Introduction
Substance abuse accounts for a significant number of referrals to supervised visitation programs. Substance abuse may involve alcohol abuse, abuse of prescription medications and/or street drugs. Parental substance abuse is one of the primary reasons for children being removed from the home by child welfare workers. Children who witness parental substance abuse are more likely to experience physical, sexual, and emotional abuse and neglect than their peers in non-substance abusing homes. There are short- and long-term consequences of children’s exposure to parental substance abuse; these include educational, emotional, medical, and behavioral consequences.

Overview
Visit monitors will encounter parents in varying stages of substance abuse and recovery. This chapter describes the reaction of substance-abusing parents to seeing their children in supervised visitation settings. These reactions may include anger, depression, hostility, denial, and/or aggression. Likewise, this chapter describes the broad spectrum of reactions that children may experience when visiting a parent with substance abuse problems. These reactions may include anxiety, fear, and shame. Finally, the chapter presents specific techniques for monitors to use in cases with a parental substance abuse history in order to provide a safe setting for visits and to reduce the risk to children or other program participants.

Objectives
Upon completion of this chapter, a visit monitor will be able to:

1. Describe the stages of substance abuse;
2. Describe the varying effects of parental substance abuse on children;
3. Identify the most commonly abused drugs and symptoms of use associated with each;
4. Discuss how identified behaviors of substance abusing parents may affect supervised visitation staff;
5. Differentiate symptoms of substance abuse from other conditions;
6. Discuss how identified behaviors of substance abusing parents may affect children during scheduled supervised visitation services;
7. Identify effective techniques to employ when supervising cases involving parental substance abuse;

8. Identify risk factors during visits; and

9. Discuss the interface between domestic violence and substance abuse issues.

Snapshots

- Substance abuse is one of the primary causes for the increase in child maltreatment reports.
- Substance abuse is a factor in 75% of all out-of-home placements of children.
- Children of substance-abusing parents stay in out-of-home placements longer than children of non-substance abusing parents.
- Eighty-five percent of states name substance abuse second only to poverty as the greatest challenge to families reported to child protective services.
- Research shows that almost 10% of children under 12 years of age in the United States are living with a family member who has a substance abuse problem.
- Methamphetamine use is resulting in the dramatic escalation of severe child abuse and child abuse homicides.
- Thirty to thirty-five percent of seized methamphetamine labs are in homes where children reside.

Commonly Abused Drugs and Their Effects

Individuals with histories of substance use may have abused legal and/or street drugs. Certain drugs move in and out of popularity for abuse; thus it is important that visit monitors keep up-to-date on the types of drug abuse most commonly found in their communities. For example, crack cocaine use has diminished in many communities in the past ten years, while the use and manufacture of methamphetamine has dramatically increased. Although each drug has its own properties, it is not always possible to predict what a person’s reaction will be to any particular drug. This is because it is common for substance abusers to mix alcohol and drugs or to use multiple drugs at the same time. However, visit monitors should not assume that a parent’s behavior is due solely to substance use. Some medical conditions may mimic substance use.

Drugs are classified into Schedules. Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (non-refillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in six months, and may be ordered orally. Most Schedule V drugs are available over the counter.

Taking drugs by injection can increase the risk of infection through needle contamination with staphylo-
cocci, HIV, hepatitis, and other organisms. Moreover, certain drugs are associated with sexual assaults: these include flunitrazepam (also called Rohypnol and roofies); and GHB (also called G, or liquid ecstasy).

Commonly abused drugs and their associated behaviors are summarized below:

- Cannabinoids (hashish and marijuana): euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination.
- Depressants (barbiturates, flunitrazepam): feeling of well being, lowered inhibitions, slowed breathing, poor concentration, slurred speech.
- Dissociative Anesthetics (ketamine, PCP): impaired motor function, delirium, and memory loss.
- Hallucinogens (LSD, mescaline): altered states of perception, weakness, and tremors.
- Opioids and Morphine Derivatives (codeine, heroin, morphine, opium): euphoria, drowsiness, nausea, and staggering gait.
- Stimulants (amphetamine, cocaine, methamphetamine): energy, weight loss, nervousness, feelings of exhilaration.
- Other Compounds (anabolic steroids, inhalants): hostility and aggression, loss of inhibition, nausea or vomiting, slurred speech.

