



DEPARTMENT OF CHILDREN AND FAMILIES (DCF)

SUBSTANCE USE PRACTICE GUIDE

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INTRODUCTION: FAMILIES IMPACTED BY SUBSTANCE USE

Many families receiving child welfare services are affected by parental substance use. Identifying substance use/misuse and meeting the complex needs of parents with substance use disorders and those of their children can be challenging. Over the past two decades, innovative approaches coupled with new research and program evaluation have helped point to new directions for more effective, collaborative, and holistic service delivery to support both parents and children. (Children's Bureau/ACYF/ACF/HHS800.394.3366)

DCF recognizes that, while parental substance use does not always negatively impact families, there is evidence to support that substance use disorders are risk factors in child abuse and neglect, , and behavioral health cases and, therefore, represent a critical service need. Both early identification and appropriate interventions can increase safety, mitigate risk, improve permanency, and improve the well-being of children and families.

In CT, there were 8,804 unique DCF cases in FY 2017 with a substance use indicator¹ at the time of referral. Of these cases, 40.5% had at least one child ages 0-2, 33.5% with at least one child ages 3-5, and 73.6% with at least one child ages 6-17. Findings from DCF's 2015 *Fatalities Study: Children Ages 0-3*, indicate that when parental substance use is present, a child fatality is more likely to occur than in cases where parents did not have a substance use problem. In addition, there is an intergenerational impact on families impacted by substance use.

DCF Social Workers are expected to screen for and plan for youth and family substance use problems to make informed and timely decisions about safety, risk and needed services intended to safeguard children. The purpose of this practice guide is to provide guidance in meeting these expectations. The DCF Policy specifically expects all DCF staff working with families to be able to:

- Identify for substance use indicators that result in impact on parental capacity; and child risk, safety and well-being;
- Assess for need for and referral for additional assessment/evaluation for substance use treatment; and
- Meet the needs of families identified as impacted by substance use.

This practice guide offers the specific knowledge and information needed by staff to achieve this aim.

DEFINITIONS

Addiction – a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors. (National Institute on Drug abuse)

Recovery - the ways in which a person with an addiction experiences and manages his or her disorder in the process of reclaiming life in the community.

Screening - an ongoing process to identify substance use disorder indicators that warrant further assessment for intervention or treatment needs.

Substance use – when someone consumes alcohol or drugs.

¹ Substance use indicators are documented in casework associated with the CPS report and response (whether Investigation or Family Assessment).

Substance misuse – the harmful use of substances for non-medical purposes.

Substance Use Disorder (SUD) - a treatable, long-term health condition in which the misuse of substances (alcohol and/or both legal and/or illegal drugs) results in significant functional impairment or distress.

Substance Use Disorder (SUD) evaluation - a formal structured interview with an individual by a licensed or certified professional trained in the assessment and treatment of substance use-related disorders to assess the severity of substance use; the level of care required; and the relationship of the substance use to social, family, interpersonal, occupational, legal, financial, emotional, physical and spiritual functioning.

Substance use disorder (SUD) testing - a biological test for the presence of psycho-active substances in the body and may include a:

- urine drug screen (UDS);
- hair test; or
- breathalyzer.

Substance use disorder (SUD) treatment - the engagement of an individual in a particular plan of action for intervention and services, the aim of which is to arrest, reverse and ameliorate substance use problems.

Additional definitions related to substance use can be found in Appendix A.

MYTHS ABOUT DRUG USE AND ADDICTION

Myth 1: Overcoming addiction is simply a matter of willpower. You can stop using drugs if you really want to.

Reality 1: Prolonged exposure to drugs alters the brain in ways that result in powerful cravings and a compulsion to use. These brain changes make it extremely difficult to quit by sheer force of will.

Myth 2: Addiction is a disease; there's nothing you can do about it.

Reality 2: Most experts agree that addiction is a brain disease, but that doesn't mean there is nothing you can do about it. The brain changes associated with addiction can be treated.

Myth 3: People using substances have to hit rock bottom before they can get better.

Reality 3: Recovery can begin at any point in the addiction process—and the earlier, the better. The longer drug misuse continues, the stronger the addiction becomes and the harder it is to treat.

Myth 4: Treatment didn't work before, so there's no point trying again.

Reality 4: Recovery from drug addiction is a long process that often involves setbacks. Relapse doesn't mean that treatment has failed. Rather, it's a signal to get back on track, either by going back to treatment or adjusting the treatment approach. (Robinson, Smith, & Saison, 2014)

IMPACT OF SUBSTANCE MISUSE ON FAMILIES

Parenting Capacity

The way parents with substance use disorders behave and interact with their children can have a multifaceted impact on the children. The effects can be both indirect (e.g., through a chaotic living environment) and direct

(e.g., physical or sexual abuse). Parental substance use can affect parenting, prenatal development, and early childhood and adolescent development. It is important to recognize, however, that not all children of parents with substance use issues will suffer abuse, neglect, or other negative outcomes.

A parent's substance use disorder may affect his or her ability to function effectively in a parental role. Ineffective or inconsistent parenting can be due to the following:

- Physical or mental impairments caused by alcohol or other drugs
- Reduced capacity to respond to a child's cues and needs
- Difficulties regulating emotions and controlling anger and impulsivity
- Disruptions in healthy parent-child attachment
- Spending limited funds on alcohol and drugs rather than food or other household needs
- Spending time seeking out, manufacturing, or using alcohol or other drugs
- Incarceration, which can result in inadequate or inappropriate supervision for children
- Estrangement from family and other social supports (Children's Bureau/ACYF/ACF/HHS800.394.3366)

A parent's substance use may also affect the parent's protective factors. Protective factors are conditions in families and communities that, when present, increase the health and well-being of children and families. The five protective factors are:

- Nurturing and Attachment: Building a close bond helps parents better understand, respond to and communicate with their children.
- Knowledge of Parenting – Child and Youth Development: Parents learn what to look out for at each age and how to help their children reach their full potential.
- Parental Resilience: Recognizing the signs of stress and enhancing problem-solving skills can help parents build their capacity to cope.
- Social Connections: Parents with an extensive network of family, friends and neighbors have better support in times of need.
- Concrete Supports: Parents with access to financial, housing and other concrete resources and services that help them meet their basic needs can better attend to their roles as parents.

Nearly 12% of children under the age of 18 in the United States live with at least one parent who is dependent on or misused alcohol or an illicit drug within the past year (SAMHSA, 2009). Besides neglect, substance use (alcohol or other drugs) was the number one reason nationwide for a child's removal from their home (Child and Family Futures, 2015). Caregivers who misuse substances may have impaired parenting as a result of their substance misuse. Examples include:

- the inability to adequately provide resources, such as diapers, food, and clothing,
- the inability to adequately read and respond to an infant's cues, resulting in a lack of bonding and attachment to the infant and a feeling of confidence and enjoyment in being a parent,
- Inadequate supervision, as a result of being impaired by the substance and/or recovering from its effects,
- exposure to trauma,
- unsafe sleeping conditions, and
- accidental poisonings.

Prenatal and Infant Development

According to the National Center on Substance Abuse and Child Welfare (NCSACW), about fifteen percent of infants born annually in the U.S. are affected by prenatal alcohol or illicit drug use. Fifty (50) percent of pregnancies in the United States are unintended, which may be one contributing factor to substance use during pregnancy as the woman is not yet aware of her pregnancy status. In utero exposure to substances including tobacco, alcohol and both licit and illicit drugs can have a negative impact on mother and/or her newborn and infant. This can include:

- Medical complications during pregnancy and/or birth
- Premature birth and related outcomes, such as low birth weight,
- Delayed growth and development, and
- Sleep, gastrointestinal, and other symptoms

In utero alcohol exposure can result in Fetal Alcohol Syndrome and have long-term outcomes on the child. Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person whose mother drank alcohol during pregnancy. These effects can include physical problems and problems with behavior and learning. Often, a person with an FASD has a mix of these problems. FASDs are caused by a woman drinking alcohol during pregnancy. Alcohol in the mother's blood passes to the baby through the umbilical cord. When a woman drinks alcohol, so does her baby.

There is no known safe amount of alcohol during pregnancy or when trying to get pregnant. There is also no safe time to drink during pregnancy. Alcohol can cause problems for a developing baby throughout pregnancy, including before a woman knows she's pregnant. All types of alcohol are equally harmful, including all wines and beer.

To prevent FASDs, a woman should not drink alcohol while she is pregnant, or when she might get pregnant. This is because a woman could get pregnant and not know for up to 4 to 6 weeks. In the United States, nearly half of pregnancies are unplanned.

If a woman is drinking alcohol during pregnancy, it is never too late to stop drinking. Because brain growth takes place throughout pregnancy, the sooner a woman stops drinking the safer it will be for her and her baby. FASDs are completely preventable if a woman does not drink alcohol during pregnancy. (Center for Disease Control and Prevention). Please review Appendix B for FASD resources.

It is important to encourage mothers to inform the child's pediatrician of any potential in utero substance exposure to ensure that any potential associated treatment needs will be identified and addressed. This can be done by acknowledging that it can be difficult to discuss, promoting this is a health issue, and refraining from judgment. For more information on the impact of in utero substance exposure, see Appendix C.

Child and Adolescent Development

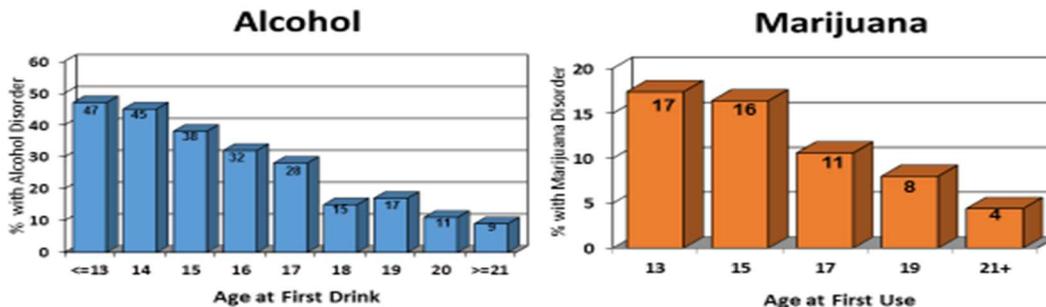
Brain development occurs throughout childhood and into young adulthood and is not fully developed until the mid-20's. Substances can impact several areas of the brain permanently, affecting the structure and functioning of different brain areas. Delaying the onset of substance use is critically important to minimize these potential negative impacts. Delaying or avoiding substance use shortens the length of time the developing brain is exposed to the harmful effects of substance use, and it may help to avoid a substance use disorder from developing. There is evidence to show that initiating substance use in adolescence increases the risk of developing a chronic substance use disorder later. In particular, adolescents with regular alcohol use

9.5% (n ≈ 27,000) of CT adolescents reported using illicit drugs in the previous month.
(SAMHSA, 2015)

before age 21 have a greater rate of alcohol dependence in adulthood (Guttmanova, et al., 2011). In addition to the risk of developing later substance use disorder, early adolescent onset of substance use also has been associated with young adult mental health disorders (Gil, Wagner & Tubman, 2004). Adolescents who use alcohol and other drugs are at higher risk for truancy, declining grades, and dropout limiting their future opportunities (Hawkins, Catalano, and Miller, 1992).

Adolescent substance misuse can also impact adolescent safety through accidental injury, such as motor vehicle accidents, suicide, and alcohol poisoning.

Age at First Use and Later Risk



Source: Hingson RW, Heeren T, Winter MR. Age at drinking onset and alcohol dependence. *Arch Pediatr Adolesc Med.* 2006;160:739-746.

Adolescent Substance Use

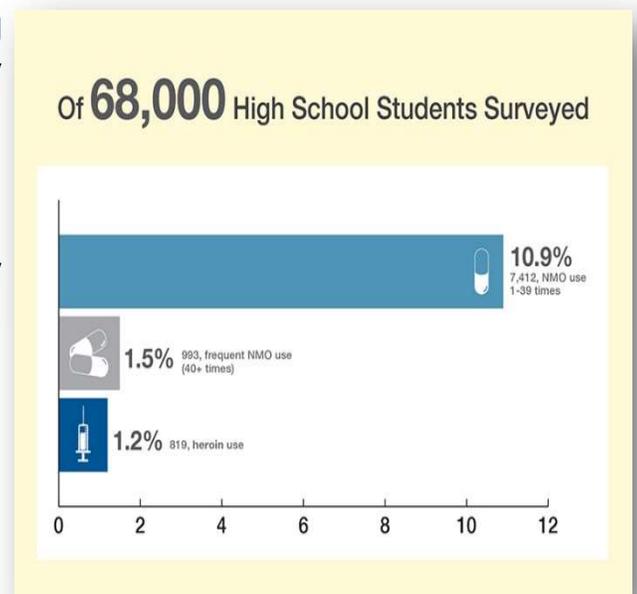
In Connecticut, nearly 1 in 10 (9.5%), or about 27,000 adolescents aged 12–17 report illicit drug use within the past month (SAMHSA, 2015). Opioid and heroin use is becoming more common, with illicit use of pain medications becoming especially problematic. In fact, non-medical opioid (NMO) use is 10 times more common than heroin use among high school seniors nationwide (Monitoring the Future, 2016).

