Parental Substance Use and the Safety Framework

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A Few Notes

- Today's focus: the nuance in how substance use is impacting parenting (this is parenting court)
  - Using the framework in the absence or presence of information
  - Understanding behavioral health change and what that can mean for reassessing safety plans and parenting time plans
- Everyone has personal experience with substance use – this is not the same as expertise in substance use and recovery in articulating threats and vulnerability.
  - Cultural bias differentiating substances
  - Community familiarity with specific substances
  - Consider what best evidence would be!

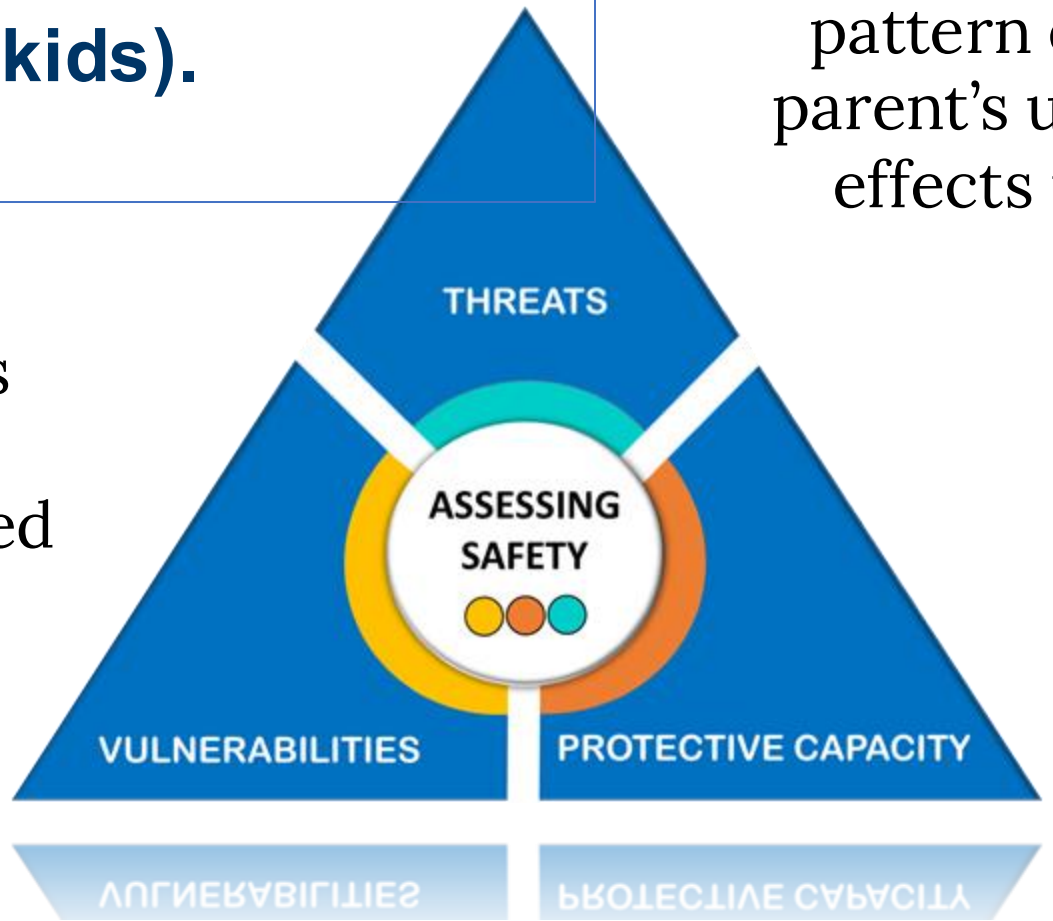
https://www.nih.gov/news-events/nih-research-matters/millions-us-kids-live-parents-substance-use-disorders

2023: 1 in 4 US children lived with a caregiver with SUD.

Half of those were moderate to severe (7.6 million kids).

What substance and how used, general use pattern effects or parent's use pattern effects if known

Specific effects and risks to children mediated by age/ability



Recovery, self-insight (and family support), impulsivity, and their interactions

Parents Deserve Care and Children Deserve Safety

- 100% of Oregon's CIRTs in 2022 involved substance use
- 2021-2022: approx. 80% of Oregonians who needed treatment didn't get it (NSDUH Report)
- What resources do you have available to clients to access substance treatment and recovery?
- We have an amazing opportunity to connect people to the help they need and deserve.

https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/state-releases/2021-2022