Additional information on this topic is included in the Administrative Supplement.

Continuum of Substance Abuse and Its Risks for Children

Substance abuse, or chemical dependency, involves a progression from casual use to abuse to dependency. As an individual moves through the progression, both the physiological and psychological consequences to the abuser escalate, as does the risk of impact on children.

Table 7.1 presents an overview of this progression.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Risks for Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Casual Use</strong></td>
<td>Even casual use during pregnancy can harm fetus. Drowsiness or other effects when using may cause inattentiveness to children.</td>
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<tr>
<td>To experience effects, reduce anxiety, stress, or to socialize</td>
<td></td>
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<tr>
<td><strong>Increased Frequency/Abuse</strong></td>
<td>• Children left in unsafe care</td>
</tr>
<tr>
<td>Characterized by routine of sporadically heavy or binge use. Tolerance increases; changes in behavior may be apparent as well as changes in user's emotional state. Denial, shame &amp; guilt are common.</td>
<td>• Driving with children while under the influence</td>
</tr>
<tr>
<td>Results in:</td>
<td>• Neglect of child's needs for regular meals, clothing, hygiene</td>
</tr>
<tr>
<td>• Failure to fulfill work, school, home responsibilities</td>
<td>• Unsupervised children in home while parent is using drugs/alcohol or recovering from use</td>
</tr>
<tr>
<td>• Substance-abuse related legal problems</td>
<td>• Inconsistent discipline/ emotional availability or lability</td>
</tr>
<tr>
<td>• Recurrent social or interpersonal problems</td>
<td></td>
</tr>
<tr>
<td><strong>Chemical Addiction/Dependence</strong></td>
<td>• Despite clear danger parent may engage in behaviors that put child at risk such as leaving child alone or with an inappropriate supervisor for extended periods while seeking drugs</td>
</tr>
<tr>
<td>Characterized by compulsive use of substances; user cannot cease usage despite attempts to do so; ability to function deteriorates; health status is compromised; social isolation occurs.</td>
<td>• Parent may divert family resources to buy drugs in lieu of food for children or diapers or instead of paying rent or utilities</td>
</tr>
<tr>
<td>Results in:</td>
<td>• Parent may not be able to think logically or make rational decisions about a child's needs or care</td>
</tr>
<tr>
<td>• Tolerance: needing more drug/alcohol for desired effect</td>
<td>• Parent may seriously harm or kill child during binge</td>
</tr>
<tr>
<td>• Withdrawal: physical symptoms (tremors, nausea, sweating) when not using</td>
<td></td>
</tr>
<tr>
<td>• Using substances in larger amounts and more frequently</td>
<td></td>
</tr>
<tr>
<td>• Unsuccessful attempts to control or reduce use</td>
<td></td>
</tr>
<tr>
<td>• Time spent focused on obtaining substance, using it or recovering from use</td>
<td></td>
</tr>
<tr>
<td>• Withdrawal from social, occupational or recreational activities due to substance use</td>
<td></td>
</tr>
<tr>
<td>• Continued use of substances despite knowledge of their impact on user's physical, psychological status</td>
<td></td>
</tr>
<tr>
<td>• Increased risk for significant chronic physical and emotional problems</td>
<td></td>
</tr>
<tr>
<td>• Increased risk for divorce or separation; loss of children due to neglect or abuse</td>
<td></td>
</tr>
</tbody>
</table>
Impacts of Parental Substance Abuse on Children

Children of alcoholics or substance abusers typically experience behavioral, medical, educational and emotional consequences of their parents’ abuse. Parental substance abuse negatively affects a child’s normal development, causing increased risk of long-term problems for a child including greater risk for child abuse and neglect.