In addition to substance use problems, CT youth entering all levels of DCF-funded substance use treatment show especially high risks in other life areas as reported on the GAIN-Q3:

- school problems such as high absenteeism (36%),
- expulsion or drop out (37%), and
- falling behind more than one grade level (49%); any juvenile justice involvement (49%);
- violent crime (41%);
- HIV risk (49%);
- poverty (92%); and
- victimization (48%).

They also had co-occurring mental health problems:

- ADHD or Conduct Disorder (58%);
- anxiety (44%);



People are most likely to begin abusing drugs—including tobacco, alcohol, and illegal and prescription drugs—during adolescence and young adulthood. –National Institute on Drug Abuse (NIDA).

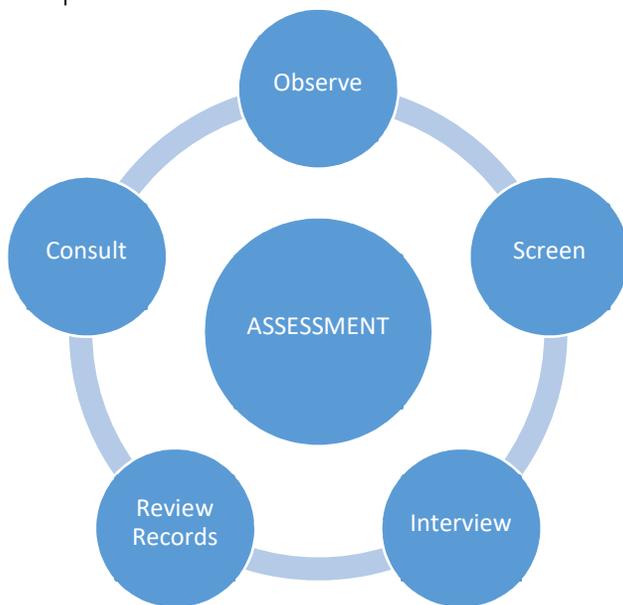
SCREENING

Drug trends change over time. The Department’s response must ensure the safety and well-being of children for all substance types. Regardless of substance type, including licit or illicit, the DCF Social Worker seeks to understand the impact of the substance use on child safety, risk, and well-being. This determination includes a variety of factors, including, but not limited to:

- age of child, with infants and pre-school aged children being most vulnerable,
- impact of the substance use on parental functioning, and
- existence of other protective factors in the home

Please see the [Substance Use SharePoint](#) site for additional information, including best practices and education specific to evolving drug trends, services and resources available, and other useful information on working with families impacted by substance use.

When working with families, DCF Social Worker must determine if there are substance use indicators and the need to refer for a substance use treatment assessment. These are the 5 components that need to be completed to make that decision:



Observations/Indicators

Observations/Indicators for substance use/misuse can include, but is not necessarily limited to, the following:

- parent/caregiver or adolescent appears to be under the influence of drugs or alcohol, admits to having a substance use disorder (SUD), or exhibits other signs of use/misuse (needle marks, etc.)
- evidence of use in the home (baggies, spoons, residue, empty bottles, etc.);
- parent/caregiver or adolescent had a positive drug screen at the birth of a child;
- biological child had a positive toxicology screen at birth and the primary caregiver is the birthing parent;

- biological child is diagnosed with Fetal Alcohol Spectrum Disorder, Syndrome or Exposure (FASD, FAS or FAE);
- prior unsuccessful substance use disorder treatment;
- negative consequences or problems from use (medical, legal, child welfare legal involvement, intimate partner violence, child/family relationships, work/school, etc.); or
- positive score on an approved screening tool

In order to be able to identify substance use indicators, DCF Social Workers should be familiar with routes of administration, environmental, physical, and behavioral indicators of substance use in the home.

There are many routes of administration for substances. This varies by substance type and results in a variety of drug paraphernalia that can be used:

- Smoked in joints, pipes, blunts
- Ingested orally through teas, food, pills
- Snorted
- Injected
- Inhaled through vaping, e-cigarettes
- Ingested through skin, eyes

Environmental indicators that may suggest that there is substance use occurring in the home include:

- Distinct and pungent odor
- Powder residue
- Paraphernalia (baggies, spoons, residue, empty bottles, etc.)

A NOTE ON SOCIAL WORKER SAFETY:

Do not, under any circumstances, handle any paraphernalia or substances that you may see in the home. Instead, if there is a child in the home who may have contact with the substance/paraphernalia, ensure the safety of the child by contacting the supervisor from the field.

Behavioral indicators that someone may be under the influence include:

- Rapid talking, conversation lacks continuity
- Sleepy, Lethargy, Slurred speech
- Forgetfulness, amnesia
- Excessive activity
- Argumentative and nervous
- Mood swings, anxiety
- Impaired judgment
- Hostility, irritability
- Bizarre behaviors

Physical indicators include:

- Bloodshot eyes, extremely dilated pupils or constricted pupils

- Dry mouth and bad breath, frequent lip licking, excessive salivation
- Runny nose with frequent sniffing
- Lack of coordination
- Grimacing facial expressions
- Staring gaze with rigid muscles
- Track marks (needle marks on arms and other parts of the body)
- Nausea, and vomiting, tremors, convulsions

When DCF receives allegations that there is substance use/misuse in a CPS report, the details of such allegations should be clearly reported and must mirror the observations/indicators listed above. Simply reporting that someone is using/misusing substances does not provide enough evidence of use/misuse. Providing detail of the specific observations and indicators provides critical information that is needed to adequately address the impact of the substance use in the home.

Screening

Standardized screening for treatment need is important to reduce disparities in identifying substance use problems, and for facilitating services for people who need them. By asking **all** caregivers about their substance use, unintentional bias is minimized and/or eliminated. By screening all caregivers and adolescents for substance misuse, the department is helping to address the issues of disparity often experienced by families involved with child welfare. Validated screening tools for treatment need to quickly and accurately identify individuals who are likely to benefit from substance use treatment. Effective screening also rules out people who are not likely to have a substance use disorder.

Validated and reliable screening tools consist of a standardized set of questions that hone in on whether or not a problem exists, and if the threshold is met to refer someone for further assessment for substance use disorder. Screening tools may be administered orally, using a computer, or self-administered by the person being screened.

By asking **ALL** caregivers about their substance use, unintentional bias is minimized and/or eliminated.

DCF Social Workers will administer a set of standard questions to screen for the presence of substance use problems. The questions shall be presented in the parent/caregiver's or adolescent's own primary language in a setting that maintains the confidentiality of responses. The purpose of the screening is to determine:

- the impact of substance use; and
- the need for a substance use evaluation.

Required Screening Tools

The **UNCOPE** is the required screening tool for adults (Appendix D). The **S2BI/CRAFFT** is the required screening tool for adolescents (Appendix E).

This screening shall be conducted at intake *and as needed throughout the life of a case*. The tools will be administered in a trauma-sensitive manner and using family-centered engagement practices. During the life of a case, a new screening should occur when:

- There are observational indicators (examples of indicators are provided in a later section) that substance use may be occurring,
- There are new indicators that include substance use/misuse, and/or

- Youth/caregivers are not responding to the treatment they are receiving and/or making progress on their case planning goals.

Documentation of the use of the screening tool and a summary of the results is required. Should the screen be done in hardcopy, the documents are filed in the confidential section of the DCF case record.

Interview

DCF Social Workers should also interview different people in order to obtain additional information regarding the parent/caregiver or adolescent's substance use concerns. This is especially important because the screening and substance use evaluation for treatment rely heavily on the individual's self-report. There are many reasons why an individual's self-report may not be sufficient to identify a substance use problem. For example, they may not realize or remember that negative consequences are due to their substance use.

The protocol for the Social Worker interviews includes:

- the reporter in child welfare referrals,
- household members,
- relatives,
- treatment providers, and
- other people with appropriate knowledge of the alleged substance use problem.

Questions that may be asked during an interview include:

- What specific substances are being used by the parent/caregiver?
- What is the frequency of the substance use?
- Do the children have knowledge of the substance use?
- Are the parents high or intoxicated while directly caring for the children?
- Are there drugs, either legal or illegal, in the home? If so, where are they located?
- Do the children have access to the drugs?
- Is there drug paraphernalia in the home?
- Have the parents ever experienced blackouts?
- How well are the children supervised? Are they left alone for extended periods of time?

The Structured Decision Making (SDM) safety assessment includes gathering information regarding alcohol or substance misuse. Answers to the interview questions above shall be used in the completion of the SDM tools.

Record Review

DCF Social Workers should review all available records in order to get a historical perspective of the substance use. Records to be reviewed include: child welfare, police/legal, medical, and behavioral health, including previous evaluations and treatment services.

Consultation

After gathering all necessary information, DCF Social Workers may consult with their Supervisors and/or Regional Resource Group (RRG) – Substance Use Specialist in accordance with [RRG practice guide](#) for:

- Parent/child case and treatment planning;
- placement needs;
- assessment of functioning;

- assistance with assessment of level of care and provision of services;
- assistance with safety planning and implementation of support services;
- assistance with discharge planning and aftercare services; and
- assessment of cultural and linguistic resources pertinent to the clinic needs of the parent/caregiver or adolescent.

Consultation with the RRG will assist DCF Social Workers in confirming or clarifying substance use needs and services for the parent/caregiver or adolescent. In addition, DCF Social Work Supervisors should review the information and provide feedback on necessary steps to meet the substance use needs.

ASSESSMENT

Once the items above have been obtained, and there is concern of substance use/misuse impacting parental functioning and/or child risk and safety, a direct referral for treatment, and/or a referral for SAFE Family Recovery service(s) is made by the Social Worker.

Caregiver substance misuse can have child welfare impact in a variety of ways, such as:

- Impaired ability to function effectively in a caregiver role due to:
 - Impairments (both physical and mental)
 - High levels of caregiver stress due to unemployment or other stressors
 - Untreated mental health symptoms
 - Expenditure of often limited household resources on purchasing alcohol/other substances
 - Time spent seeking/using drugs
 - Increased violence
 - Illegal activity
- Inability to meet Basic needs of children, such as:
 - nutrition
 - supervision
 - nurturing
- Decreased safety and monitoring of all aged children
- Caregiver substance use impacts safe sleep through Co-Sleeping and Bed Sharing and not securing and /or maintaining a safe sleep environment:
 - Substance use can lead to diminished awareness of baby in bed
 - Leads to rolling over and suffocation of baby
 - Impaired judgment can result in not securing a safe sleep environment (leaving infant in car seat, sofa)

Negative impact on child well-being may be evidenced through:

- Increased stress of child manifested through health symptoms (gastro-intestinal, headaches)
- Increased mental health symptoms for depression/anxiety or acting out behaviors
- Impaired functioning at school (for example, worry/lack of sleep impacting ability to concentrate)
- Taking on developmentally inappropriate tasks (young child caring for younger children, cooking)
- Feelings of guilty, shame, confusion, fear

The following items are completed and documented in advance of the referral:

- observations;

- screening;
- interviewing of others;
- a review of available records; and
- consultations with other staff.

Voluntary Assessment, Refusals, and Further Actions

Participation in screening is voluntary. Parents, caregivers, and adolescents may refuse the entire screening, or to answer specific questions. If a parent/caregiver or adolescent refuses to participate in a substance use screening or evaluation, and there are significant indicators of risk or need for this service, the DCF Social Worker shall consult with his or her Supervisor and the RRG as necessary. The RRG shall be available to make home visits to further assess a parent/caregiver or adolescent's need for a substance use evaluation or other services.

The parent/caregiver or adolescent's refusal to cooperate shall be factored into the determination as to the safety of the child. If it is determined that the safety of the child is at risk, the DCF Social Worker shall consult with the Area Office legal staff or the Assistant Attorney General to determine potential legal options.

Releases of Information

Prior to a referral for testing, evaluation, or treatment, the [DCF-2131T](#) and [DCF-2131F](#) "Authorization for Release of Information" forms shall be completed and properly filled out.

In Connecticut, minors have the legal right to access substance use treatment without parental consent or notification (CGS Sec. 17a-688). DCF Social Workers, with the minor's permission, shall assist in engaging and involving the parent or guardian in the consent process as much as possible.

Written consent by a conservator may be required for adults with cognitive impairments, based on the legal conditions of the conservatorship.

Releases of information shall be kept current and reflect that the intended purpose is to provide ongoing information to DCF regarding the individual's treatment information including but not limited to:

- attendance;
- progress toward treatment goals;
- successful completion of the program; and
- recommendations from the treatment provider.