Criteria for Substance Abuse Disorders

Cravings to use the substance

Wanting to cut down or stop but not managing to

Taking the substance in larger amounts or for longer than you're meant to

Neglecting other parts of your life because of substance use

Continuing to use, even when it causes problems in relationships

Using substances even when it puts you in danger

Understanding Substances: Defining Threat

- What Substance? What Form?
  - Method of use will change effect rate and risks such as overdose and transmissible
- Illicit supply – need to consider variance in dose and contamination risks (often $ mediated)
- Physiology – how does it operate in the body and typical effects (consider factors like sustainability and ADHD)
- If no specifics how do we generally default?
  - Population level patterns of use aka the norm
  - Understanding Substance Use Disorders as chronic
  - Tolerance – withdrawal: understanding the window
  - Denial/compulsion as part of substance use disorder

Drug	Category	Risk: Smoking Contamination	Medical support detox?	Illicit concerns?	High use side effects	Withdrawal side effects
Alcohol	Depressant	N/A	Yes – highest risk to patient	Atypical	Cognitive imp, emo dysreg, blackouts	Seizure, physical illness,
THC	Depressant	No – evidence that products stick but low skin absorption	No	Possible risk – meth is cheap	‘Couch lock’, drowsiness hallucinations	Anxiety, low appetite, restlessness
Meth (current P2P)	Stimulant	Yes – think cigarette residue exposure, high skin absorption	No	High rates of fentanyl contamination	Mania, disorg thoughts, HTN, hallucinations*	Exhaustion, long sleep periods, anhed
Fentanyl	Depressant	No – no active substance in residue	Yes: longer&more psych sympt than other opioids	Changing adulterant landscape	Emotional dulling, fast metab, drowsy	Intense phys illness, anxiety, neg sensitivity
Benzo-diazepine	Hypnotic (depressant potentiantor)	N/A	Yes – high risk to patient	If it’s illicit it’s almost always fentanyl	Blackouts, emotional dulling	Seizures, physical illness, neg sensitivity
Cocaine	Stimulant	Yes – similar skin absorption to meth but less adherent	No	Fent contam is often price mediated	Mania, hyperfocus,	Exhaustion, long sleep periods, anhed

How… Or follow the money

- Substances cost money, alcohol and THC included
- No one gives away drugs for free.
- Do the math - how are they paying for housing/food/supplies (kids are expensive!)
- How are the kids parented while the parent is getting the money/with the partner/working/boosting/doing sex work etc.
- If the partner is the dealer, how do they factor into the equation? Where are they keeping their supply? Where are they selling?

