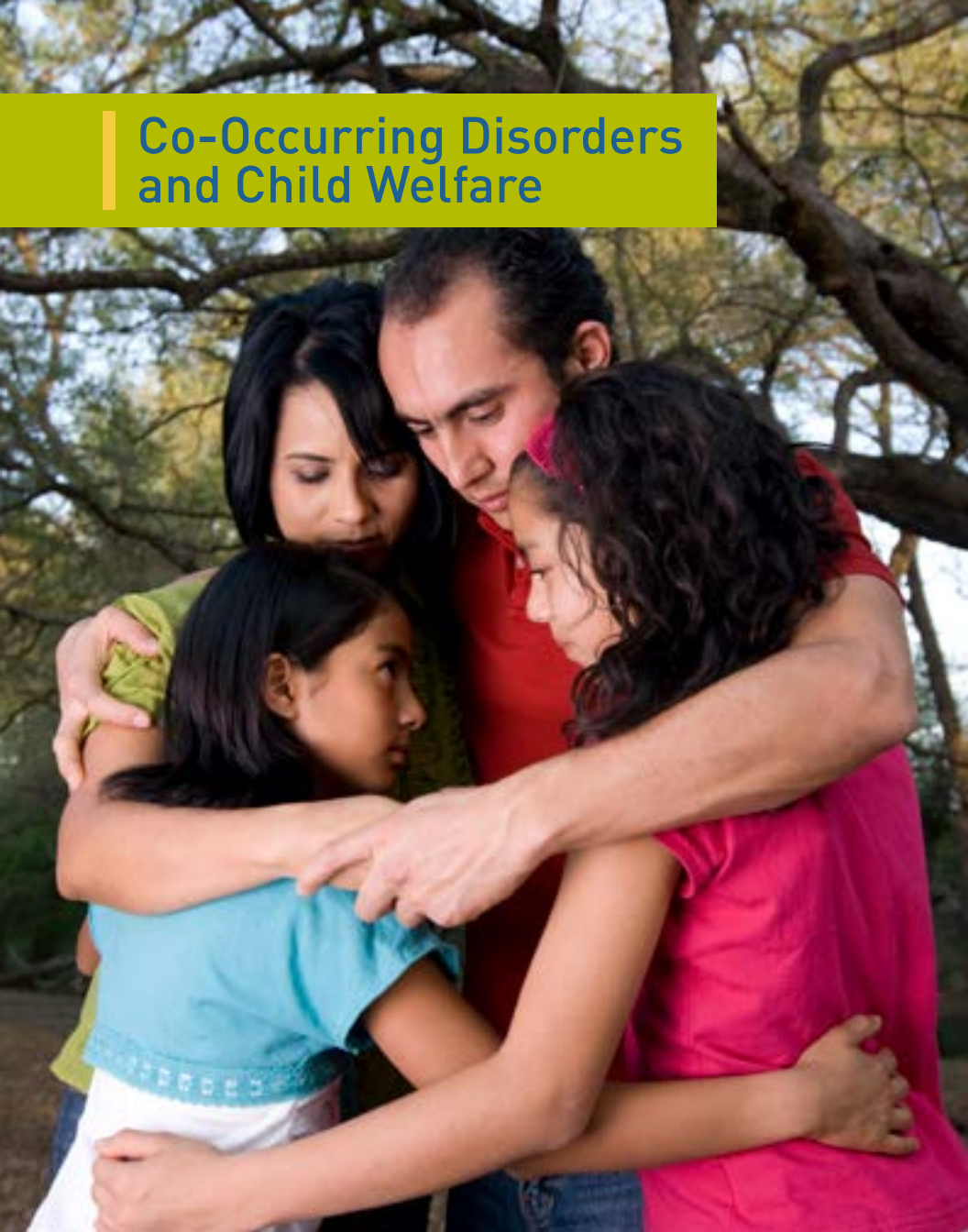
Co-Occurring Disorders and Child Welfare



Co-Occurring Disorders and Child Welfare

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Hope for Recovery

There is hope for recovery for individuals managing co-occurring mental health and substance disorders. With the right support networks, integrative treatments, and community resources an individual living with a co-occurring disorder (COD) can parent effectively and meet the needs of their children.