Confidentiality

All drug and alcohol testing, evaluation and treatment information is protected under state and federal law. Any request for DCF records shall be directed to Area Office legal staff.

Parents/caregivers and adolescents in substance use treatment have special privacy protections to their alcohol or drug use records by 42 Code of Federal Regulations (CFR) Part 2. These protections are motivated by the understanding that stigma and fear of prosecution might discourage people with substance use disorders from seeking treatment. Therefore, 42 CFR Part 2 requires written consent before any substance use related disclosures of information. Social Workers should obtain and maintain current releases of information (DCF-2131) and recognize that substance use clinicians will only release substance use treatment information with a

signed consent. DCF clients must sign the release of information in two places: to specifically release substance abuse (alcohol/drug) use information, and at the bottom of the form.

Evaluation Referral

When making a referral for an adult or adolescent substance use information, it is critical to include all information related to substance use in advance of the evaluation. Evaluations rely heavily on the self-report of the individual and the Clinician completing the evaluation needs as much information about the substance use problem as is available to make accurate and appropriate recommendations. Self-report, without supporting information from the referral source, can result in no treatment or the wrong treatment intervention recommended. Self-report may not be accurate for several reasons: the individual is unaware that there are negative consequences as a result of the substance use, may experience shame about his/her substance use, may not recognize that the substance use has caused problems and may not trust the clinician out of fear of losing his/her child (caregiver) or getting in trouble with their parents (adolescent) or may be in a pre-contemplative level of change (see stages of change below).

Adults

Adult referrals to substance use evaluation can be initiated primarily through a) a direct referral to a treatment provider or b) a referral for a Screening and Brief Intervention and Referral to Treatment (SBIRT). With the exception of referrals to Family Based Recovery (FBR), Building Stronger Families (BSF), and SAFE Family Recovery (SAFE-FR) which occur through the DCF service gatekeeper, the DCF

Social Worker should initiate a request for an SBIRT by answering all questions in the SBIRT Referral Form (Appendix F). If the parent/caregiver is already in treatment, the Social Worker will obtain and share information from/to the provider with the necessary release, in order to assess the parent/caregiver's status in treatment and safety risk to the children. A new evaluation is not needed.

Reasons NOT to make a SBIRT referral:

- "Rule out" of substance use without any concerns identified

Reasons to make a referral:

- Positive drug screen at birth,
- appearing under the influence,
- evidence in the home,
- negative consequences (legal/medical/family)

Youth

DCF Social Workers should initiate referrals for youth directly with local providers of Adolescent Community Reinforcement Approach - Assertive Continuing Care (ACRA-ACC) or another adolescent substance use provider who will complete an evaluation. Adolescents should consent in advance to referrals for substance use treatment. Adolescents cannot be referred to SAFE Family Recovery.

SUBSTANCE USE EVALUATION ELEMENTS

A substance use evaluation will contain the following elements:



The following bullets are included in the bio psychosocial, functional, substance use, and mental health assessments:

- screening for co-occurring mental health conditions, including trauma exposure and mood disorders.
- obtaining information about any negative consequences, such as legal, as a result of the substance misuse.
- patterns of substance use: age of onset, types of substances used, how the substances are used, frequency, and periods of abstinence

The **American Society for Addiction Medicine criteria uses six dimensions** to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care.

The six dimensions are:

- Dimension 1 - Acute intoxication and/or withdrawal potential – Exploring an individual’s past and current experiences of substance use and withdrawal
- Dimension 2 - Biomedical Conditions and Complications – Exploring an individual’s health history and current physical condition
- Dimension 3 - Emotional, Behavioral, or Cognitive Conditions and complications – Exploring an individual’s thoughts, emotions and mental health issues
- Dimension 4 - Readiness for change – Exploring an individual’s readiness and interest in changing
- Dimension 5 - Relapse, Continued Use or Continued Problem Potential – Exploring an individual’s unique relationship with relapse or continued use of problems
- Dimension 6 - Recovery/Living environment – Exploring an individual’s recovery or living situation, and the surrounding people, places, and things. (The ASAM criteria: treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions, 2013)

Stages of/ Readiness for Change:

The Readiness for Change is a framework to describe the normal and expected process that everyone goes through when making changes in their lives, including addressing untreated substance use. The Stage of Change is assessed as a component of a substance use evaluation, because the level of intervention is determined, in part, by the individuals’ Stage of Change. Recommendations are tailored to an individual’s level of change. When discussing treatment recommendations and progress with a substance use clinician, ask what Level of Change the individual is in.

Below is a list of the Stages of Change that an individual will experience when changing a substance use problem:



Pre-contemplation

- The individual is not considering change, is aware of few negative consequences, and is unlikely to take action soon.

Contemplation

- The individual is aware of some pros and cons of substance abuse but feels ambivalent about change

Preparation/Determination

- This stage begins once the individual has decided to change and begins to plan steps toward recovery

Action

- The individual tries new behaviors, but these are not yet stable. This stage involves the first active steps toward change

Maintenance

- The individual establishes new behaviors on a long term basis

Relapse

- Relapse results in the parent re-engaging in the contemplation, decision and action stages

Results of the substance use evaluations are used as one of many factors that need to be considered to make informed decisions regarding safety, permanency, and well-being of children in addition to treating the identified disorder.

A substance use evaluation will not be used to rule out a substance use disorder when there are no indicators of substance use/misuse.

Diagnosis, Level of Care, and Recommendations:

A diagnosis for a substance use disorder is made by following the Diagnostic and Statistical Manual, 5th Edition (DSM-5) criteria. The DSM-5 is a guidebook used by practitioners to ensure a consistent framework to determine if an individual has a mental health condition and is used by all behavioral health practitioners.

Substance use disorders (SUDs) per the DSM-5 comprise a cluster of physiological, cognitive, and behavioral symptoms which indicate an individual continues to use a substance despite substantial substance-related problems. A salient feature of SUDs is the underlying change in brain pathways that may continue to be evident well after detoxification, particularly when the SUD is severe. The diagnosis of SUD can be applied to nine (9) classes of drugs: 1) Tobacco; 2) Cannabis; 3) Inhalants; 4) Stimulants; 5) Opioids; 6) Alcohol; 7) Hallucinogens; 8) Sedatives, hypnotics, and anxiolytics; and 9) Other/Unknown substances. These substances may be obtained over the counter, by prescription, and/or illegally. Behavioral effects of brain changes from use of these substances may become manifest in repeated relapses, as well as intense drug cravings, when people with SUD are exposed to substance-related stimuli (American Psychiatric Association, 2013).

Once a diagnosis has been determined, the practitioner makes a level of care recommendation, which are described in the Treatment and Recovery section of this manual. DSM provides a description of problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. The substance is taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful effort to cut down or control use of the substance.
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
4. Craving, or a strong desire or urge to use the substance.
5. Recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
7. Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
8. Recurrent use of the substance in situations in which it is physically hazardous.
9. Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance as defined by either of the following:
 - a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of the substance.
11. Withdrawal, as manifested by either of the following:
 - a. The characteristic withdrawal syndrome for that substance (as specified in the DSM-5 for each substance).
 - b. The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

DRUG TESTING

Drug testing refers to the analysis of biologic sources (urine, hair, saliva, etc.) to determine the presence of specific substances and/or their metabolites in their system. While drug testing is one of the tools used, it alone cannot determine if a person has a substance use disorder. There are many reasons why a drug test result may not accurately represent use. Drug testing is not 100 percent accurate. Accuracy depends on a number of factors, such as the type of test, the substance being tested for, the presence of legally prescribed medications in the body, and the length of time that has passed since last use. WebMD states that positive results are false up to 10 percent of the time, while negative results are false up to 15 percent of the time. Commonly used medications

and even certain food products can trigger false positive results, including cold and allergy medicines, diet pills, certain antidepressants, and poppy seeds. Testing is most accurate within a specific timeframe known as the “detection window.” The detection window varies from one chemical to another. Some drugs, such as alcohol, are eliminated from the body within a matter of hours, while residual traces of other substances can be detected over longer periods like several weeks. If testing is conducted before or after the detection window, the results may be inaccurate. A complete substance use evaluation is needed.

Drug testing determines if a substance type was identified in the sample.

Drug testing does not necessarily determine what substances were or were not in the individual’s systems.

Drug testing is performed during a substance use evaluation as well as throughout treatment. The substance use provider can determine the type of drug test and the frequency based on standards from the American Society of Addiction Medicine (ASAM)². Typically, drug testing is conducted at random intervals during the course of treatment and used as a clinical tool to inform the substance use clinician of unidentified substance use, mark progress in treatment, and create the opportunity for dialogue with the patient about their treatment progress.

Drug testing by substance use provider is used as a tool for supporting recovery. Every effort should be made to emphasize its therapeutic importance rather than used as a punishment. Drug testing assists in treatment planning in combination with a psychosocial assessment, and it assists in monitoring the treatment plan.

When obtaining information from the youth/caregiver’s substance use provider, specifically ask for:

- type of substance used
- frequency and route of administration
- types and frequency of drug testing done and the results, as they relate to their progress,
- attempts at obtaining drug tests that were unsuccessful and reason for this.

Drug testing of any kind is not indicated when:

Inappropriate uses for drug and alcohol testing

² *ASAM Criteria* – a collection of written objective guidelines that give clinicians and care managers a way to standardize treatment planning and determine where patients are placed in treatment, as well as how to provide continuing, integrated care and ongoing service planning and disease management.

| |
|---|
| <ul style="list-style-type: none"> ▪ there are no substance use indicators |
| <ul style="list-style-type: none"> ▪ the parent/caregiver admits to use |
| <ul style="list-style-type: none"> ▪ the parent/caregiver is complying with and making progress in substance use treatment |
| <ul style="list-style-type: none"> ▪ the parent/caregiver successfully completed substance use treatment and there are no allegations of a relapse and no behavioral indicators of use |
| <ul style="list-style-type: none"> ▪ used to determine the types of substances used/misused |
| <ul style="list-style-type: none"> ▪ used to compare drug concentrations |
| <ul style="list-style-type: none"> ▪ the substance of concern is not part of the panel (e.g., using a hair test to identify alcohol use) |

Detection Window

Timing is a major factor in drug testing as individual differences may affect the results. The following affect how long a drug remains in the body:

- type of drug used,
- amount of substance consumed,
- frequency of use, and
- a person’s metabolism.

Selection of specimen will be dependent on the available detection window. The table below shows the different detection windows by type of specimen available through SAFE Family Recovery. Additional information on specimens available through medical insurance or private payment can be found in Appendix G.

Specimen Types

| Pros and Cons of Different Specimen Sources Available through SAFE Family Recovery | | | |
|--|---------------------|------|------|
| Specimen | Window of Detection | Pros | Cons |
| | | | |

| | | | |
|-------|----------------|---|---|
| Urine | Up to 2–4 days | <ul style="list-style-type: none"> • Least expensive • Flexibility for testing different drugs types • Most likely to withstand legal challenge | <ul style="list-style-type: none"> • Specimen can be adulterated, substituted, or diluted • Limited detection window • Collection can be invasive or embarrassing |
| Hair | Up to 3 months | <ul style="list-style-type: none"> • Collecting the hair specimen can be observed • Long detection window • Does not deteriorate • Can be used to measure chronic drug use • More difficult to adulterate than urine | <ul style="list-style-type: none"> • Moderate to high cost • Cannot be used to reliably detect alcohol use, or other substances • Cannot be used to detect drug use 1–7 days prior to drug test • Not effective for compliance monitoring • External contamination |

(CSAT, 2010)

Frequency of Testing Associated with Treatment

The frequency of drug testing is determined only by the substance use provider. The DCF Social worker and provider should be sharing relevant information regularly regarding treatment progress. The substance use provider will take all relevant information to determine the type and frequency of testing.

Drug Testing is only available for adults. Testing on children is not used to determine substance exposure, except for meconium testing of newborns. Concerns regarding child exposure to substances should be addressed by consultation with pediatrician and/or RRG.

Drug testing is one tool used to address substance use issues that is used in conjunction with other tools. Drug testing may be used without concurrent treatment only for legal proceedings when documentation of abstinence is required. Lack of indicators of current substance misuse as the sole reason for drug testing will not be approved.

Understanding Drug Test Results

Drug test results indicate only that the drug or its metabolite is present at or above the established concentration cutoff level in the test specimen. Results do not determine whether a person has a substance use disorder. **As a result, child welfare personnel should not rely on a drug test result as the sole determining factor for ruling out substance use, misuse, or disorder.** A negative drug test result only indicates that the test did not detect the drug or its metabolite or that its concentration is below the established cutoff level in that particular specimen at that time. (CSAT, 2010)

Some medications may cross-react in the Instant Drug Screen and yield a false positive test result. Only a laboratory confirmation will identify the substances. Laboratory results are final.