Behavioral impact: Children in substance-abusing homes are more likely than their peers to have problems in school, to be diagnosed with learning disabilities, to miss school routinely, to have to repeat grades or repeat classes, to transfer schools frequently, to experience economic problems and transportation issues, to be aggressive, and to have encounters with law enforcement. Additionally, children may be more at risk for both physical and sexual abuse than children in non-substance abusing homes.

Medical impact: Child neglect is highly associated with parental substance use including the failure of the parent to seek appropriate and timely medical care for children, to provide adequate nutrition, and to safeguard the home against poisoning or accidents. Additionally, significant alcohol use by women during pregnancy can result in Fetal Alcohol Syndrome or Fetal Alcohol Effects in infants, which in turn results in lifelong, organic dysfunctions in children. Further, children of substance abusers may exhibit “failure to thrive” syndrome because of their neglect experiences.

Educational impact: Children whose parents abuse drugs or alcohol often experience problems in school performance, anxiety, and household disruption. Thus, research indicates that these children – much more than their peers – have problems completing schoolwork, with absenteeism and poor concentration in the classroom resulting in failure in classes and grade progression.

Emotional impact: Almost all children who have been exposed to parental substance abuse experience a number of types of emotional consequences of this experience, including mistrust, guilt, anger, shame, confusion, fear, ambivalence, insecurity, loss of self-esteem, anxiety, and/or sexual conflict. These types of emotional experiences can lead to eating disorders, anxiety and depressive disorders, drug or alcohol dependence and sociopathy, such as antisocial personality disorder.

Table 7.2 describes various parental behaviors and characteristics with the associated impacts on staff and children at supervised visitation programs.
Table 7.2
The Impact of Parental Behaviors and Characteristics on Staff and Children

<table>
<thead>
<tr>
<th>Parental Behavior/Characteristic</th>
<th>Impact on Staff</th>
<th>Impact on Child at SV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial of abuse</td>
<td>Feelings of frustration or annoyance with parent</td>
<td>Frustration, anger, mistrust</td>
</tr>
<tr>
<td>Anger</td>
<td>Feelings of fear or annoyance with parent</td>
<td>Fearful, may try to intervene to reduce parent’s anger</td>
</tr>
<tr>
<td>Aggressiveness</td>
<td>Becoming a victim of attack by parent</td>
<td>Embarrassment, fear</td>
</tr>
<tr>
<td>Verbal abuse</td>
<td>Being yelled at, cursed, or insulted by parent</td>
<td>Fear, attempts to comply to reduce verbal abuse, self-blame</td>
</tr>
<tr>
<td>Poor impulse control</td>
<td>Seeing unpredictable behavior results in staff anxiety over response</td>
<td>Mistrust, uncertainty, anxiety, frustration</td>
</tr>
<tr>
<td>Physically ill</td>
<td>May need to provide first aid for parent</td>
<td>Shame, guilt, fear</td>
</tr>
<tr>
<td>Poor hygiene</td>
<td>May be offended by parent’s poor hygiene, which impedes the visit</td>
<td>Shame, guilt, blame</td>
</tr>
<tr>
<td>Threatening behavior</td>
<td>May be frightened and feel the need to retaliate</td>
<td>Fear, anger, self-blame, attempts to appease</td>
</tr>
<tr>
<td>Poor reliability</td>
<td>May have to reschedule visits when parent fails to arrive</td>
<td>Sadness, mistrust, anger</td>
</tr>
</tbody>
</table>

Identifying Parental Intoxication

Visitation staff may be called upon to determine whether a parent is intoxicated during intake for either supervised visitation or monitored exchange. Beyond the commonly described signs such as staggering, loss of motor control, inappropriate verbal responses, and slurring of words, there are other observable signs of intoxication. The following table may provide some guidelines to identify this, but it is crucial for visit monitors to also acknowledge that other conditions may mimic drug/alcohol intoxication.

