are examples of objectives/safety actions that can be used in case plans:

- Develop a safety network that can support your sober lifestyle
- Create and maintain a drug free living environment for you and your child
- Show up to visits clean and sober.

NOTE: See Case Plan policy and Case Plan Field Tool for more information.

Parent Treatment Services

SAS

Parents in VS, FR, and FM will be referred to the Substance Abuse Specialist (SAS) when the SW assesses and/or suspects that the parent(s) has SUD. The SAS will complete an initial substance use screening and make appropriate recommendations for treatment if found appropriate.

If the SAS recommends the parent to treatment, the SAS will:

- Provide the parent(s) an intake appointment for the treatment center, and
- Inform the SW of the location, time, and date of the parent's appointment.

DDCP

The SAS works in conjunction with the Dependency Drug Court Program (DDCP). The DDCP provides additional support and accountability for parent's that may be struggling in treatment. The DDCP is only offered to parents with active dependency cases (FR and FM).

If the parent(s) is referred to the DDCP, the SAS will:

- Make referrals for appropriate recovery treatment (if not already in treatment)
- Monitor the parent's participation, and
- Report results of random drug testing to the DDCP

The court unit will provide the SW with weekly updates regarding the parent's progress in DDCP.

NOTE: See Dependency Drug Court Program (DDCP) policy for more information on this service and for SAS hours and locations.

Treatment considerations

There may be circumstances that the SW will need to take into consideration when providing referrals and making recommendations for treatment.

The following are treatment considerations:

If the parent...	Then the…
Resides **in** the County of San Diego and found appropriate by SAS for SUD services	Parent receives SUD treatment services.
Resides **outside** of the County of San Diego and is found appropriate (by SW and is assessed by treatment provider) for SUD services	SW will provide the parent with referrals within that county. SW's are encouraged to contact CWS in that county to obtain referrals.
Is found **not** to be **appropriate** by SAS for SUD services (i.e. mental health, prescription medication for physical pain, poor health, etc.)	SW will reassess the needs of the client and provide the appropriate referrals to address the concerns.
Is found appropriate for SUD services by SAS, but has private insurance	SW will encourage the client to use their private insurance for SUD treatment services. The SW should take into consideration whether the covered insurance treatment facility has recovery meetings, inpatient/outpatient (depending on what assessed as needing) and family visitation.

Residential treatment

A SW may assess that a parent can safely care for their child(ren) at a residential treatment facility that allows children. The SW will document this assessment in CMS/CWS, the Court report and make a recommendation to the Court that the child reside with the parent in the facility. The Court will make this an order for placement if found appropriate.

If a parent has custody of the child(ren) and is recommended by the SAS to enroll in a residential drug treatment program which cannot accommodate the child(ren), then the SAS will:

- Assign the parent to an alternative appropriate treatment placement (e.g. intensive outpatient treatment 2-5x/week). This substitute treatment is considered temporary until the issue(s) precluding residential placement can be resolved.
- Contact the SW or PSS.
- Appropriately note the situation/plan in CWS/CWS and Court report (if upcoming hearing).
- Work with the treatment provider to move the parent into residential treatment as soon as the issue(s) precluding residential placement is resolved.

SW responsibilities

CWS staff must communicate directly with SUD treatment providers to obtain necessary progress information on their substance abuse clients for reporting out to the Juvenile Court. The assigned SW is the principal case manager and is responsible for the overall case management.

The assigned SW will:

- Assess parents for SUD and associated child safety threats and make appropriate recommendations to the court for a referral/order to treatment.
- Document any SUD issues in the Detention Hearing Report (DHR) and/or subsequent hearing reports and recommend a referral and/or order for an initial screening with the SAS for treatment recommendations.
- Follow up with the SAS after the parent(s) initial substance use screening for information regarding recommendations.
- Collaborate with the parents in creating their case plans, harm/danger statements, and safety goals.
- Provide the Court with updates regarding progress in the parent(s) case plan objectives and services.
- Notify the treatment provider staff whenever the assigned SW changes.
- Notify the treatment staff immediately upon learning a parent is incarcerated, or other significant changes in a client's circumstances.
- Communicate with the treatment provider staff to discuss the client's progress and concerns at minimum monthly.
- Meet with the treatment staff and the client to develop a recovery services plan prior to treatment discharge.
- Submit the recovery services plan to the court via ex parte. Request that SUD treatment be terminated and that the recovery services become part of the case plan.
- Arrange for all services identified in the recovery services.
- Provide SUD treatment information to a parent's probation officer only upon request by the PO**.**
- Notify the treatment provider immediately if reunification services and/or jurisdiction has been terminated by the Court.

Drug Testing

Procedure	CWS on-demand drug testing can be used to confirm a reasonable suspicion of substance use or as a part of a recovery plan to support sobriety. Use the 04-130D Drug Testing Authorization form for drug testing. *All drug testing will be On-Demand only.* On-demand drug testing is limited to three tests during a three-month period. The SW decides when the test occurs. **NOTE:** See CWS Drug Testing (On-Demand) for specific information.
Termination	The SW should consider the following factors when terminating on-demand drug testing: • If the parent is drug testing at SUD treatment and the SW no longer needs to complete on-demand drug testing (can still be used if suspected use while testing in treatment). • The parent's treatment provider and SW determine the parent no longer needs the support of on-demand drug testing services to maintain sobriety.