For additional questions regarding current results and interpretations, please refer to the Frequently Asked Questions in the Overview of Drug Testing (Appendix H).

Sharing Results with the Parent/Caregiver or Adolescent

Providers should be communicating the drug test results directly with the parent/caregiver or adolescent similarly to other medical conditions. Positive and non-stigmatizing language should be used by everyone (“positive/negative” instead of “clean/dirty”) when discussing drug test results. For additional information on recovery oriented language, please refer to the Language of Recovery document (Appendix I).

Court Ordered Hair Testing

When Juvenile Court orders DCF to obtain a hair test for child protection concerns the Social Worker will consult with the RRG to:

- assess whether the suspected substance is able to be detected by a hair test,
- review current substance use indicators, and
- review status of substance use treatment including previous test results.

There may be occasions where a hair test is being court ordered but there are no current substance use indicators, the parent/caregiver is compliant with treatment, or the substance cannot be detected (alcohol). In those situations, the DCF Social Worker shall consult with the Principal Attorney and/or Assistant Attorney General in order to review the appropriateness of the hair test. Hair tests should not be used in isolation from substance use indicators.

Hair Tests are NOT used when individuals:

- admit use
- have positive drug screens
- are compliant with treatment
- successfully completed treatment
- misuse substances not included in the panel
- staff desire to screen for additional substances

Drug Test Results

Treatment providers in both adult and adolescent services often maintain that drug test results are confidential, as they are not always confirmed results. In addition, treatment providers and child welfare staff use drug test results for different purposes. Treatment providers use drug testing as a clinical tool embedded within their intervention to effect or continue positive behavior change. In child welfare practice, drug test results may be documented to inform current or potential legal action. There are also some treatment programs that specifically do not share drug test results. However, all providers should be sharing information on the progress or status of treatment, which takes the drug test results into consideration. A release of information is required.

TREATMENT AND RECOVERY

Referrals to Treatment

Adults

The recommendations of the substance use evaluation will determine the indicated level of intervention needed, if any, for problems related to substance use. Adult parents/caregivers whose responses indicate a need for substance use treatment shall be referred to an appropriate provider through either a direct referral to a substance use treatment provider, Family Based Recovery (FBR), Multi-Systemic Therapy-Building Stronger Families (MST-BSF), SAFE Family Recovery (SAFE-FR), or other private provider. Substance use treatment

providers may offer early intervention/relapse prevention services, outpatient services, intensive outpatient services, or partial hospitalization program. Additionally, there are residential treatment programs located throughout the state that are available for pregnant and parenting women and their children. These settings typically permit the mother to bring 1 or 2 pre-school children into care with her. All pregnant women have priority access to all levels of care within the Department of Mental Health and Addiction Services (DMHAS) treatment system.

If the parent/caregiver self-reports a need for treatment or if there is a current recommendation for treatment, he or she shall be referred directly to treatment. Substance use services for adults are available through the DMHAS providers or private practitioners.

Youth

Adolescents whose response indicate a need for community based treatment shall be referred to ACRA-ACC or another appropriate adolescent substance use program where a substance use evaluation will be completed. Adolescents whose response indicate a need for an in-home based treatment shall be referred to Multisystemic Therapy (MST) or Multidimensional Family Therapy (MDFT), as appropriate.

90% of people who needed substance use treatment **DID NOT** receive services. (CFF, 2015)

Substance use treatment shall be available to adults and adolescents regardless of residency or immigration status. For those adults without medical insurance, payment for services follows the community standard (e.g., sliding-scale). SAFE Family Recovery will not pay for deductibles or spend downs. Medical insurance is NOT required for those parents/caregivers referred to FBR or MST-BSF since DCF funds the provision of these services through a contract. All families with insurance are expected to utilize their plan.

Treatment Options

Treatment interventions vary based on the unique needs of the individual and, depending on the intervention, are delivered in treatment settings or the home/community. It is important to note that youth have different treatment needs than adults, as they are in a different developmental stage of life. Effective treatment should be:

- culturally informed,
- engaging, empowering, and strengths-based,
- trauma-informed and gender responsive,
- developmentally appropriate,
- based in evidence,
- seamless, comprehensive, integrated, and coordinated

Treatment options in CT include:

- Residential Treatment
- Medical detoxification
- Medication assisted treatment (evidence shows that medication treatment works best in conjunction with additional counseling therapies)
- Community-based Family Interventions
- Outpatient treatments:
 - Partial Hospitalization (PHP) (5 x weekly for 4 or more hours a day)

- Intensive Outpatient (IOP) (3-5 x weekly for 3 or less hours per session)
- Individual, Family and/or Group Sessions (Early Intervention, Relapse Prevention)
- Recovery support/Support Groups

Connecticut has access to substance use treatment services statewide. The Department of Mental Health and Addiction Services (DMHAS) is the state agency charged with this service array and offers the full continuum of services ranging from recovery support, outpatient, inpatient, detoxification, and specialty residential treatment programs for pregnant/parenting mothers and their children. For more information on services, see the [DMHAS website](https://www.ct.gov/dmhas/site/default.asp) (<https://www.ct.gov/dmhas/site/default.asp>). In addition, DCF funds community based programs statewide that provide services to families delivered in the community. For more information on DCF funded services, admission criteria, location, and other information on how to access these services, see the [DCF Substance Use](#) website or the [Substance Use SharePoint](#) site.

Residential Treatment

Residential treatment ranges typically from stays of 30 days to 6 months, based on the program type. In addition, DMHAS offers specialty programs for pregnant and/or parenting mothers for up to 6 months. These programs permit mothers to obtain residential treatment along with up to 2 pre-school aged children. *When a mother goes to a women and children’s residential treatment program, every effort should be made for the mother and child to go to the program together at the same time without delay to promote optimal attachment and bonding between mother and child.*

Outcomes for youth in residential treatment are mixed. Current research indicates that the optimal residential stay for youth is six months (or less). Residential stays longer than six months show no evidence of continued improvement. In fact, stays of 10 months or more often result in a deterioration of youth behavioral health (Strickler et al., 2016). Instead community and in-home interventions are preferred options for treatment, unless a residential treatment setting is recommended by a substance use evaluation, and treatment in less restrictive settings is contraindicated or unavailable. Both Multidimensional Family Therapy (MDFT) and Adolescent Community Reinforcement Approach (ACRA) have evidence as effective community care alternatives to residential settings for some youth and should be considered.

Medical Detoxification

Detoxification is a medical intervention and is available for physical dependence requiring medical monitoring for safe detoxification. These substances include: alcohol, opioids, and benzodiazepines. Many substances, including marijuana and cocaine, do not require a medically monitored detoxification and are therefore not admitted into this level of care. Detoxification from benzodiazepines (for example, valium) and alcohol can be life threatening and it is very important for an individual to receive a medical assessment when detoxifying from these substances.

Mediation Assisted Treatment (MAT)

MAT has been proven very effective in assisting with the treatment of substance use disorders and DCF supports and endorses the use of MAT when recommended. MAT is presently available in Connecticut as methadone, suboxone, and extended-release injectable Naltrexone (Vivitrol).

When a family member is on MAT, the DCF Social Worker shall obtain Releases of Information and gather collateral information inclusive of type of MAT, dosage, and compliance with treatment. It is important that effective communication exist so that DCF Social Workers can ask questions or relate concerns about the MAT. For example, methadone dosing should occur at the level in which the MAT recipient can care for child in a fully

alert manner. If the DCF worker observes, suspects, is told by a caregiver, or obtains collateral information that the caregiver is not able to stay alert while parenting, immediate consultation with supervisor, RRG consultation, and contact with MAT provider should occur and safety plan addressing this should commence.

Community Based Family Interventions

DCF funds a mix of engagement, treatment and recovery support interventions available to caregivers and youth with substance use disorders that are delivered in the community including some services that are delivered in the home. For more information on available DCF funded services, see the service grid in Appendix J.

For DCF-involved caregivers the following services are available:

- Family Based Recovery (FBR)
- Multidimensional Family Recovery (MDFR)
- Multi-systemic Therapy-Building Stronger Families (BSF)
- Recovery Management Checkups and Support (RMCS)

For youth the following are available:

- ACRA-ACC
- Multi-dimensional Family Therapy (MDFT)
- ASSERT Treatment Model (ATM)
- Multi-systemic Treatment (MST). MST has several adaptations that focus on specific youth populations, which are:
 - Problem Sexual Behavior (PSB)
 - Emerging Adults (EA)

Outpatient Treatments

These services are delivered at outpatient behavioral health clinics that are located throughout the state. There is a range of frequency and duration of settings, based on the need of the participant and include:

- Partial Hospital Program (PHP): group sessions, 5 x weekly for 4 or more hours a day, 4-6 weeks
- Intensive Outpatient Program (IOP): group sessions, 3-5 x weekly for 3 or less hours per session, 4-6 weeks
- Outpatient sessions: individual, family, or group sessions (such as Early Intervention or Relapse Prevention group), 45 minutes-1.5 hours in length, 1-3 times per week, short and long term options available.

Recovery Support/Support Groups

Substance Use Recovery is “a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.” (Substance Abuse and Mental Health Administration (SAMHSA)).

SAMHSA has delineated four major dimensions that support a life in recovery:

- **Health**—overcoming or managing one’s disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being
- **Home**—having a stable and safe place to live
- **Purpose**—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- **Community**—having relationships and social networks that provide support, friendship, love, and hope

SAMHSA has also delineated a process of change that underlies recovery hinges on ten guiding principles

1. **Recovery emerges from hope.** The individual has to believe that recovery is real and that people can and do overcome the external and internal barriers challenges, and obstacles that they will encounter. Hope must be internalized and can be fostered by many possible sources, including families, friend, peers, providers, etc. Hope is the driver of the recovery process.
2. **Recovery is person-driven.** Self-direction and self-determination are the foundations for recovery as people define their own life goals and design their distinct path(s) toward those goals. Individuals enhance their independence and autonomy to the greatest extent possible by controlling, exercising, and leading choice over the services and supports that help their resilience and recovery. This empowers them and provides resources necessary to make informed decisions, build on their strengths, initiate recovery, and gain or regain control over their lives.
3. **Recovery occurs through many pathways.** Individuals have unique issues that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, talents, coping abilities, strengths, resources, and inherent value of each individual and its pathways are highly personalized. These pathways may include professional clinical treatment; use of medications; support from families; support in schools and communities; faith-based approaches; peer support; and other approaches. Recovery is definitely not linear. Instead it is characterized by continual growth and improved functioning that may involve setbacks. Thus, it is essential to foster resilience for all individuals and their families. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the developmental or legal capacity to set their own course.
4. **Recovery is holistic.** Recovery comprises an individual's whole life, including body, mind, spirit, and community. This includes addressing: self-care practices, family, housing, employment, education, clinical treatment for mental disorders and substance use disorders, transportation, services and supports, primary healthcare, dental care, alternative and complementary services, faith, spirituality, creativity, social networks, and community participation. The array of available services and supports should be coordinated and integrated.
5. **Recovery is supported by peers and friends.** Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, valued roles, supportive relationships, and community. By helping others and giving back to the community, individuals can help themselves. Peer-operated services and supports provide important resources to help people along their journeys of recovery and wellness. Of course, professional support plays an important role in the recovery process, providing clinical treatment and other services that support individuals in their chosen recovery paths. However, peer supports for families are very important, especially for children with behavioral health problems, and can also play a supportive role for youth in recovery.
6. **Recovery is supported through relational and social networks.** An important factor in the recovery process is the presence and involvement of people who believe in the ability of an individual to recover; who offer hope, encouragement, and support; and who also suggest resources and strategies for change. Family members, peers, providers, faith groups, community members, and other supporters form vital support networks. These relationships help people leave unhealthy and/or unfulfilling life roles behind and engage

in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of personhood, belonging, empowerment, social inclusion, autonomy, and community participation.

7. **Recovery is culturally-based and influenced.** Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are critical in determining a person’s journey and unique pathway to recovery. Services should be culturally grounded, sensitive, attuned, congruent, and competent, as well as personalized to meet each individual’s unique needs.
8. **Recovery is supported by addressing trauma.** Experiencing trauma is frequently a precursor to or associated with substance use, mental health problems, and related issues. Services and supports must be trauma-informed to foster safety (emotional and physical) and trust, as well as promote choice, collaboration, and empowerment.
9. **Recovery involves individual, family, and community strengths and responsibility.** Individuals, families, and communities have resources and strengths that serve as a foundation for recovery. Additionally, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals need to be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, and especially the children and youth in recovery. Communities have responsibilities to provide resources and opportunities to address discrimination and to foster recovery and social inclusion. Individuals in recovery also have a social responsibility and should be able to join with peers to speak collectively about their strengths, wants, desires, needs, and aspirations.
10. **Recovery is based on respect.** Community, systems, and societal acceptance and appreciation for individuals affected by substance use and mental health problems, including protecting their rights and eliminating discrimination, are also crucial in the achievement of recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one’s self are particularly important (SAMHSA, 2012).