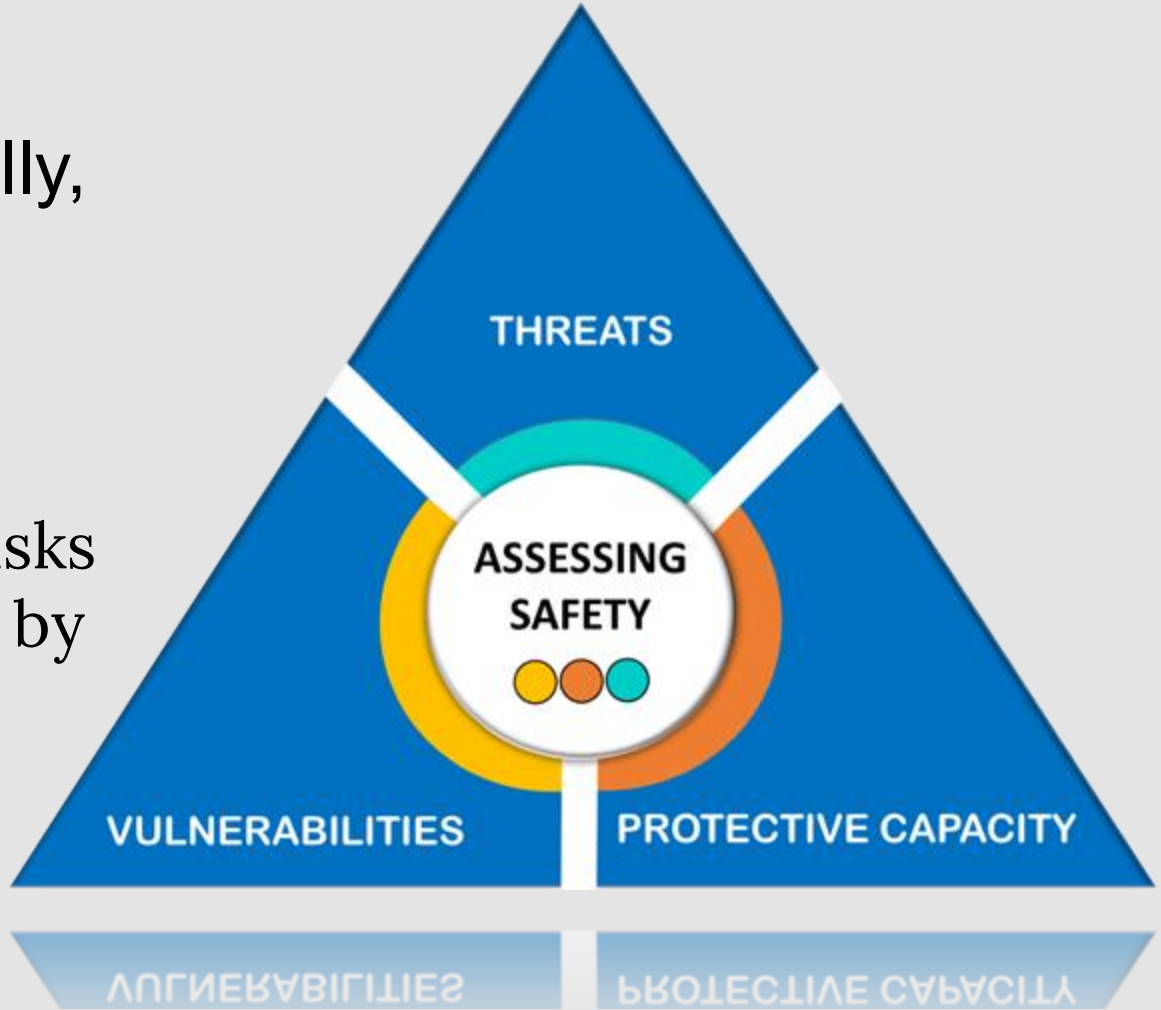
Impulsivity and Parenting

- Focus on parenting related impulsivity—not has the client stopped using but what does their behavior look like?
- When a parent is “sober” you might identify impulsivity from lack of coping skills, mental health issues, personality traits, relationships with people (these are all things recovery works to manage)
  - When a client wants to leave treatment
  - When a client has no coping skills
  - When a client is returning to use consistently
  - When a client says “I will do whatever it takes” but actions do not show this
  - When a client is still participating in criminal activity

Kids are not just small adults.

Biologically, developmentally, legally, or practically.

Specific effects and risks to children mediated by age/ability



Exposure Basics for Children

Faster metabolism – quicker to process, larger effect, faster elimination

- Smaller sizes means dose from an adult strength exposure compounds
- Shorter testing windows
- Approx positive rates in an Oregon CAC's testing: 70-80% positive in hair, 18-25% positive in UAs, and 0-7% positive for oral swabs

Ingestion vs skin absorption vs secondhand smoke

- Difficult to untangle chronic low dose exposure effects from effects of parental neglect in research
- Chronic exposure: development periods mean brain/organs at higher disruption risk with greater impact

Powdered and smoked: particles settle lower with gravity

- Risk is mediated by time spent touching low surfaces like the floor and putting hands in mouth/membranes

Vulnerability to Substances

- Unable or less able to protect themselves from unexpected situations: how unpredictable is the home?
- Access to phone/adult supports if parent is not consistently doing basic parenting needs?
- Access to substances: crawling vs cruising vs toddler racoon phase vs preteens
- Parental capacity to reliably safely store or consistently use in non-child space as mediated by risk posed by substance exposure

The Next Layer

- How is the parent meeting development needs while in active use? Withdrawal? Early sobriety?
- Does the parent understand their child's access capacity and plan to manage it?
- Substance acquisition – who is involved? Are kids brought along? Left at home? Left in car?
- Child exposure to a dealer/provider or other users unknown/less known to parent?
- Ages 9 and up – potential to begin substance use?

Discussion Time

- Mom has 2 developmentally typical kids 6 and 10. A teacher asked the 6-year-old why he had missed school and he said she didn't get back from being gone overnight in time to take them. They are 70% tardy 15-60 min. The 10 year old has a Wi-Fi phone. School is 8:15 to 2:10 and they don't have a bus, mom has been transporting by car.
- She reports using fentanyl 4 times daily, 2 pills per use kept in an old pill bottle. She keeps supplies in her bedside drawer and uses in her room with the door locked. Children denied seeing any pills or paraphernalia.
- She drives Lyft/UberEats, $300 in out of state child support, rent was late last month but paid. Grandma unaware of any new/increasing money issues.
- Her partner is supplying the pills, he is reliably reported to not live in the home but visits frequently.
- Safety plan proposed with Grandma who works 8 – 5 plus 45 min bus commute from the home.