When working with families coping with a COD, it is important to acknowledge the incredible resilience and strength displayed by all members of the family. Always remember, it takes courage and trust for families to engage with child welfare professionals. By working together, with grace and mutual respect, we can support Minnesota families living with CODs.

This booklet includes valuable information and practice considerations to inform your work with families in which parents or caregivers have both a COD and need for child welfare services. For more information or additional resources, contact MNCAMH or CASCW.

Understanding Co-Occurring Disorders

CODs, previously referred to as dual diagnoses or dual disorders, are defined by the coexistence of both a mental health and a substance use disorder.[1] More than one-third of adults with substance use disorders will also have a co-occurring mental illness.[2]

Do CODs begin as a mental illness or a substance use disorder? The answer is as individual as the diagnosis itself. Some individuals experience childhood-onset mental health issues and later experiment and develop a substance use disorder.[3] Other people turn to substances after a traumatic event or adult-onset mental illness.[3] There are also instances where one's addiction to substances becomes so severe that mental health symptoms or illness develop, which might not have otherwise surfaced.[3] It is important not to have preconceived notions about individuals coping with a COD, as everyone's past experiences and present needs are unique to them.

Knowing about the impact of co-occurring disorders on child welfare is important because:

- 1 in 5 American adults have a mental illness and 1 in 25 have a serious mental illness, and 10.2 million American adults have a COD. [5]
- An estimated 50 to 80 percent of all confirmed child neglect and maltreatment cases involve a parent struggling with substance abuse.[6]
- In 2016, 27 percent of child welfare home removals were due to parental drug abuse.[7]
- Between 2010-2016 in Minnesota, deaths related to opioid use increased by 66% and continue to grow.[7]
- Once a report is substantiated, children of parents with substance use issues are more likely to be placed in out-of-home care and stay in care longer.[2]
- Parents with substance abuse issues are at a higher risk of experiencing social isolation, poverty, unstable housing, and domestic violence.[2]
- There is a critical link between stress and negative effects within the brain, which can lead to both the desire to use substances and inappropriate caregiving.[2]

CODs in Child Welfare

- It is important that child welfare professionals understand how to best support parents living with CODs. Child welfare professionals may not know where to start or what treatments to prioritize. CODs may affect a parent or caregiver's ability to provide adequate care to their children.[5] However, successful parenting is possible with the appropriate support and treatments.

- Substance use and mental illness affects all families differently, but it can result in an increased risk of poverty, violence, trauma, as well as, homelessness, social isolation, unemployment, and psychiatric hospitalizations.[5] For children, there is also an increased risk of developing a substance use disorder or COD themselves.[7] These risk factors can contribute to child safety concerns, which can lead a family into the child welfare system.[5]

Spotlight on the Opioid Crisis

Opioid-related hospital stays and deaths are rising across America.[6] In Minnesota, opioid-related deaths have increased 15.8 percent from 2014 to 2015.[6] In 2016, opioid overdoses killed more than 42,000 people nationwide, leaving many children and families behind.[10] Of those deaths, 40 percent involved a prescription opioid.[10]

The number of children exposed to opioids in utero is also growing, which is directly linked to increasing cases of neonatal abstinence syndrome (NAS).[11] Children of parents struggling with opioid addiction are also at a greater risk of experiencing abuse or neglect. Through education on current drug abuse trends and signs of overdose, we can better serve families and children impacted by the opioid crisis in Minnesota.

Importance of Family Supports

The impact of a COD on a family member is unique to that individual, and consequently, unique to that family. There are however some common experiences in families coping with a COD. CODs can inhibit a family member's developmental, attachment, economic, and safety needs from being met.[8] For families with a parent with a COD, the home can become an environment of instability, abuse, neglect, and trauma.[8]

In families coping with a COD, oftentimes members of the family will function in a certain way to keep the system in balance, even if it is not healthy for the individuals.[8] While these resilient adaptations to COD symptoms maintain the equilibrium, they may also sustain the negative effects related to the diagnoses.[8]

Practice Tip

When assessing a family's welfare, it is important to consider how the child's behaviors or actions might be coping techniques or signs of resourcefulness in maintaining their family system.[8] Referrals to family therapy, parent training, or coping skills workshops can help a family with a COD move toward recovery.[8]

Intimate Partner Violence (IPV)