The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches.

Recovery is characterized by continual growth and improvement in one’s health and wellness that may involve setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.

Resilience refers to an individual’s ability to cope with adversity and adapt to challenges or change. Resilience develops over time and gives an individual the capacity not only to cope with life’s challenges but also to be better prepared for the next stressful situation. Optimism and the ability to remain hopeful are essential to resilience and the process of recovery.

Recovery Capital is the sum total of all the personal, social, and community resources a person can draw on to begin and sustain his recovery from drug and alcohol problems. (SAMHSA) Recovery efforts should be built into all treatment interventions and be developmentally appropriate to meet the needs of youth and adults. Recovery support and capital are considered protective factors.

It is important to note that substance misuse impacts other family members who may also benefit from treatment. Encourage other family members to seek out treatment, support and guidance on how to address familial substance use problems. Recovery support groups, such as AA and NA, offer corresponding support groups for family members (Nar-Anon/Al-Anon).

RECOVERY SUPPORTS

- SMART Recovery Support Groups
- Alcoholics Anonymous (AA)
- Narcotics Anonymous (NA)
- Faith-based Support Groups

Collaboration with Treatment Providers

Routine and timely communication with treatment providers is necessary to ensure that the DCF Social Worker has the information necessary to inform parental functioning and child safety and well-being. It is the responsibility of the Social Worker to request regular updates from the provider, at minimum, a monthly intervals. These updates can occur in written and/or verbal format and should include, at least, the following information:

- Attendance and level of participation in treatment
- Substance use/recovery status
- Stage of change

Substance use treatment providers are expected to share information in a way that preserves the privacy and confidentiality of the client. This is done to promote honest sharing by the client. It is also important to note that the substance use provider goal is to improve the Substance Use Disorder and although a mandated reporter and required to report any risk, the content of treatment may likely focus on substance use recovery absent family functioning. Therefore, the Social Worker may ask questions of the provider to assist in obtaining the information that is needed for the DCF case planning effort.

If the DCF SW is unsuccessful at obtaining a response from the provider, Social Worker shall contact their supervisor for assistance in obtaining a response to the request for treatment updates.

DCF Social Workers shall communicate with treatment providers to ensure there is no duplication of services and to share other information relevant to treatment, including trauma history or symptoms related to trauma. Treatment providers for adults and adolescents should provide regular updates when current releases of information are signed and available. If communications or reports from treatment providers are not regularly received, the DCF Social Worker will increase contact with the treatment provider through phone calls or emails, as appropriate, and through consultations with the RRG for additional suggestions.

DCF Social Workers must try to obtain collateral contact from a Medication Assisted Treatment provider when there is a child below the age of 5. Collateral contact information will include medication type, dosage, and caregiver compliance with treatment.

It is critical that coordination between DCF and the substance use provider occur to ensure that treatment needs are being met. Here are a list of questions that may help to guide the Social Worker in obtaining relevant information about the family. In addition, the DCF Social Worker shall initiate contact with the treatment provider with any concerns related to substance use.

- What can you tell me about _____'s substance use history and periods of sobriety?
- What assessment information do you gather from the client to determine level of engagement and treatment success?
- How does _____'s substance use impact their functioning, including their parenting capacity?

- What modality of treatment are you providing for _____? Do you think it is effective at the present time?
- Tell me about _____'s recovery capital?
- What are _____'s strengths/motivation/progress?
- Who in _____'s resource network can be incorporated into _____'s treatment and recovery?
- Has there been a lapse/relapse? If so, how has _____ managed this?
- In addition to the treatment you are providing, are there any other recommendations you would make to support ongoing abstinence and recovery?

Specifically for Medication Assisted Treatment Providers:

- What medication and dosage is being prescribed and does _____ take the medication as prescribed?
- Are there any side effects or other concerns with this medication plan?

Substance Use Managed Service Systems (SUMMS)

Efforts to improve child welfare, substance use, and behavioral health services involve collaboration to enhance service delivery and ultimately improve outcomes for the children and families being served. The Substance Use Managed Service System (SUMSS) model allows a forum for case collaboration and networking between public and private agencies, communities, and programs for adult parents/caregivers with a substance use problem.

SUMSS meetings, with active participation from all members, take place regularly where Case Management and Recovery Support Programs are offered.

A DCF Social Worker or a treatment provider may present complex cases. SUMSS offers:

- The opportunity to network with clinical and community providers to create individualized plans to support the multiple systems serving the child and family.
- Integrated planning to address child welfare and substance use needs while identifying service gaps and systems issues to avoid duplication, a delay in service, and confusion for the families involved.
- Discussions using a common recovery language and perspective among all participants.
- An efficient and effective way to broker services.
- Accountability within the local collaborative system by clarifying and assigning roles and responsibility to actualize the agreed upon plan.

From a systems perspective, SUMSS members share risk, responsibility and success for each case. Cases presented at SUMSS will follow the [SUMSS Practice Guide](#).

Co-Occurring Disorders

People with a substance use and mental health disorders are diagnosed as having a co-occurring disorder, previously known as dual diagnosis.

Undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, or even early death (SAMHSA, 2005).

Approximately 7.9 million adults in the US had co-occurring disorders in 2014. (NSDUH, 2015)

People with co-occurring disorders are best served through integrated treatment, where both the substance use and other condition are treated at the same time.

The most common co-occurring conditions found with substance use are: trauma and post-traumatic stress syndrome, mood disorders (such as depression, anxiety, and bi-polar disorder) and being both the victim and/or aggressor in intimate partner violence.

- Substance misuse is associated with the following medical issues: liver disease, hepatitis C, stroke, heart disease, HIV and AIDS.
- Substance misuse is associated with mental health issues and people sometimes use substances to self-medicate. Examples include: depression, anxiety, poor coping skills, poor impulse control, and poor insight.
- Substance misuse involves habitual and sometimes compulsive behaviors that can be very challenging for the individual to break and can be triggered by people, places, times, certain emotions, and certain situations. Research has shown, for example, that substance misuse is correlated with intimate partner violence, both on the part of the primary aggressor as a trigger, and on the part of the victim, as a coping mechanism.
- Peer acceptance or pressure turns into regular group activities during which alcohol/drug consumption is expected
- Functioning in one or more areas may be impacted, such as: the ability to care for children responsibly the ability to work, manage money, and drive safely
- Substance misuse is highly correlated with financial problems and homelessness.

SAFETY PLANNING

Safety planning for families impacted by substance use includes assessing for impact of caregiver substance use on child safety, risk, and well-being. This includes assessing capacity to provide constant and consistent care and supervision for infants and toddlers and to also assess the impact of substance use by others in the home. Caregiver substance use may impact parenting capacity such that safety planning needs to occur to mitigate safety concerns.

Planning for safety through caregiver abstinence from substance use shall include specific methods for maintaining this abstinence and preventing relapse. Examples, include involvement with community support groups (such as 12 Step groups like Alcoholics and Narcotics Anonymous), regular contact with an Alcoholic Anonymous sponsor, attendance at substance use treatment, and regular involvement in other support systems, such as faith-based communities. Effective safety planning can still occur in families impacted by substance use when substance use occurs. Examples include:

- securing caregiver responsibilities with an approved caregiver when substance use is active, such as having child stay with another family member, and

- ensuring that caregiver with substance misuse is not alone and caring for the child(ren).

When conducting a Considered Removal Teaming meeting, encourage the caregiver to identify and include individuals who are supports in their recovery efforts. This may include a 12 Step meeting sponsor, Recovery Coach, and/or substance use treatment provider.

Assessing for safety and risk may look different dependent on the ages of the children in the home. Children under the age of 5 are the most vulnerable. For example, caregiver substance misuse is found to be a risk factor in safe sleep fatalities. While all caregivers of infants should be educated on safe sleep environments, caregivers who may misuse substances safety plans should include specific discussion on how to ensure a safe sleep environment in homes where substances may be misused.

All children are at risk of ingestion of substances in homes where substance use occurs and caregivers should be instructed to make sure that all substances, whether licit or illicit are not accessible to children of any age. This includes substances that are available in edible forms, such as confectionaries

In 2011, the American Academy of Pediatrics (AAP) Task force on Sudden Infant Death Syndrome revised its recommendations for safe sleep environments for infants to include the following:

- Always place a baby on his or her back to sleep for every sleep, every nap, and with every caregiver
- Use a firm sleep surface
- Infants should share a room with adult caregivers without bed-sharing
- Keep soft objects and loose bedding out of the crib
- Avoid smoke exposure during pregnancy and after birth
- Avoid alcohol and illicit drug use during pregnancy and after birth
- Breast feeding should be promoted
- Use a pacifier at nap time and bedtime for infants who will take one
- Avoid overheating.

Parental substance misuse increases the risk of co-sleeping fatalities.

Standards and Practice for Naloxone (Narcan®) Use and Availability

DCF Social workers shall provide information to all households where there is a risk of opioid overdose on how to obtain naloxone and assist with any barriers to obtaining naloxone. Social workers shall provide such households with the [Naloxone brochure in English](#) or the [Naloxone brochure in Spanish](#), develop a plan with the family to address any barriers in obtaining the naloxone, and document that informational brochure has been provided and solutions to barriers have been identified and implemented.

There are 2 primary ways that Social Workers should educate households to prevent opioid abuse and overdose: 1) how to obtain naloxone/Narcan and 2) safe storage and destruction of unused medications:

Naloxone (also known as Narcan®) is an “opioid antagonist” medication used to counter the effects of opioid overdose, for example morphine and heroin overdose. Specifically, naloxone counteracts life-threatening depression of the central nervous system and respiratory system caused by opioid overuse, allowing an overdose victim to breathe normally. It works by displacing the opioid from the receptor in the brain that effects breathing. Naloxone is a nonscheduled (i.e., non-addictive), prescription medication. Naloxone only works if a person has opioids in their system; the medication has no effect if opioids are absent. It is available in formulations that can be sprayed in the nose or injected into the skin/muscle.

People dependent on opioids are the group most likely to suffer an overdose, but overdose education, prevention and monitoring efforts should be undertaken for all individuals who are known to use opioids. The incidence of fatal opioid overdose among opioid-dependent individuals is estimated at 0.65% per year. Non-fatal overdoses are several times more common than fatal opioid overdoses. In 2017, Connecticut averaged average 2.8 fatal overdoses per day. More than half of these contained a substance known as fentanyl, which is a synthetic opioid. According to the Drug Enforcement Agency (DEA) fentanyl is 100 times more potent than morphine and 50 times more potent than heroin.

People who are at a higher risk of opioid overdose may:

- Inject opioids;
- use prescription opioids, in particular those taking higher doses;
- use opioids in combination with other sedating substances (such as benzodiazepines-known commonly as Ativan, Valium);
- be opioid dependent, in particular following reduced tolerance due to stopping use for a period of time (such as, following detoxification or another form of treatment, release from incarceration)
- use opioids and have medical conditions such as HIV, liver or lung disease or suffer from depression;
- live with other household members in possession of opioids (including prescription opioids).

People likely to witness an opioid overdose:

- people at risk of an opioid overdose, their friends and families;
- people whose work brings them into contact with people who overdose (health-care workers, police, emergency service workers, people providing accommodation to people who use drugs, peer education and outreach workers).

Risk factors for overdoses with prescribed opioids include a history of substance use disorders, high-prescribed dosage (over 100mg of morphine or equivalent daily), male gender, older age, and multiple prescriptions including benzodiazepines, mental health conditions and lower socioeconomic status³

Medication Safe-Storage and Disposal

Ingestion of licit and illicit substances presents significant safety risk for children and ingestion of substances can result in serious injury and death. All medication must be safely secured such that children are not able to access the medication. In addition to safe storage of all medications, caregivers who are on medications shall be educated on safe storage and disposal of medications. Please review [Safe Storage and Disposal of Prescription Medication Brochure](#). Under no circumstances should the DCF Social Worker handle any medication that is in the home.

CASE PLANNING

When substance use is identified, the case plan shall include

- the current use of alcohol, illegal substances or prescription drugs by the parents/caretaker/child.
- the impact of the substance use on the family functioning.
- readiness for change and if the parent/child has been referred for a substance abuse evaluation and what recommendations were made (include need for treatment and level of treatment).
- provider feedback in regards to compliance, treatment goals, progress with program.

³ http://www.who.int/substance_abuse/information-sheet/en/

- barriers to engagement in treatment.
- If substance abuse has never been a problem or is a resolved issue for the parent/child, recognize this as a strength.

Of critical importance in case planning is assessing for the ongoing impact of substance use on child safety, risk and well-being. While caregiver substance use can have a negative impact on children of all ages, it is of critical importance to assess the impact of younger children.