Youth Treatment Services

Referrals	For youth in new referrals needing SUD treatment, a *determination may be made to Evaluate Out (EO) the referral if it does not meet assignment criteria or work with the family on a voluntary basis*. Youth in need of SUD treatment services will receive the same case management services as adult clients. New referrals regarding youth in need of SUD treatment will be assessed by the SW for level of risk and services needed. The level of risk is assessed in order to determine the level of intervention needed. The SW will consider the following case management practices when assessing an youth for SUD: • Consult with any current service providers • Present case in Case Consultation • Consider On-Demand drug testing.

Open CWS case	For youth in an open CWS case, the SW will work with any existing service providers, caregivers and family members to ensure the treatment plan is appropriate. This will occur during the CFT meeting. If a CFT has not yet been established, this should be discussed with the current treatment provider to determine care coordination. Referrals to treatment will be considered as well as level of care necessary to address SUD and/or additional emotional and behavioral factors that are affecting that youth. When assessing a youth for SUD, the SW will: • Involve the Child and Family Team (see Child and Family Team Meetings) which must include the current behavioral health services provider and CASA (if child approves) • Present case in case consultation • Consider drug testing with youth's consent (otherwise, the youth's attorney must be consulted and concur after which an ex-parte submitted to the court). • Create/Update a Case Plan to address SUD treatment services for the youth.
Treatment considerations	The SW will consider age, developmental stage, gender identity, culture, sexual orientation, and behavioral, emotional, or legal/criminal issues to ensure the most appropriate intervention and treatment program is identified. The SW will utilize the Case Plan Field Tool to identify individual and family strengths, which support the recovery process. This will help determine the kind of treatment services that will be offered in the CWS case plan. Program options will be discussed at a CFT meeting and with the youth and parent/caretaker during the formation of the Case Plan, or Case Plan update. **NOTE:** County of San Diego's Substance Use Disorders Services website offers a directory for youth substance abuse treatment services.

Relapse

While in recovery	Recovery from active SUD is an ongoing process that passes through several stages: early, middle, and late recovery/maintenance. Given the chronicity of abuse/addiction, relapse is common and is not necessarily a failure of recovery or treatment. Relapse can begin at any point in the recovery process. All providers interacting with the client should always remain cognizant of the client's recovery process, including any relapse triggers he/she may be experiencing. **Relapse prevention is an essential part of the recovery treatment plan and consists of identifying possible relapse triggers and strategies to cope with them.** Sudden changes in a client's recovery-based activities, including attitudes, values, behaviors, and relationships, often signal that a relapse process has begun. Stopping the relapse process should be the immediate focus of providers, as continued substance use typically returns rapidly to the pre-intervention level of abuse and addiction. Based on a re-assessment, increasing treatment activities, self-help activities, as well as moving the client to a higher level of recovery services may be in order. Other considerations, such as mental health needs, can be evaluated in a re-assessment and amended in the treatment plan (and case plan) accordingly.
Indicators of active recovery	The following are examples of behaviors frequently exhibited by people actively working in a recovery program: • Talking about the program, sponsor, steps, etc. • Getting tokens for periods of sobriety • Discussing meetings that they like or dislike • Discussing personal experience from meetings • Complying with court orders, reunification requirements, etc. • Building social networks of recovering, clean/sober people • Assuming more personal responsibility.

Indicators of relapse	Just as recovery is a process, relapse is also a process, which can begin days, weeks, or months before actual use occurs. An individual in relapse, or in danger of relapse, may show the following signs: • Shift in focus from recovery to job concerns, family matters, etc., before the recovery process is stabilized • Meeting/program participation decreases and/or stops • Sporadic or no sponsor contacts • Premature termination of treatments • Increased, unmanaged stress • Increased isolation and/or argumentativeness • Change in quality and/or quantity of communication with SW • Resuming old patterns, people, and places.
SW considerations	The SW must continually re-assess the risk factors and protective issues regarding the children and the parent's ability to adequately care for the children. Repetitive episodes of relapse may indicate the need for a more regimented treatment program, such as residential treatment. The SW will get input from Child Family Team (CFT) meetings with the family, case consultations and continued consultations with treatment providers when considering a change in placement, program, visitation (e.g., VS to court), etc.
Recovery tool	When relapse is approached as a component of recovery instead of as a time to apply punitive consequences, the recovery process can use relapse as a learning experience. Relapse applied as a tool may increase a person's chance of successful recovery. Most recovery programs incorporate relapse prevention into their program's curriculum. The goal for the recovering parent is to learn to identify the early warning signs of relapse and seek help before relapse occurs. The SW and treatment providers should collaboratively re-evaluate the client's treatment needs and revise the treatment/case plans accordingly.