Research shows that approximately 25 to 50 percent of intimate partner violence (IPV) incidents involve the consumption of alcohol and almost 50 percent of all perpetrators who enter an intervention program abuse alcohol.[14] If a survivor also uses substances, whether as a means to cope with the trauma or due to their own substance use disorder, this may lower their ability to protect themselves and their children from further abuse.[15]

Families experiencing IPV may require child welfare intervention. Risk factors for cases involving IPV often include parental substance use and mental illness.[14] Child welfare professionals should assess all of a family's barriers in order to create a safety plan and goals that sufficiently address the needs of the parent and the family.[14]

Impacts on Children

A parent living with a COD may experience different symptoms and stressors that may also impact their ability to successfully provide for and protect their children. Some of these factors may include, a decreased capacity to respond to a child's cues and needs, difficulty regulating emotions, controlling anger, and managing impulsivity, unexpected disconnection from social supports, and increased financial stress and instability. With that said, success is possible and looks different for each family managing a COD.[2]

The impact of having one or more caregivers diagnosed with a COD can vary between individuals. Effects can be subtle: difficulty establishing trusting relationships with people, feeling overly emotionally responsible in relationships, and at times taking on adult responsibilities.[8] More severe effects can range from birth defects, fetal alcohol spectrum disorders (FASD), along with mental and physical disabilities.[8]

Practice Tip

If you are working with an individual diagnosed with a substance use disorder or COD, offer education and resources on the risks associated with alcohol and drug use for a developing fetus.[8] By offering preventative resources, families are given the ability to make educated choices and changes with their family. If an individual is currently pregnant and dependent on substances, always refer them to a Perinatal Addiction Clinic and/or high-risk pregnancy OB/GYN clinic for treatment and care.[8]

Understanding ACEs

Adverse Childhood Experiences (ACEs) are traumatic events in a child's life that occur before age 18 and are recalled into adulthood.[12] There are nine types of ACEs: physical abuse, sexual abuse, verbal abuse, mental illness in a household member, alcohol abuse, illegal or prescription drug abuse, divorce or separation of a parent or caregiver, domestic violence toward a parent, and incarceration of a household member.[12]

ACEs can cause toxic stress in a child; stress that is characterized by the intense, prolonged activation of the body's stress response system without adult support as a buffer.[12] This stress can manifest into disrupted brain chemistry and child development.[12]

These ACEs are often daily realities for the children involved in the child welfare system. By identifying and preventing ACEs today, children are given a better chance to reach their full potential in the future. By working together with families toward their recovery, additional ACEs can be mitigated or prevented.

What is Recovery?

There is no "correct" definition of recovery from mental illness, substance abuse, or a COD.[16] For many, recovery means successfully managing symptoms.[16]

In the past, it was considered good practice to treat mental illness after a person no longer uses substances.[5] However, individuals often waited a long time and juggled a number of separate treatment plans and expectations between multiple programs.[17] An estimated 8.9 million Americans live with a COD and fewer than 7.5 percent will enter an integrated treatment program.[3]

Today, it has been proven that addressing both diagnoses simultaneously, through an *integrated treatment* plan, is the most effective approach to COD recovery.[5] Integrated treatment is a comprehensive rehabilitation model that offers both the medical and therapeutic resources necessary for individuals to heal physically, mentally, emotionally, and spiritually.[2]

An integrated approach to case planning across providers, including child welfare, can also streamline the treatment plan process and increase engagement and positive outcomes for both individuals and professionals.[17]

To view an example integrated treatment plan visit **z.umn.edu/build_your_program** (see page 36)[18] and read more about case planning in this booklet on **pages 19 and 20**.