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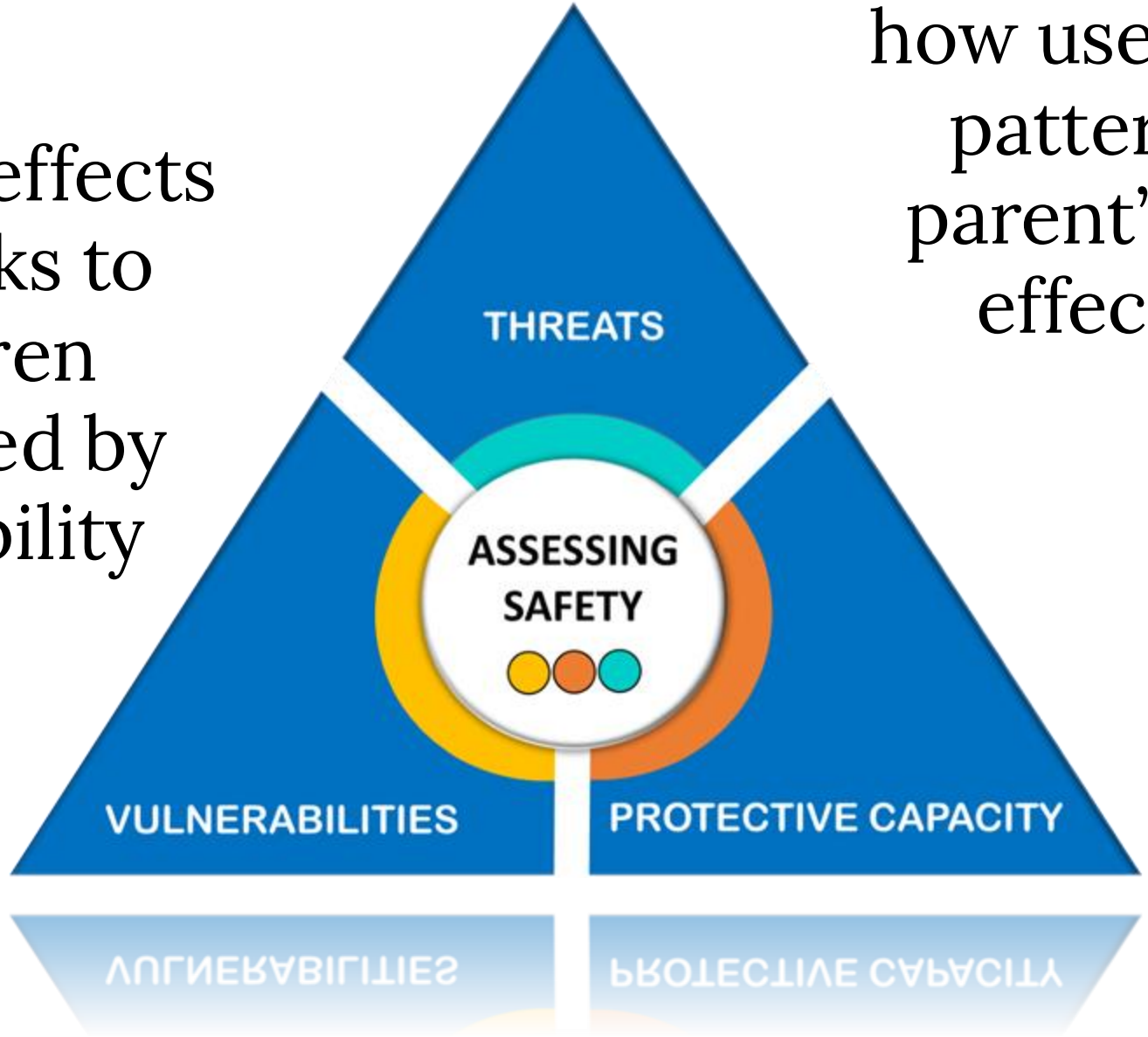