Some programs use breathalyzers or other tools to assess whether a parent has been using drugs/alcohol before visits or have security staff make this assessment. Others require a drug test be administered in a specified period preceding a scheduled visit. In these programs, visits are cancelled if the test is positive.
While it may be beyond a visit monitor’s expertise and skill to confirm whether a parent is intoxicated, a visit monitor can determine by the parent’s presenting behavior whether the visit or exchange should proceed. For example, if the parent is extremely agitated and behaving in a hostile manner to staff, a decision needs to be made about the risk in allowing a visit to proceed – whether or not the parent’s behavior is due to drug use or something else.

Visit monitors should focus on the parents’ behavior and whether it justifies terminating or canceling a visit.

Additional information on this topic is included in the Administrative Supplement.

Symptoms that Mimic Intoxication

As stated previously, visit monitors should be aware that a number of health conditions unrelated to substance use may account for a parent’s behavior. The primary ones are noted below:

- **Over-the-counter medicines (OTCs)**
  Examples: Antihistamines make users drowsy; both decongestants and OTC diet formulations can make users agitated and/or dazed.

- **Prescription medications**
  Examples: Some anti-emetics (anti-nausea) pills are opium-based and make users sleepy as do medically prescribed and legitimately used barbiturates, tranquilizers and painkillers. Some antipsychotic medications make users appear to be stuporous – lethargic, unresponsive.

- **Physical disabilities/illnesses**
  Examples: Diabetes patients may appear faint or feel woozy if their blood sugar is low or if they are having an insulin reaction. Meniere’s syndrome and vertigo can cause dizziness and loss of balance or coordination. Fever can cause individuals to appear lethargic, confused or even disoriented.

- **Mental disabilities or illnesses**
  Examples: Closed head injuries can cause confusion or agitation; psychoses can produce hallucinations or delusions; bipolar disorder can cause euphoria, exhilaration and excitement. Presumably visitation staff would become familiar with the typical behavior of parents at intake so that they would not deny visitation to parents with mental health conditions unless their behavior threatened the safety and well-being of others.
Case Example & Discussion Questions

Read the case example below and then answer the questions about the case.

A father and a mother in a dependency case arrive for their scheduled visitation. The court had ordered the father to receive substance abuse treatment, and to refrain from drinking alcohol as a prerequisite for receiving visits. The monitor could smell alcohol, but could not determine where the smell was coming from. Neither party was staggering nor acting intoxicated, but the odor was very strong. The monitor asked another staff member to make sure the smell was alcohol. She agreed that there was a definite alcohol smell; however, she could not discern where it was coming from. The monitor telephoned the CBC worker and requested that she come and provide an alcohol test to both parents, as was the program’s policy. The father was found to have been using alcohol, although he denied doing so in the past four hours. The monitor terminated the father’s scheduled visitation with his children and the CBC worker escorted him from the premises. The mother was allowed to continue with her visit. She reported to her children that their father had violated the court order and couldn’t visit them that day, but that he would be there next week. The children accepted this and the visitation went as usual.

Discussion Questions:

1. Do you think the incident was handled appropriately?

2. What are the policies about informing children of cancelled visits at your supervised visitation program?

3. If the staff could not determine the source of the alcohol smell, and the father complied with all other program rules, could the visit have continued?

Techniques for Dealing with Substance Abuse in Visitation Programs

Interacting with Parents:

- If the worker has observed parental behavior that indicates substance abuse may be a problem (for example, the parent arrives at the program intoxicated), recognize that risks for unpredictable behavior or violence exist and that a crisis could develop. Program-specific policies and procedures must be followed in these situations. General tips for dealing with parents are:
  - Use assertive communication skills: 1) avoid lecturing; 2) use “I” statements, not “You” statements; 3) keep verbal communication simple and direct – e.g. “I need you to wait here” as opposed to “You must stay here;”
• Separate the parent from others coming for intake;

• Focus only on disruptive behavior at the moment – not on what the parent has or has not done in the past;

• Assess for medical need – If the parent passes out, has difficulty breathing, exhibits signs of withdrawal (seizures, vomiting), or appears to be an immediate threat to himself or others, call for medical or law enforcement help;

• End the visit – “I’m sorry Mr. Jacobs, the visit won’t be held today. We will reschedule for next week;”

• Document the termination after the parent has left the premises; and,

• Provide reports pursuant to program policy.