Barriers to Recovery

It is critical for child welfare professionals to consider not only a family's barriers to COD treatment but other challenges they might be facing.[21] Common co-occurring issues seen in CPS, besides CODs and child maltreatment, include IPV, trauma, poverty, food insecurity, housing instability, and crime.[21] When all obstacles are appropriately addressed in treatment, an individual's chances of attaining sustained recovery increases exponentially.[21]

Here are some common barriers to recovery that can be assessed and discussed:

- Thoughts that treatment isn't necessary or helpful[19]
- Insistence to solve problems without any assistance[19]
- Confidentiality and privacy concerns[19]
- Stigma and embarrassment[19]
- Level of accessibility and availability of drugs or alcohol[20]
- Proximity to treatment or rehabilitation resources[20]
- Economic stressors and cost prohibitive programs[19]
- Lack of specific and specialty treatment programs—such as those tailored to women, people with disabilities, or people of color.[20]

Family's Role in Recovery

A family member's influence and role is important in the treatment and recovery of a person with a COD.[8] Just as the impacts of a COD affect all members, so too does positive behavior change.[8] It is important to incorporate the entire family system into the case and treatment plans, as all family members bring their own sets of strengths and support to the table. By including family, the impact of the COD on all members and the powerful support that can exist within the system can be recognized.[8]

What can families do to support COD recovery?[22]

- Educate themselves on addiction, mental health, and CODs
- Engage in family support groups or therapies
- Encourage the individual in their rehabilitation program or therapeutic journey
- Establish healthy coping techniques and boundaries, and create a personal self-care plan
- Know the signs of relapse and COD recovery resources

When working with a family experiencing a COD, it is important to integrate recovery-oriented language in both your conversations, case notes, and court reports. Recovery-oriented language displaces the blame and stigma away from the individual or family and opens up the possibility for hope, healing, and recovery.

Table 1: Recovery-Oriented Language

Deficits-Based	Strengths-Based
Addict	Person with a substance use disorder
Hostile, Aggressive	Protective
Mentally ill	Person with a mental illness
Lazy	Ambivalent, Working to build hope
Manipulative	Resourceful
Unfit parent	Person experiencing barriers to successful parenting
Resistant	Chooses not to, Isn't ready for

Stages of Change

It is not unusual for individuals to experience ongoing ambivalence when facing a lifestyle change.[23] The behavioral change model, Stages of Change, can be utilized to assess a person's readiness for behavior change.[23] The Stages of Change model is widely recognized and used in substance use and mental illness treatment.[23]

This approach works to meet the individual where they are at, offer support appropriate to the stage of change that they're in, and increase the likelihood of sustained behavior change.[23] Recovery is not a linear process, so it is important to revisit the Stages of Change at various points of the case and re-asses where an individual is at.

Practice Tip

Find more information about the Stages of Change model and to access a stage identification table for use in your every day practice visit ***z.umn.edu/8stages***. You will also find the corresponding motivational techniques, meant to encourage the individual in their recovery and change-making process.

Engagement in Recovery

By supporting a recovery philosophy and utilizing the Stages of Change in your practice you are engaging with key treatment principles found in successful integrative treatment programs.[5] Another way to support individuals and their families is through the use of motivational interviewing (MI).[5] MI can be used to build rapport, increase a family's readiness to change, and decrease individual or familial resistance.[8]

MI is a person-centered approach to goal-setting employed to enhance an individual's motivation for change by exploring and resolving their ambivalence to the change process.[25] It is important to remember that motivation is a part of the change process and not a fixed character trait of that individual.[25]

As a child welfare social worker, your role could be to help the individual and family weigh the benefits and costs of making change. The MI Decisional Matrix can be found at ***z.umn.edu/motivational_interviewing***, and can help facilitate a conversation that ensures all outcomes of a potential change are considered.[26]

When working with families managing a COD, you will utilize many of the same engagement skills you would use for any other family. Create a warm and welcoming environment: offer them a glass of water, inquire as to how their day is going, and ask if there's anything you can do to make them more comfortable.[27]

Trust is essential. Marvin Clark, a recovery coach, once said, "If you lose their trust, you lose them."[27] Social workers should be aware of their own biases regarding substance use and mental illness.[27] Only once individuals feel a positive therapeutic alliance has been established with the social worker will they disclose personal information regarding their COD.[8] Bias or misunderstandings by a social worker can create additional barriers for a family.[16] Processing interactions with the family or progress of the case plan should be done through case consultation with co-workers and supervisors, where neutral advice can be obtained.[27]

When working with families, they are the experts on their diagnoses and lived experiences. Engage in a person-centered approach by asking the individual and family members how they perceive the illness and its effect on their lives.[27] The case, treatment, and safety plans should all work toward the individual's self-identified goals and objectives, along with meeting their clinical needs.[27]