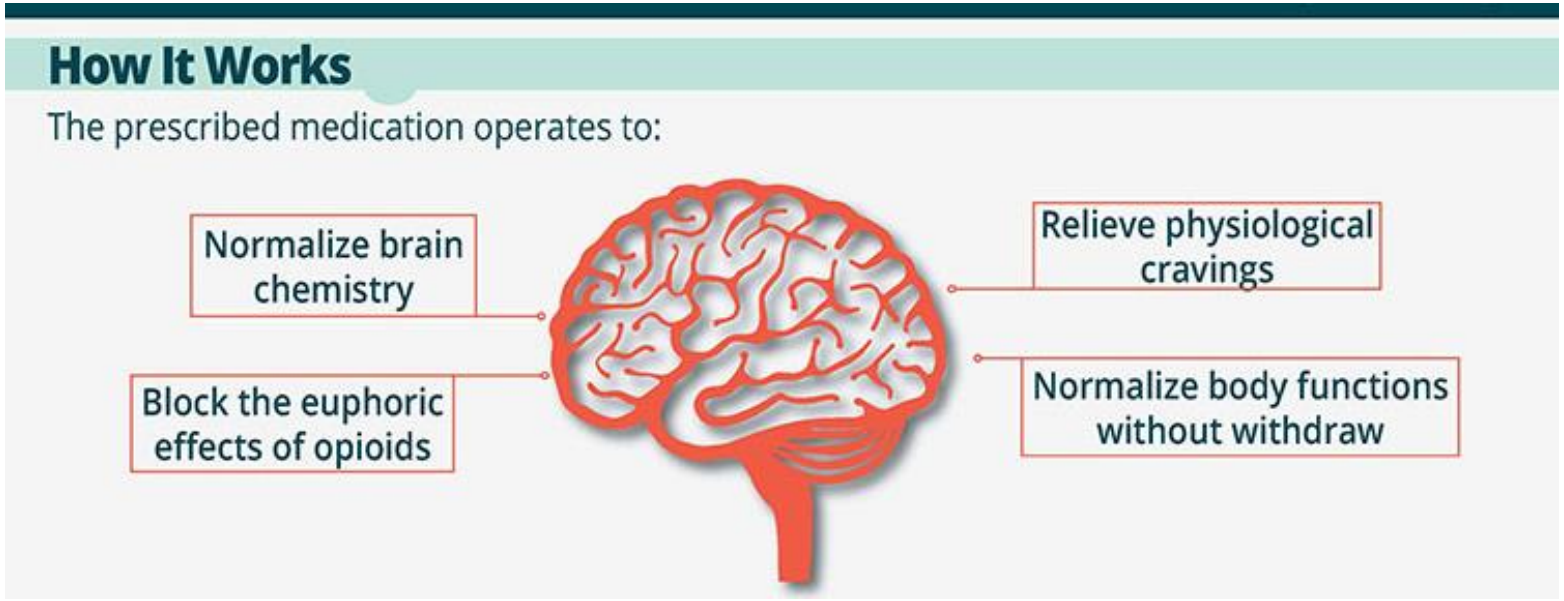
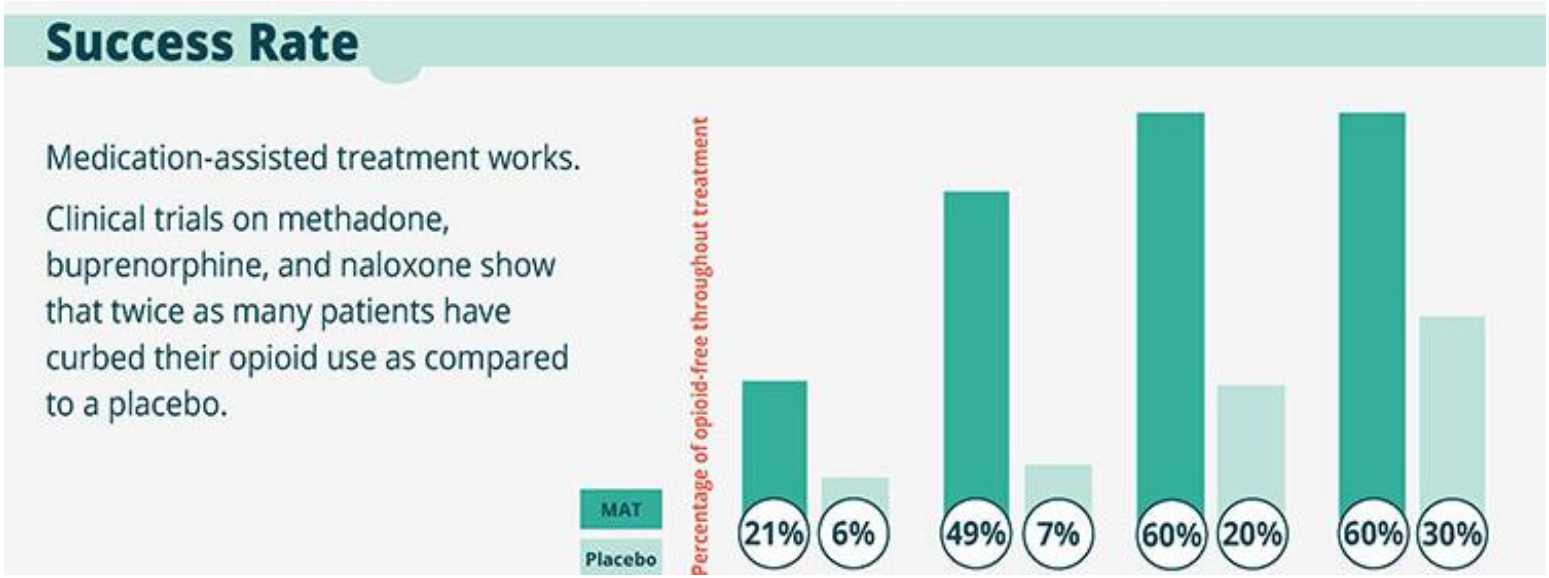