Identified substance use disorders shall be addressed in the case plan. If a substance use disorder is initially ruled out as a factor in family case planning, the DCF Social Worker shall reassess whether substance use disorder indicators are present at any time during the involvement based on ongoing interviews, observations, and indicators. If an indicator of impact on risk and safety is identified, consultation with supervisor or RRG shall occur.

The case plan shall include use of and impact of substance use, readiness for change, and include referred, provider feedback. If substance use is resolved, recognize this as an area of strength. Please refer to the case planning practice guide.

Medical Marijuana and its Use by Caregivers and with Children < 18 in DCF's Care

Medical Marijuana is available in CT to adults and youth. The Department of Consumer Protection (DCP) administers the program. See the DCF Health and Wellness Practice Guide for more information about medical marijuana.

High Risk Newborns

As noted in the High Risk Newborn policy, indicators that a newborn has special needs may include positive urine or meconium toxicology for substances and the condition of parental substance use. Born under such circumstances, a newborn shall be considered and addressed following the High Risk Newborn policy standards. This includes that the investigation shall include an assessment of the following:

- the extent of the mother's pre-natal care;
- the parents' willingness to participate in appropriate services;
- the support services within the family or community that are available to the parents;
- the safety and adequacy of the home;
- potential postpartum depression and other mental health concerns; and
- parents' ability to provide appropriate care in the home

DCF Social Worker shall visit with the child and family in the home within three days of discharge from the hospital and in-home visits shall occur at least twice a week for at least four weeks. One of the weekly visits may be made by an in-home service provider.

Infants Born Substance Exposed

As a result of the opioid epidemic, there has been a rise in the incidence of Neonatal Abstinence Syndrome (NAS). NAS is the term used to represent the pattern of effects that are associated with opioid withdrawal in newborns (Hudak & Tan, 2012). Infants experiencing NAS may exhibit symptoms such as feeding difficulty, crying, and irritability. Depending on the severity of the NAS, a medication protocol may be utilized. Non-pharmacological

treatment includes: soothing strategies, swaddling, skin to skin contact, creating a quiet environment, and reducing external stimulation such as bright light.

It is important to note that pregnant women who are misusing opioids are recommended to be on Medication Assisted Treatment for the course of the pregnancy, in the form of methadone or buprenorphine. The reason for this is that stopping opioid use during pregnancy can result in preterm labor, fetal distress, and fetal demise. Furthermore, it is recommended that mothers of infants on MAT be encouraged to breastfeed.

Breastfeeding and substance use:

DCF shall follow the recommendations of the pediatrician regarding breastfeeding. The American Association of Pediatrics (AAP) encourages breastfeeding whenever possible, because of the many health benefits and promotion of attachment and bonding between mother and infant. In situations where substance use is involved, a thorough, individualized assessment that weighs the benefits of breast-feeding is considered by the pediatrician in making recommendations with the mother and infant.

Considerations include:

- current substance use and substance use treatment
- medical and psychiatric status
- medication needs, including Medication Assisted Treatment
- infant health status
- support system

In general, AAP encourages breastfeeding in these circumstances related to substance use:

- engaged in substance use treatment
- abstinence from substance misuse for 90 days prior to delivery and ability to maintain recovery efforts
- engaged in prenatal care

Mothers who are on methadone and buprenorphine MAT are generally encouraged to breast-feed. Social Workers should consult with the child's pediatrician and other members of the treatment team.

CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA) AND INFANTS BORN SUBSTANCE EXPOSED

CAPTA is federal legislation addressing child abuse and neglect, originally enacted in 1974 and reauthorized in 2010. Among the elements of CAPTA, the states are required to develop policies and procedures for the notification to child protective services of the birth of an infant affected by prenatal drug or alcohol exposure, ensure the development of a Plan of Safe Care (POSC) for infants who are prenatally exposed, and ensure a referral for those infants to screening and early intervention services.

The Comprehensive Addiction and Treatment Act (CARA) of 2016 aims to address the problem of opioid addiction in the United States. Included in the CARA requirements are; the establishment of a POSC to address the needs of both the infant and parent(s), increasing States' compliance with CAPTA and amending the legislation to include the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.

DCF is federally charged with developing policies and procedures that comply with the CAPTA/CARA expectations. While these procedures include a requirement that health care providers involved in the delivery or care of such infants notify DCF, the legislation specifies that this notification shall not be construed as a mandated report. Plans of Safe Care should include the provision of services and supports that address the infant's and their caregivers physical, social-emotional health, and safety needs and is developed in an interdisciplinary and family focused manner. It is based on the results of a comprehensive, multidisciplinary assessment that is coordinated across disciplines addressing the treatment needs of the infant and family or caregiver. Specifically, Plans of Safe Care should address: health, substance use and mental health, parenting and family support, and infant health and development.

DRUG ENDANGERED CHILDREN

The National Alliance for Drug Endangered Children and the CT Alliance for Drug Endangered Children defines drug endangered children as children who are at risk of suffering physical or emotional harm as a result of illegal drug use, possession, manufacturing, cultivation, or distribution. They may also be children whose caregiver's substance use/misuse interferes with their ability to provide a safe and nurturing environment.

The CT Alliance for Drug Endangered Children approach for addressing the needs of children in dangerous drug environments focuses on the formation of community-based partnerships that encourage agency personnel from across multiple disciplines to coordinate their mutual interests, resources, and responsibilities.

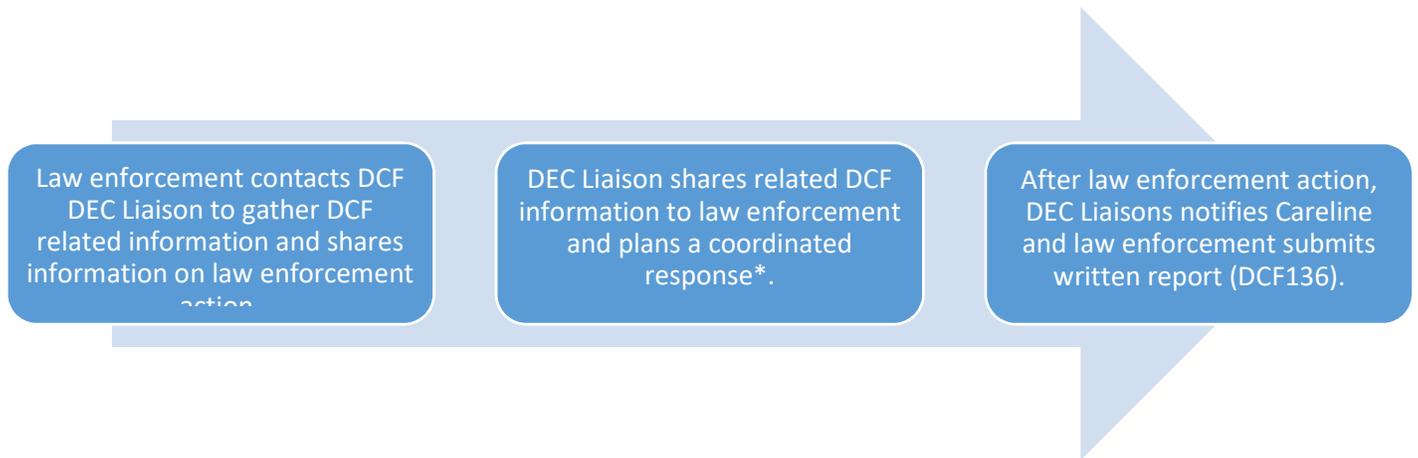
Members of a Local DEC Team / Alliance

DEC members are those engaged in all aspects of substance use and child well-being including: law enforcement, child protection, parole, probation, courts, social services, medical professionals, treatment providers, schools, public health workers, prevention specialists, crime victim advocates, and other community leaders working together to craft policies and strategies aimed at rescuing and protecting children endangered by substance use/misuse.

Benefits

- Information sharing prior to a law enforcement action provides a better representation of the child(ren)'s situation.
- Early notification of the law enforcement action to DCF allows DCF DEC Liaison to assess and prepare a response.
- Collaboration improves the working relationship between law enforcement and its DCF DEC Liaisons.

DEC Notification Process



*Social Workers will only enter the scene after law enforcement has cleared the site.

Confidentiality

All information gathered prior to the law enforcement action will be maintained confidential and will not be shared outside of the designated DCF staff or documented until the Careline report is made.

DOCUMENTATION

The Social Worker shall document in the case record:

- Indicators of substance use impacting the family,
- Screenings completed and results,
- Evaluation results or the client's refusal to cooperate,
- Follow ups on recommendations or reasons recommendations have been, changed or declined by DCF or the client,
- Monitoring of progress, and
- Current impact of substance use to the family.

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http://www.ct.gov/dcf/lib/dcf/policy/pdf/34-2_Investigations.pdf
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http://www.ct.gov/dcf/lib/dcf/policy/pdf/Family_Assessment_Response_Practice_Guide_final_%282%29.pdf
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http://www.ct.gov/dcf/lib/dcf/policy/pdf/RRG_Practice_Guide.pdf
- CT Department of Children and Families. Project SAFE 2016 Report Card.
- CT Department of Children and Families. Substance Abuse Disorder Screening and Testing Policy
<http://www.ct.gov/dcf/lib/dcf/policy/pdf/35450300.pdf>
- CT Department of Children and Families. Substance Use Managed Service System Practice Guide, 2017.
<http://bhm.dcf.ct.gov/sites/BHM/SU/SitePages/SAMSS.aspx>
- CT General Statutes Sec. 17a-688. Record Keeping and Confidentiality
http://search.cga.state.ct.us/dtsearch_pub_statutes.html
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<https://ok.gov/odmhsas/documents/Children%20Living%20with%20Substance%20Dependent%20or%20Abusing%20Parents%202002-2007.pdf>

APPENDICES

Appendix A: Definitions

Addiction – a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors. (National Institute on Drug abuse)

Adolescent Community Reinforcement Approach-Assertive Continuing Care (ACRA-ACC) is an evidence-based adolescent substance use treatment model which is delivered in a clinic, community, or home based setting to treat the unique needs of the substance using adolescent.

Binge alcohol use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

Case Management and Recovery Support Programs are voluntary case management and recovery support programs used to engage and maintain parents/caregivers in appropriate substance use treatment services and support them in developing or increasing recovery supports. Programs include Recovery Specialist Voluntary Program (RSVP) when children have been removed from the home and Recovery Case Management (RCM) when the children remain home with their parents/caregivers.

Family Based Recovery (FBR) is an intensive, in-home clinical treatment program for families with infants or toddlers (birth to 36 months) who are at risk for abuse and/or neglect, poor developmental outcomes, and removal from their home due to parental substance use.

Multidimensional Family Therapy (MDFT) is an intensive, in-home model that is a family-centered, comprehensive treatment program for adolescents and young adults with substance use and related behavioral and emotional problems.

Multi-Systemic Therapy (MST) is an evidence-based in-home treatment for youth with complex clinical, substance using, social, and educational problems. MST emphasizes behavioral change in the natural environment and uses interventions to promote the parent’s capacity to monitor and intervene positively with each youth.

Multi-Systemic Therapy-Building Stronger Families (MST-BSF), which is based upon an evidence-based treatment model, provides intensive in-home family and community based treatment to families that are active cases with the Department of Children and Families (DCF) due to the physical abuse and/or neglect of a child in the family **and** due to the abuse of or dependence upon marijuana, cocaine, heroin, alcohol, or other substances by at least one caregiver in the family.

Project SAFE is a program designed to provide priority access to evaluation, testing and treatment for adult parents and caregivers involved in child welfare cases who have been impacted by substance use.

Recovery - the ways in which a person with an addiction experiences and manages his or her disorder in the process of reclaiming life in the community.

Recovery Capital refers to the combination of external and internal resources that a person can bring to bear on the initiation and maintenance of recovery from a long-term disorder. Examples include:

- Substance use treatment
- Mental health treatment
- Advocacy
- Basic needs
- Childcare
- Education/vocational training
- Employment
- Entitlements
- Housing
- Self-help groups/sober supports
- Transportation
- Parenting resources

Relapse is the return to alcohol or drug use after an attempt to stop.

Reliable screening tool has the ability to produce consistent results.

SAFE-Family Recovery (SAFE-FR) – provides screening for co-occurring disorders, treatment engagement interventions, and recovery support services to DCF-involved adult caregivers with substance use problems.

S2BI/CRAFFT (Screening to Brief Intervention/Car, Relax, Alone, Forget, Friends, Trouble) is specifically designed for adolescents. The S2BI asks 3 questions regarding the frequency of use of alcohol, marijuana, and tobacco. The CRAFFT has six yes-or-no questions used during feedback to explore the substance use and elicit change.