Planning with Families

When beginning work with a family, where you suspect substance abuse and mental health disorders are co-occurring, first look for signs of a COD.[28] Oftentimes, it is the substance abuse that is the most obvious, presenting sign of the two disorders.[28]

An integrated approach to the case plan and treatment of a COD is vital. Mental health and substance use disorders aren't managed or experienced separately by the individual, and therefore treatment for both should be experienced simultaneously.[17] Consult with a mental health and substance abuse specialist to determine the best way to approach the family and connect them with the appropriate services.[28]

Practice Tip

Once the initial assessments have been done, sit down with the family and let them tell you their story.[28] Together with the family, process what anticipated barriers to recovery are present, both personal and systemic.[28] This gives the family more control over their treatment and can positively affect recovery outcomes.[27] Utilizing this information, begin to construct a case plan with the family.

A case plan, for a family coping with a COD, should never be without an accompanying safety plan. A safety plan is a physical document, for either the COD or each diagnosis separately, written and agreed upon by both the family and the agency.[27] It lists the key support systems in a family and individual's life, potential relapse triggers, and steps to take if a relapse occurs.[27] A safety plan can help a family cope and prepare for times when abstinence or symptom management is not always attainable.

With some families, experiencing multiple barriers to recovery, planning may need to be more creative.[28] Through prioritizing what success looks like for that family and the steps to get them there, a case and safety plan can be tailored to meet the unique needs of the individual family.

Putting the Plan into Practice

Practice is key. If a family specifies a particular set of action steps they would like to take after a relapse occurs, practice it with them.[27] For example, if the safety plan states that the eldest child will call the grandmother if the mother abuses substances, then role-play the situation. Play the part of the grandmother, or have the family call the grandmother and practice the scenario with all the key players. That way, everyone feels comfortable utilizing the plan they agreed upon, if, or when the situation arises.[27]

Case and safety plan adherence shouldn't be the only determinate of achievement.[17] Success will not always mean abstinence from substance use or full remission of mental illness signs and symptoms. Case and safety plans need to be living documents that accommodate the journey to recovery, while also ensuring the safety of the child(ren).[17] Relapse should not be addressed with a punitive response but should be framed as an opportunity to identify where the safety plan was not effective and ways to better identify triggers and prevent a relapse going forward.[28]

Increasing awareness and building capacity in service systems are crucial to identifying, diagnosing, and treating CODs.[1] Early COD detection and integrated treatment can improve the quality of life for both individuals and their families.[1]

In child protection, having a recovery philosophy means planning and supporting the recovery process beyond the timeline of a CPS case.[5]

Social workers can work with a parent with a COD from day one to identify and to help a person connect to long-term resources and supports that assist the individual and their family even after the CPS case plan is complete.[5] Professionals should support small successes with individuals and families along the way. By focusing on a family's strengths and resiliency, you can bring hope to a family that they can parent successfully again and recovery is possible.[26]

Advocacy and Support:

- **Substance Abuse and Mental Health Services Administration (SAMHSA)**
  www.samhsa.gov
- **U.S. Department of Health and Human Services (DHS)**
  https://mn.gov/dhs/people-we-serve/adults/health-care/substance-abuse/programs-and-services
- **National Association of Mental Illness — Minnesota (NAMI MN)**
  https://namimn.org
- **Minnesota Recovery Connection**
  https://minnesotarecovery.org

Co-Occurring Disorder Treatment Support:

- **Facility Locater by State**
  https://co-occurring-disorder.org/

Looking for assistance with a crisis?

- **SAMHSA's National Helpline**
  1-800-662-4357
- **National Suicide Prevention Line**
  1-800-273-8255
- **Crisis Call Center**
  (775) 825-4357
- **County Mental Health Crisis Team Line**
  CRISIS (274747)

Additional Child Welfare Resources:

- **Videos Series: Supporting Recovery in Parents with Co-Occurring Disorders in Child Welfare**
  https://z.umn.edu/parentswithcod
- **Practice Notes Issue 26**
  z.umn.edu/pn26recovery
- **Practice Notes Issue 31**
  z.umn.edu/pn31cods
- **Children's Bureau: Mental Heath and Substance Use Disorders**
  https://www.childwelfare.gov/topics/systemwide/bhw/casework/co-occurring/mh-sud/

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