Recovery, self-insight (and family support), impulsivity, interaction

MAT: MEDICATION ASSISTED TREATMENT AND VULNERABILITY

- On medication as prescribed = sober.
- It is SAFE and often encouraged to breastfeed while stable on MAT (not using substances) unless specifically otherwise directed by a provider
- Like any new prescription there may be short stabilization time to therapeutic effect





MAT: The ADA, 8th Amendment, & 1983 Actions

- ADA accommodation and nondiscrimination for SUD includes all medications.
- 2017: Department of Justice Letter to New York Attorney General
  - Explained why courts that prohibit MAT as a condition of child custody or visitation may be discriminating in violation of the Americans with Disabilities Act.
- 2020: DHS OCR Vol. Res. Agreement with WV Dept of Health & HR
  - Couple denied custody of their niece based on use of medically prescribed Suboxone and history of OUD, in violation of the ADA and Rehabilitation Act.
  - DHHR agreed to cease discrimination against individuals with disabilities, including OUD, in child placement/other services, as well as ensure that any grant sub-recipients and contactors also comply with the ADA and Rehabilitation Act.
- Support all choices with no preference and encourage bodily autonomy (including continuation or discontinuation) no different to other meds.

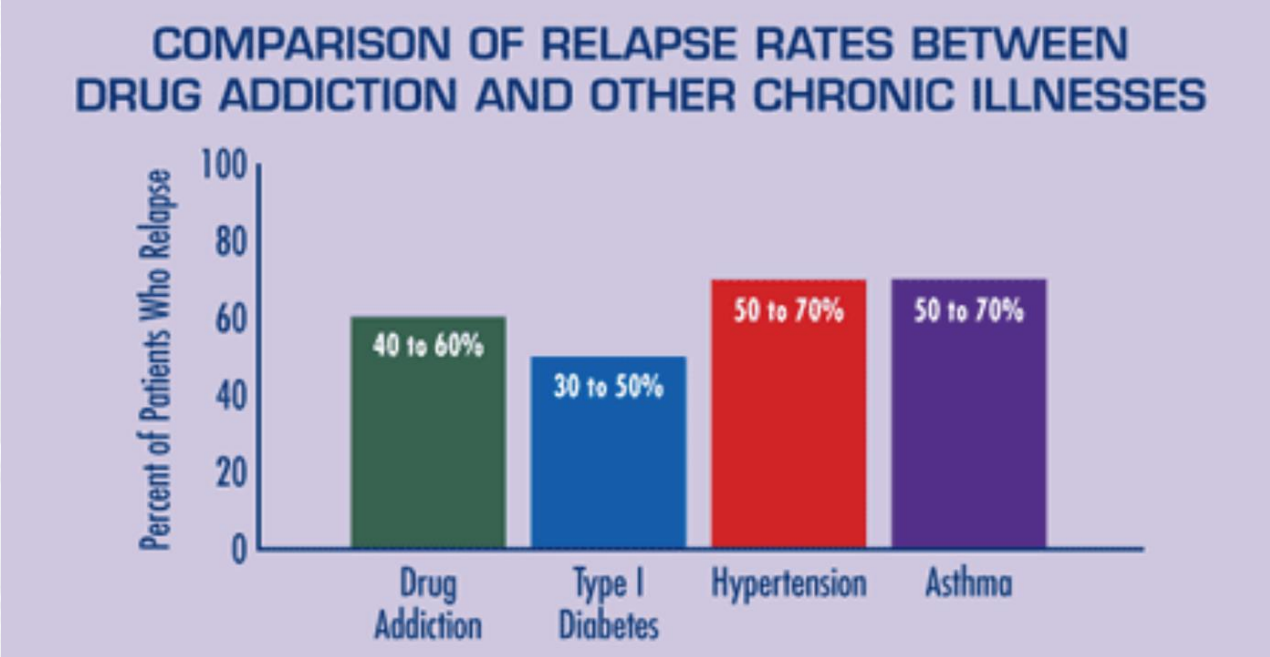
Links:
https://www.justice.gov/opa/pr/justice-department-issues-guidance-protections-people-opioid-use-disorder-under-americans
https://www.justice.gov/media/1214786/dl?inline https://www.ada.gov/resources/opioid-use-disorder/
https://www.lac.org/assets/files/Cases-involving-denial-of-access-to-MOUD.pdf