Screening - an ongoing process to identify substance use disorder indicators that warrant further assessment for intervention or treatment needs.

Screening and Brief Intervention and Referral to Treatment (SBIRT)- an evidence-based public health approach to identify substance use problems and use motivational interviewing techniques to promote healthy behaviors and increase motivation for treatment when needed.

Substance abuse is when a person consumes alcohol or drugs regularly, despite the fact that it causes issues in their life.

Substance dependency or addiction is a chronic, relapsing brain disease characterized by compulsive drug seeking and use, despite harmful consequences. Symptoms include:

- developing a tolerance for the drug,
- going through withdrawal symptoms without it, and
- struggling to cut back on it.

Substance Exposed Infants (SEI) refers to infants exposed to alcohol and other drugs ingested by the mother while in utero, whether or not the exposure is detected or known.

Substance misuse is the harmful use of substances for non-medical purposes.

Substance use is when someone consumes alcohol or drugs.

Substance Use Disorder (SUD) - a treatable, long-term health condition in which the misuse of substances (alcohol and/or both legal and/or illegal drugs) results in significant functional impairment or distress.

Substance Use Disorder (SUD) evaluation - a formal structured interview with an individual by a licensed or certified professional trained in the assessment and treatment of substance use-related disorders to assess the severity of substance use; the level of care required; and the relationship of the substance use to social, family, interpersonal, occupational, legal, financial, emotional, physical and spiritual functioning.

Substance Use Disorder (SUD) testing - a biological test for the presence of psycho-active substances in the body and may include a:

- urine drug screen (UDS);
- hair test; or
- breathalyzer.

Substance Use Disorder (SUD) treatment - the engagement of an individual in a particular plan of action for intervention and services, the aim of which is to arrest, reverse and ameliorate substance use problems.

UNCOPE (Used, Neglected, Cut down, Objected, Preoccupied, Emotional discomfort) consists of six questions for adults regarding the impact of substance use. Two or more questions answered in the affirmative indicate abuse or dependence.

Valid screening tool has the ability to produce consistent true and accurate results.

Appendix B: FASD Resources and Links

Fetal Alcohol Spectrum disorders and the Brain

<http://come-over.to/FAS/brochures/FASbrainBrochure.pdf>

What is Fetal Alcohol Syndrome Disorder and Fetal Alcohol Syndrome?

<http://come-over.to/FAS/brochures/WhatIsFASD.pdf>

Challenges faced by people with Fetal Alcohol Related Conditions

<http://come-over.to/FAS/brochures/AintMisbehavinBroch.pdf>

Prenatal Substance Abuse: Short- and Long-term Effects on the Exposed Fetus

<http://pediatrics.aappublications.org/content/early/2013/02/20/peds.2012-3931>

Short and long term effects of prenatal substance abuse

<https://www.mofas.org/wp-content/uploads/2015/01/Pernal-Substance-Abuse-Short-and-Long-term-Effects-on-the-Exposed-Fetus2.pdf>

Article – “A comparison of the prevalence of prenatal alcohol exposure obtained via maternal self-report vs. meconium testing: a systematic literature review and meta-analysis.”

<https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-14-127>

Strategies for Infants and Toddlers with a Fetal Alcohol Spectrum Disorders (FASD)

<http://health.hawaii.gov/fasd/files/2013/09/Strategies-for-Infants-and-Toddlers-Handout-Rev-8-11.pdf>

Strategies Parents Find Helpful In Raising Their Children Living With FASD©

<http://come-over.to/FAS/PDF/TorontoStrategiesParents.pdf>

National Institute of Health – National institute on Alcohol Abuse and Alcoholism



NIAAA_Spectrum_Newsletter_Spring_2018.pdf



FASD Informational Resources (2).pdf

Appendix C: Short-Term Effects of Prenatal Exposure by Substance

SHORT-TERM EFFECTS OF PRENATAL EXPOSURE BY SUBSTANCE

| | Nicotine | Alcohol | Marijuana | Opiates | Cocaine | Methamphetamine |
|---------------|----------|---------|-----------|---------|---------|-----------------|
| Fetal Growth | + | + | - | + | + | + |
| Anomalies | ○ | + | - | - | - | - |
| Withdrawal | - | - | - | + | - | ? |
| Neurobehavior | + | + | + | + | + | + |

LONG-TERM EFFECTS OF PRENATAL EXPOSURE BY SUBSTANCE

| | | | | | | |
|-------------|---|---|---|---|---|---|
| Growth | ○ | + | - | - | ○ | ? |
| Behavior | + | + | + | + | + | ? |
| Cognition | + | + | + | ○ | + | ? |
| Language | + | + | - | ? | + | ? |
| Achievement | + | + | + | ? | ○ | ? |

Adapted from: Behnke, M., & Smith, V. C. (2013). Prenatal Substance Abuse: Long and short term effects on the exposed fetus. *Pediatrics*

 Strong Effect
  Effect
  No Effect
  No Consensus
  Not Enough Data

Appendix D: UNCOPE

The UNCOPE

U – Have you continued to use alcohol or drugs longer than you intended?

N – Have you ever neglected some of your usual responsibilities because of alcohol or drug use?

C – Have you ever wanted to cut down or stop using alcohol or drugs but couldn't?

O – Has your family, a friend or anyone else ever told you they objected to your alcohol or drug use?

P – Have you ever found yourself preoccupied with wanting to use alcohol or drugs?

E – Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger or boredom?

Scoring: Two or more positive responses indicate possible abuse or dependence and need for further assessment

Hoffman, N.G. *UNCOPE*. Smithfield, RI: Evince Clinical Assessments. Retrieved July 28, 2006 from http://www.evinceassessment.com/UNCOPE_for_web.pdf

Appendix E: S2BI/CRAFFT

Link to the S2BI: https://www.mcpap.com/pdf/S2BI_postcard.pdf

Link to the CRAFFT tool: https://www.integration.samhsa.gov/clinical-practice/sbirt/CRAFFT_Screening_interview.pdf

Appendix F: SAFE-FR Referral Form

 SBIRT

 MDRR

 RMC

| Referral Date: | DCF Social Worker Name/E-Mail: <input type="checkbox"/> Intake <input type="checkbox"/> Ongoing <input type="checkbox"/> FASU <input type="checkbox"/> SIU @ct.gov <input type="checkbox"/> Other | DCF SWS Name/E-Mail: @ct.gov | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|-------------------|-----|---------------------------|--|--|--------------------------|--|--|--------------------------|--|--|--------------------------|--|--|--------------------------|--|--|--------------------------|--|--|--------------------------|
| Client Last Name: | Client First Name: | Link ID: | | | | | | | | | | | | | | | | | | | | | |
| Client Address: | Client Race (as noted in LINK): | Client Ethnicity (as noted in LINK): | | | | | | | | | | | | | | | | | | | | | |
| DCF Office: | Are children at risk of imminent removal? <input type="checkbox"/> No | Language: | | | | | | | | | | | | | | | | | | | | | |
| Reason for CPS Involvement: | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <thead> <tr> <th>Names of Children</th> <th>Age</th> <th>Check if household member</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td><input type="checkbox"/></td></tr> </tbody> </table> | | | Names of Children | Age | Check if household member | | | <input type="checkbox"/> |
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| | | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| | | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| | | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| What substances does the client admit to using/misusing in the last twelve months? | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Heroin | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Amphetamine | <input type="checkbox"/> Opioids | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Nicotine/Tobacco/E-Cigs | <input type="checkbox"/> Other Stimulants | <input type="checkbox"/> Other Prescription Drugs | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Benzodiazepine | <input type="checkbox"/> PCP | <input type="checkbox"/> Other Anti-depressants | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Inhalants | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | | | | | | | | | | | | | | | | | | | | | |
| What substances are suspected the client has misused in the last twelve months? | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Heroin | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Amphetamine | <input type="checkbox"/> Opioids | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Nicotine/Tobacco/E-Cigs | <input type="checkbox"/> Other Stimulants | <input type="checkbox"/> Other Prescription Drugs | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Benzodiazepine | <input type="checkbox"/> PCP | <input type="checkbox"/> Other Anti-depressants | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Inhalants | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | | | | | | | | | | | | | | | | | | | | | |
| Substance Use Indicators: (please check all that apply) | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Physical</p> <input type="checkbox"/> small blood spots or bruises on skin <input type="checkbox"/> skin lesions <input type="checkbox"/> black finger tips <input type="checkbox"/> bloodshot or watery eyes <input type="checkbox"/> runny or irritated nose, irritating cough, sore throat <input type="checkbox"/> speech pattern changes, slurred speech, faster speech, slower speech <input type="checkbox"/> tremors or jitters <input type="checkbox"/> constant scratching of skin, "picking" at skin and hair on arms, etc. <input type="checkbox"/> poor coordination, tripping, spilling, bumping into things and other people <input type="checkbox"/> large or small (dilated) pupils <input type="checkbox"/> a faint skin odor- either sweet or acrid <input type="checkbox"/> easily fatigued or constantly fatigued <input type="checkbox"/> hyper-excitability <input type="checkbox"/> sudden weight loss or weight gain <input type="checkbox"/> changes in appetite or sleep patterns <input type="checkbox"/> Other | <p>Behavioral</p> <input type="checkbox"/> Drop in attendance and performance at work or school <input type="checkbox"/> Unexplained financial problems; borrowing or stealing <input type="checkbox"/> Engaging in secretive or suspicious behaviors <input type="checkbox"/> Forgetfulness, amnesia <input type="checkbox"/> Sudden change in friends, favorite hangouts, and hobbies <input type="checkbox"/> Frequently getting into trouble (fights, accidents, illegal activities) <input type="checkbox"/> Other | | | | | | | | | | | | | | | | | | | | | | |
| <p>Psychological</p> <input type="checkbox"/> Unexplained change in personality or attitude <input type="checkbox"/> Sudden mood swings, irritability, or angry outbursts <input type="checkbox"/> Periods of unusual hyperactivity, agitation, or giddiness <input type="checkbox"/> Lack of motivation; appears lethargic or "spaced out" <input type="checkbox"/> Appears fearful, anxious, or paranoid | <p>Environmental</p> <input type="checkbox"/> Distinct and pungent odor <input type="checkbox"/> Possession of illicit drugs or excessive alcohol <input type="checkbox"/> Possession of hypodermic needles, balloons, aluminum foil, wrappers, mirrors or flat metal, short straws, glass pipes, smoking pipes, capsules, vials, butane torch, or folded paper envelopes | | | | | | | | | | | | | | | | | | | | | | |

| | |
|--|--------------------------------|
| <input type="checkbox"/> Mental health diagnosis/treatment history <input type="checkbox"/> Other | <input type="checkbox"/> Other |
|--|--------------------------------|

Please describe in detail all indicators identified (what, when, where):

Parental Substance Use Behaviors That May Impact Children:

| |
|--|
| <input type="checkbox"/> Access to alcohol, drugs, or drug paraphernalia within the home (pills, needles, etc.) |
| <input type="checkbox"/> Exposure to caretakers that are under the influence |
| <input type="checkbox"/> Exposure to violence and/or trauma (verbal, physical, sexual) |
| <input type="checkbox"/> Exposure to strangers or inappropriate people who may be potentially dangerous (violent, intimidating, threatening) |
| <input type="checkbox"/> Exposure to alcohol and other substances during pregnancy |
| <input type="checkbox"/> Child spends a lot of time outside of the home under the care of others |
| <input type="checkbox"/> Lack of basic needs (housing, food, clothes) due to spending on drugs or alcohol |
| <input type="checkbox"/> Lack of supervision due to parental absence or impairment |
| <input type="checkbox"/> Missed medical/dental/behavioral health/educational appointments or appointments not sought out |
| <input type="checkbox"/> Unrealistic expectations of a child's abilities (to take care of self, others, or the household while the caregiver is under the influence) |
| <input type="checkbox"/> No clear boundaries between family roles with the child assuming a parental role |
| <input type="checkbox"/> Lack of boundaries and routines |
| <input type="checkbox"/> Unsafe sleeping conditions |
| <input type="checkbox"/> Isolation from family and friends due to stigma, secrecy, embarrassment, etc. |
| <input type="checkbox"/> Other |

Please describe in detail the impact to children identified (what, when, where, how):

| | | | | | |
|--|---|--|---|------------------------------|-----------------------------|
| Does the client have any recovery capital deficits or barriers to treatment? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Health Insurance | <input type="checkbox"/> High Co-Pays/Deductible | <input type="checkbox"/> Lack of social supports/recreation | | |
| <input type="checkbox"/> Stable Housing | <input type="checkbox"/> Child Care | <input type="checkbox"/> Work Schedule | <input type="checkbox"/> Other: | | |

Client Strengths:

| | | |
|---|------------------------------|-----------------------------|
| Do you have a preference for a particular Substance Use Treatment Provider? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|------------------------------|-----------------------------|

If so, please name:

Appendix G: Pros and Cons of Different Specimen Sources Not Available Through SAFE Family Recovery

| Pros and Cons of Different Specimen Sources NOT Available through SAFE Family Recovery | | | |
|--|------------------------|--|--|
| Specimen | Window of Detection | Pros | Cons |
| Oral Fluid | Up to 48 hours | <ul style="list-style-type: none"> a) Collecting the oral fluid specimen can be observed b) Minimal risk of tampering c) Noninvasive d) Can be collected easily in virtually any environment e) Can be used to detect alcohol use f) Can be used to detect recent drug use | <ul style="list-style-type: none"> a) Drugs and drug metabolites do not remain in saliva as long as in urine b) Less efficient than other testing methods for detecting marijuana use c) pH changes can alter specimen d) Moderate to high cost |
| Sweat | FDA cleared for 7 days | <ul style="list-style-type: none"> a) Relatively noninvasive b) Sweat patch typically worn for 7 days c) Quick application and removal of sweat patch d) Patch seal tampering minimized e) Longer window of drug detection than urine and blood f) Relatively resistant to specimen adulteration g) No specimen substitution possible | <ul style="list-style-type: none"> a) Only a few laboratories offer sweat patch testing b) Those with sensitive skin may react to the patch c) Possible time-dependent drug loss from the patch d) Possible external drug contamination from improper skin cleansing prior to application e) For marijuana, current use by a naïve user may not be detected f) For marijuana, positive sweat results are possible in current abstinent, but previously chronic high dose, users g) Sweat production dependent h) Moderate to high cost |
| Breath | Up to 12–24 hours | <ol style="list-style-type: none"> 1. Minimal cost 2. Reliable detector of presence and amount of alcohol 3. Noninvasive | <ol style="list-style-type: none"> 1. Very limited detection window for alcohol 2. Can only be used to detect presence of alcohol |
| Blood | Up to 12-24 hours | <ol style="list-style-type: none"> 1. Can be used to detect presence of drugs and alcohol 2. Test produces accurate results | <ol style="list-style-type: none"> 1. Invasive 2. Moderate to high cost |
| Meconium | Up to 2-3 days | <ol style="list-style-type: none"> 1. Can be used to detect long-term use 2. Can be used to detect presence of drugs and alcohol 3. Easy to collect and highly reliable | <ol style="list-style-type: none"> 1. Short detection window after infant's birth |

(CSAT, 2010)

SAFE Family Recovery Overview of Urine Toxicology Process

Effective January 1, 2019 SAFE Family Recovery is implementing urine toxicology as part of the Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol to determine the recent use/misuse of substances. SBIRT uses quick-read instant cups to obtain urine toxicology results within five minutes. Results disputed by the client are not sent to a lab for GC/MS confirmation.

Urine toxicology is performed as part of the SBIRT service. Single and random urine drug screens are not available through SAFE Family Recovery.

See the SAFE-FR SBIRT Practice Guide for additional details about urine screening.

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Frequently Asked Questions

1. *What substances are being tested for using the Instant Drug Screens?*

13 total substances are being test as part of the instant drug screen. A dip stick test is used for PCP. The substances being tested are:

Amphetamines, Barbiturates, Benzodiazepines, Buprenorphine, Cocaine, Opiates, Oxycodone, PCP, THC (Marijuana), MDMA, Methamphetamine, Methadone, and Morphine

2. *How will SAFE Family Recovery providers report the results of urine drug screens to DCF?*

Urine toxicology results are part of the SBIRT report being sent to DCF social workers within 24 hours of the completed SBIRT appointment.

3. *What if the instant drug test is positive for one or more substances and the client denies use?*

Positive results on the Instant Drug Test are considered presumptive. If the client denies use, the test may be repeated, or a referral can be made to a treatment provider for a full substance use evaluation which includes toxicology. SBIRT will not submit urine samples to a lab for confirmatory testing.

SAFE Family Recovery

Hair Toxicology Process Overview

Hair testing is utilized to determine a three-month history of substance use/ misuse prior to the hair test. Hair testing requires special prior authorization from the DCF RRG. Careful collection of samples by authorized treatment providers following collection guidelines is necessary to ensure effective use of hair testing. Positive hair test results can be further analyzed to determine if the client's use/misuse of substances occurred within 30/60/90 days prior to collection.

Frequently Asked Questions

1. What categories of drugs does hair testing test for?

There are five distinct groups: Cocaine, Opiates, PCP, Amphetamines, and Marijuana. Ecstasy will show up under the Amphetamine category as MDMA.

2. What drugs are tested for in the Opiate category?

In the Opiate category are Codeine, Morphine, and Heroin (6-MAM). Other opioids reported are Oxycodone (Oxycontin), Oxymorphone, Hydrocodone (Norco, Vicodin), and Hydromorphone.

3. Does the hair test detect Oxycontin use?

Yes, Oxycontin can be tested for through hair testing.

4. What types of psychiatric medication is tested for?

The hair test does not test for psychiatric medications.

5. What categories would psychiatric medication show up under?

None. The hair test does not test for psychiatric medications.

6. Is there a way to correlate the amount of the drug specified in the hair test results with how much drug the person actually used?

Yes, to a point. Each ingestion of the drug is trapped and accumulates in the hair as it grows. Therefore, the higher the concentration of the drug found translates into total dose ingestion. Since the cutoff by definition is a concentration supported by clinical studies which clearly differentiates a user (someone to ingest multi times) from someone who is exposed with a large margin of conservatism, concentrations in excess of the cutoff represent multi-use and can be qualitatively interpreted to amount of drug ingested.

7. Can someone falsify the results of a hair test by using a special kind of shampoo or by ingesting something bought from a "head shop"?

No. When an individual uses a substance being tested for, it is metabolized in the liver and the internal part of the hair is tested. Shampoo cannot wash out the drug that is ingested and metabolized internally by the body.

8. Can chemically treated hair (dyes or permanent procedures) affect the test results?

No, drug residues remain permanently entrapped in the hair.

9. If someone is taking Methadone daily and a hair test is positive for opiates, would this be due to the methadone or could the individual be using heroin, or prescription medication such as Percocet, Oxycontin, Vicodin etc.?

The hair test does not test for Methadone, therefore, if someone is positive for opiates, it is from Codeine, Morphine, Heroin, Oxycodone, Hydrocodone, or Hydromorphone use.

10. If a person is using over the counter cold medicines, can this show up in a hair test as a positive test result?

No. The hair is tested for the metabolite of the drug, which is what makes that drug what it is. Cold medicine would not test positive for an illicit drug.

11. What does it mean when the hair test results state positive for Benzoyllecgonine under the Cocaine category?

Benzoyllecgonine (BE) is the primary metabolite of Cocaine produced by human metabolism via the passage of the drug in the blood stream through the liver. Its presence at a concentration level of 5% of the Cocaine concentration is required to call a test positive, absent the presence of other cocaine metabolites.

12. Does hair color affect the results of the test?

There are reports of darker hair retaining more concentration of a drug ingested and that lighter colored hair retains the least amounts. Psychemedics separates melanin, the color component of hair from the sample; therefore, the hair that is tested is colorless. Blonde hair weighs less than darker colored hair; therefore, more hair needs to be collected when taking the actual sample from the individual in order to have a sufficient quantity to be tested.

13. Are there certain types of hair textures (such as curly hair) that a cross-sectional analysis cannot be done on?

Yes, in order to perform a cross-sectional test, the roots of the hair need to be lined up. This cannot be done with extremely curly hair.

14. Does hair testing detect alcohol consumption?

Hair tests do not test for alcohol. In some instances, in the case of cocaine ingestion concurrent with use of alcohol results in the presence of a unique marker of ingestion called Cocaethylene (CE).

15. Are there any prescription medications that can mimic THC in marijuana and therefore give a false positive hair test result for marijuana use?

Yes. The generic drug Dronabinol or name brand Marinol, is used generally to treat patients who have HIV or AIDS to help increase appetite, aid with nausea, and to help prevent weight loss.

16. What is the probability of the lab mixing up hair test samples?

Due to strict chain of custody guidelines, the probability of mixing up client hair samples is near zero.

17. Is it true one “strand” of hair is all that is necessary for the individual to give when taking a hair test?

No. The amount of hair that is needed to be tested is approximately half of the width of a pencil eraser.

18. If an individual is in a room or a car where others are smoking marijuana, can this cause that individual to have a positive hair test result for marijuana?

No. The amount of time spent in enclosed quarters, and the amount of marijuana smoked by others in order for this to happen would need to be so extreme that it is nearly impossible.

19. How does one read the multi-sectional hair test results?

The results will show three sections:

1. One section will read 0-1.3 centimeters which indicates the most recent 30-day period and is the section of the hair that is closest to the scalp.
2. The next section will read 1.3-2.6 centimeters and this is the result of the 30-60 day previous time period.
3. The next section will read 2.6-3.9 centimeters, which is indicative of the previous 60-90 day time period.

20. Can DCF Social Workers contact Psychomedics directly with questions regarding an individual's hair test result?

Due to contract guidelines and confidentiality constraints, Psychomedics cannot communicate directly on test results with DCF staff. Social Workers must communicate with the provider who performed the hair test in order to obtain information about an individual's test results.

For any additional questions, please contact the SAFE Family Recovery Supervisor serving your region.

Language Matters

Language is powerful – especially when talking about substance use.

Stigmatizing Language perpetuates negative perceptions.

“ Person first” language focuses on the person, not the disorder.

When Discussing Addictions...

| Avoid These Terms: | Use These Instead: |
|--|---|
| Addict, user, drug abuser, junkie | Person/Patient with opioid use disorder or opioid addiction |
| Addicted baby | Baby born with neonatal abstinence syndrome |
| Opioid abuse or opioid dependence | Opioid use disorder |
| Problem | Disease |
| Habit | Drug addiction |
| Clean or dirty urine test | Negative or positive urine drug test |
| Opioid substitution or replacement therapy | Opioid agonist treatment Medication for Addiction Treatment |
| Relapse | Return to use/ Setback |
| Treatment failure | Treatment attempt |
| Being clean | Being in remission or recovery |

Appendix J: DCF Funded Substance Use Service Array

6/30/2018

| Region | Area Office | ACRA-ACC | MST | MDFT | MST-TAY | MSF-PSB | SAFE-FR | CM & RSP | MST-BSF | FBR |
|----------|-------------|----------|-----|------|---------|---------|---------|----------|---------|-----|
| Region 1 | Bridgeport | X | X | X | X | X | X | X | | X |
| | Norwalk | X | | X | | X | X | X | | X |
| Region 2 | New Haven | X | X | X | X | X | X | | X | X |
| | Milford | X | X | X | X | X | X | | | X |
| Region 3 | Middletown | X | | X | X | X | X | X | | X |
| | Norwich | X | X | X | X | X | X | X | X | X |
| | Willimantic | X | X | X | | X | X | X | | X |
| Region 4 | Hartford | X | X | X | X | X | X | X | X | X |
| | Manchester | X | X | X | X | X | X | X | X | X |
| Region 5 | Waterbury | X | X | X | X | X | X | | X | X |
| | Danbury | X | | X | | X | X | | | X |
| | Torrington | X | | X | | X | X | | | X |
| Region 6 | New Britain | X | X | X | X | X | X | X | X | X |
| | Meriden | X | | X | X | X | X | X | X | X |

Acronyms:

MST=Multi-Systemic Therapy

MDFT=Multidimensional Family Therapy

FBR-Family Based Recovery

MST-TAY=Multi-Systemic Therapy-Transition Age Youth

MST-FIT=Multi-Systemic Therapy-Family Integrated Treatment

MST-PSB=Multi-Systemic Therapy-Problem Sexual Behavior

Appendix K: Marijuana Legislation Links

<https://www.cga.ct.gov/2018/rpt/pdf/2018-R-0037.pdf>

Current State Statutes:

https://www.cga.ct.gov/current/pub/chap_420f.htm

DCP Regulations Concerning Medical Marijuana:

<https://eregulations.ct.gov/eRegsPortal/Browse/RCSA/%7BB0A2E155-0100-CC28-8260-12834A29C606%7D>

DCP Regulations Classifying Marijuana as a Schedule II Drug:

<https://eregulations.ct.gov/eRegsPortal/Browse/RCSA?id=Title%2021a%7C21a-243%7C21a-243-8%7C21a-243-8>

Public Act 12-55 (original law):

<https://www.cga.ct.gov/2012/ACT/Pa/pdf/2012PA-00055-R00HB-05389-PA.pdf>

Summary of Public Act 12-55 (prepared by the Office of Legislative Research);

<https://www.cga.ct.gov/2012/SUM/2012SUM00055-R02HB-05389-SUM.htm>

Department of Consumer Protection program information:

<http://www.portal.ct.gov/DCP/Medical-Marijuana-Program/Medical-Marijuana-Program>