Interacting with Children

Children living with parents who abuse substances like drugs and alcohol need support and constructive strategies for surviving their life situations. Some general interactions that can help children in these situations include:

• Recognize children's resiliencies;

• Help parents during visits recognize children’s skills and resiliencies;

• Encourage problem-solving skills;

• Assist them in attaching to other positive adult role models;

• When and where appropriate, remind children they did not cause parent’s addiction, that they cannot cure it or control it but can learn to cope with it;

• Let them know they are cared about at your program.

• Encourage them to ask for assistance during visits if they need to do so;

• Try to provide consistency during visits;

• Stress to the older child that addiction is a disease and their parent may do things that are mean or stupid when they drink or use drugs; and,

• Use the 7C’s of addiction developed by the National Association of Children of Alcoholics.

7C’s of Addiction

I didn’t CAUSE It
I can’t CURE it
I can’t CONTROL it
I can CARE for myself
By COMMUNICATING my feelings, making healthy CHOICES
And by CELEBRATING myself.
Substance Abuse Treatment

Substance abuse treatment models incorporate a variety of interventions, which include:

- Assessment and treatment planning;
- Prescription of specific medications (Antabuse or Methadone for example);
- Crisis intervention;
- Detoxification or other medical assistance;
- Case management;
- Individual and group psychotherapies;
- Family therapy;
- Alcohol and drug abuse recovery education;
- Integrative therapies: acupuncture, diet, exercise, yoga, meditation;
- Self-Help groups (AA, NA); and,
- Specialized services: domestic violence, HIV/AIDS, parenting, etc.

Treatment may range from a few weeks to years. The type, length and intensity of treatment is determined by: severity of addiction, type of drug being used, support system available for abuser, motivation of abuser as well as other factors. Relapse is quite common among substance abusers.

Substance Abuse Recovery

The National Institute of Drug Abuse has developed research-based principles that help to understand the process of substance abuse recovery. These principles may help in monitoring visits between substance abusers and their children:

- No single treatment is appropriate for all individuals;
- Treatment needs to be readily available;
- Effective treatment attends to multiple needs of the individual, not just his or her drug use;
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness;
- Treatment does not need to be voluntary to be effective;
- Possible drug use during treatment must be monitored continuously;
- Treatment programs should provide assessments for HIV/AIDS, hepatitis B & C, tuberculosis and other infectious diseases; and,
- Recovery from drug addiction can be a long-term process & frequently requires multi-episodes of treatment.
**Risk Identification**

Supervised visitation staff should routinely be alert to alcohol and drug abuse/use in parents or other caregivers referred to their programs. While substance abuse screening alone is never diagnostic, it can reveal whether a more comprehensive assessment or evaluation is needed. Some referrals to supervised visitation will be made while parents are receiving substance abuse treatment, but other referrals will be made with the acknowledgement that while substance abuse is a concern, the parent may or may not be seeking treatment.

**More information about this topic is included in the Administrative Supplements.**

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**Case Example & Discussion Questions**

*Read the case example below and then answer the questions about the case.*

Lanie Armstrong is referred to the Sunshine Visitation Program. She has been using methamphetamine for over seven years but was arrested a few months ago when deputies raided her home. They found a meth lab that she and her partner had been using to manufacture meth. She has three children, ages nine, seven, and three. During the raid, deputies found meth oil in the refrigerator, but no food in the home. The house was filthy – strewn with drug paraphernalia and pornographic magazines and videos. Meth-making chemicals were hidden in the children's clothes and toys. After the children were placed in emergency shelter, it was discovered that the youngest child had to be fed through a gastric tube due to exposure to methamphetamine, which caused damage to his esophagus. The oldest child, Shelly, had been sexually abused by men coming into the home to buy meth. Lanie has been in rehab for four months but the judge has only recently granted her supervised visitation.