Sobriety vs Recovery

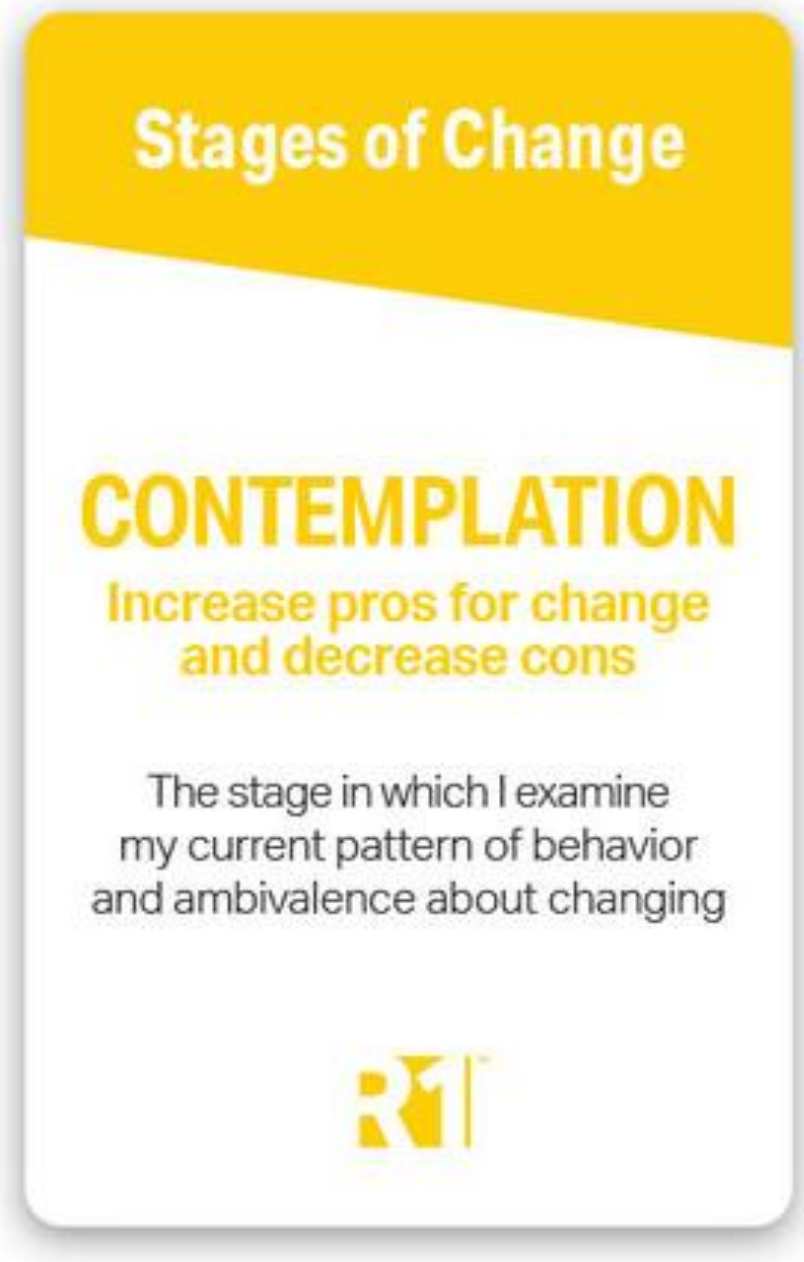
- Absence of use or use of any mood-altering substance
  - Excluding any medications used as prescribed
- Not just understanding the illness or “getting it” at an intellectual level
- Ability and willingness to act to address the illness and integrate management into all spheres of life
- Life change with many behavioral components: “way of living” vs “not using.”
- Recovery is about accountability, **community**, and transparency – not just sobriety

Reasonable Expectations of Parents w/ SUDs

- Lots of shame and guilt around substance use – if parents could stop using almost all would! Social stigmatization increases in-home use
- Recovery is a process. People achieve recovery in many different ways.



- Often called denial
- Unaware or under-aware of the problem
  - Deflection or othering
- Their use is their normal
- They have no current intention for change



- Case Plan vs Safety Plan?
- Client is thinking they might change (red talk/green talk ratio)
- Exploration stage (how might plan look vs actual plan)

- Client is committed to change
- Client understands SUD is a problem and wants to change
- This is the plan stage – partnering in parenting support development

- Measurable behavioral change
- Address obstacles and follow immediate plans
- Create continuum plans ‘what ifs’ and ‘what next’

- Clinical definition: change has occurred for more than six months
- Maintains behavior across multiple situations—behavior is consistent when not in restricted environments
- Client has/uses coping strategies
- Avoiding regression or relapses
- Client can talk about internal and external changes

Relapse

- A temporary return to old behavior
  - Typical in any behavior change
  - Slip: unplanned use with accountability or action
  - Relapse- planned use that involved not following recovery plan or using skills
- Slips/relapses are expected but not an ‘always’
- Not an abandonment of recovery
- This is more information – how does parenting happen during times of stress/relapse?