**Discussion Questions:**

1. What impact has the mother’s substance use had on her children?
2. What might be some of the reactions of the children during supervised visits?
3. What techniques might visitation monitors use to facilitate the visits?
The Interface Between Substance Abuse & Domestic Violence

There are many similarities between substance abuse and domestic violence. Because many of the families at supervised visitation programs will be dealing with both of these problems, it is important for visit monitors to understand how they interface.

Both of these conditions are characterized by the following:

- Family isolation;
- Impacts on the mental, emotional, physical, sexual and financial condition of the individual;
- Negative impact on self-esteem;
- Denial, minimization, and/or blame for each problem;
- Use of substances and/or use of violence become more frequent and more severe over time;
- Relapse is common in substance abuse and a return to an abusive relationship is common in domestic violence relationships;
- Substance abuse can result in death; domestic violence can result in fatalities as well;
- Substance abuse and domestic violence often require intervention by legal, medical and criminal justice systems;
- Advocates for both concerns must address the stigma, myths and misinformation regarding each;
- Workers must be experienced managing crisis situations with substance abuse clients and domestic violence victims; and
- There are often limited resources available to help clients with either substance abuse or domestic violence problems.

Effects on Perpetrators and Victims

Substance abuse may affect the perpetrator of domestic violence and the adult victim in different ways. For the perpetrator of domestic violence, the use of substances may increase the severity of the abuse, it may be used as an excuse for the battering, or the perpetrator may not remember inflicting abuse during periods when he was high or in a blackout.

Some domestic violence victims may begin to use or abuse drugs/alcohol as a means of coping or self-medicating. Victims who are also substance abusing may be sabotaged in their recovery efforts by the abuser, who may prevent her from entering treatment or complying with treatment plans. For some victims, the use of substances allows them to have a false sense of security that they or their children are safe from further abuse. For example, the victim may believe that if she stays high she can keep her partner high and prevent further abuse. Or she may have received the message from her abuser that if she doesn't drink or use drugs with him then she or the children will be beaten. For both the victim and abuser, substance abuse...
may increase the tension in an already stressful relationship, which then increases the potential for escalation of abuse.

Victims of domestic violence who abuse substances should be referred only to substance abuse treatment programs that understand the complex dynamics of domestic violence.

Case Example & Discussion Questions

Read the case example below and then answer the questions about the case.

Lourdes is a Cuban-American mother of three who is currently in a domestic violence center. While at the center, she was screened for substance abuse and acknowledged using heroin in small amounts. If she could not obtain heroin, she would drink until she passed out. During her assessment at the domestic violence center, Lourdes acknowledged that her husband (the children's father), had introduced her to heroin. She reported that he frequently beat her, threatened to kill her and threatened to report her for child abuse if she left him. Her husband has now obtained a court order to see his daughters at the supervised visitation center. Lourdes brings the children to the center but when she returns to pick them up she appears high to the staff.

Discussion Questions:

1. How does this case illustrate the interface between domestic violence and substance abuse?
2. Why might Lourdes get high before picking her children up?
3. If she is high, with whom should the staff allow the children to leave?
QUIZ

1. What is one of the primary causes for the increase in child maltreatment reports?

2. Describe the potential health consequences of hallucinogens, cocaine, and methamphetamine.

3. Discuss the stages of substance use from casual use to addiction, and describe the risk to children presented in each stage.

4. Discuss the behavioral, medical, educational and emotional impact of parental substance abuse on children.

5. Describe common behaviors of substance-abusing parents during supervised visitation and the impact of these behaviors on program staff and children.

6. Discuss how to use screening tools as part of an intake when substance abuse is of concern.

7. Describe techniques to employ to facilitate visits between substance-abusing parents and their children.

8. Discuss the interface between domestic violence and substance abuse.