Some Common Trip-Ups

- What does "parent's use will be under control" mean?
  - No safety plan relies on parent action, but they are based on parent behavior!
  - What information is needed to reasonably predict parenting behavior?
- Recovery resources and plans can provide both support and collaterals
- Accounting for impulsivity doesn’t necessarily mean you have to account for every minute of the day

Discussion time!

- Dad has a 3 year old: he's recently engaged in outpatient treatment with a reputable outpatient for meth use
- Treatment records show he's attending and he reports going to support meetings, he has a written recovery plan with several contacts
- No one lives in his apartment with him
- He has a recovery peer mentor and his mom can check on him in the evenings,

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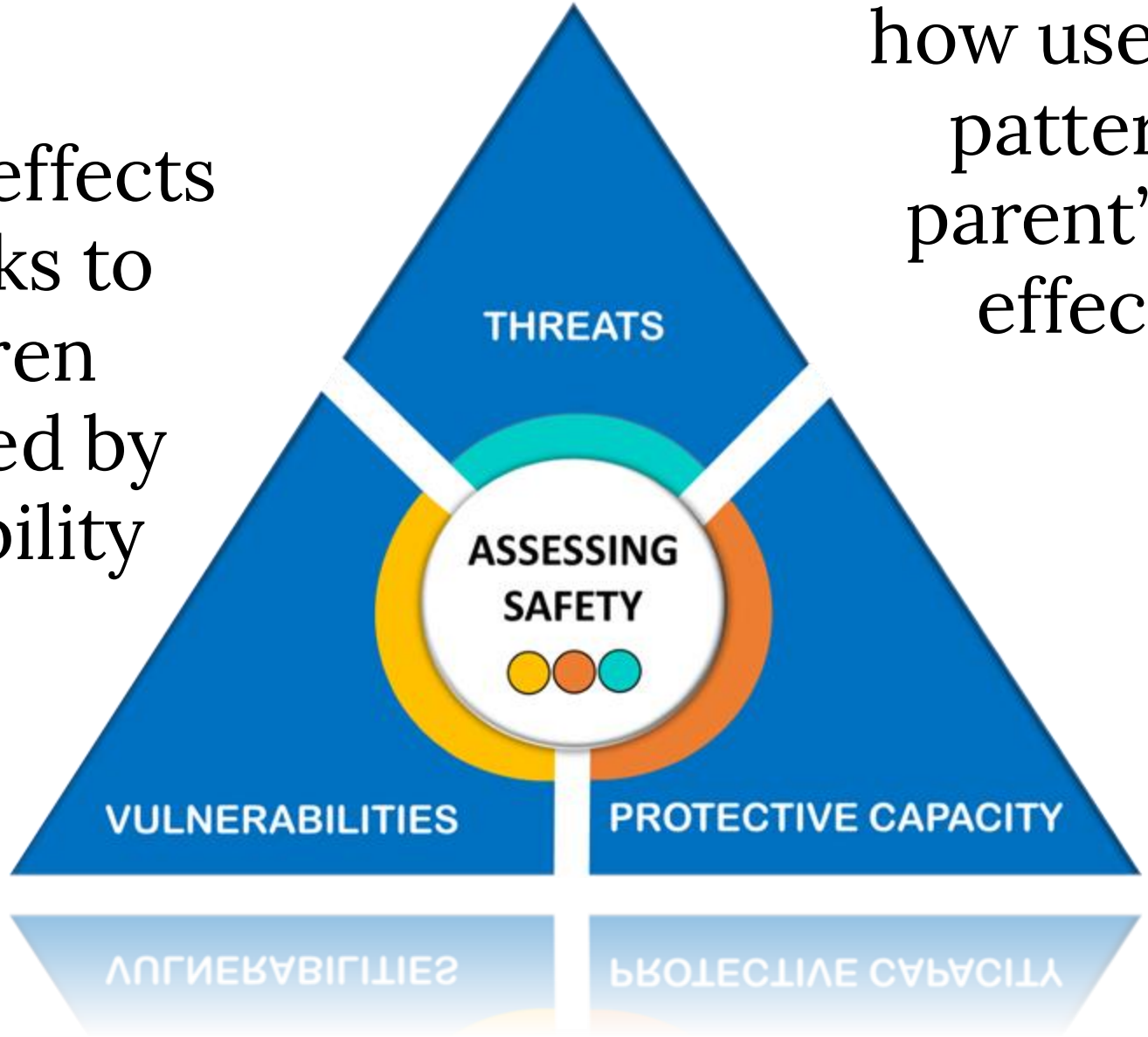

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Okay – We're Practicing!

- Break up into Roles – 4 groups of Parent/Child Attorneys
- Positions will be assigned
- Make an argument and judges will articulate their decision
- Goal is to USE the framework, not to be RIGHT
  - Cupcake points for using specific and observable facts into the argument – everyone has a different client position!
  - Reference the best interest legal standard