

Substance Abuse and Permanency Planning in the Context of Implementing ASFA

Intergenerational Implications

Washington State Child Abuse & Neglect Institute

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SESSION GOALS

To increase knowledge & understanding of the continuum, multiple factors, & processes related to

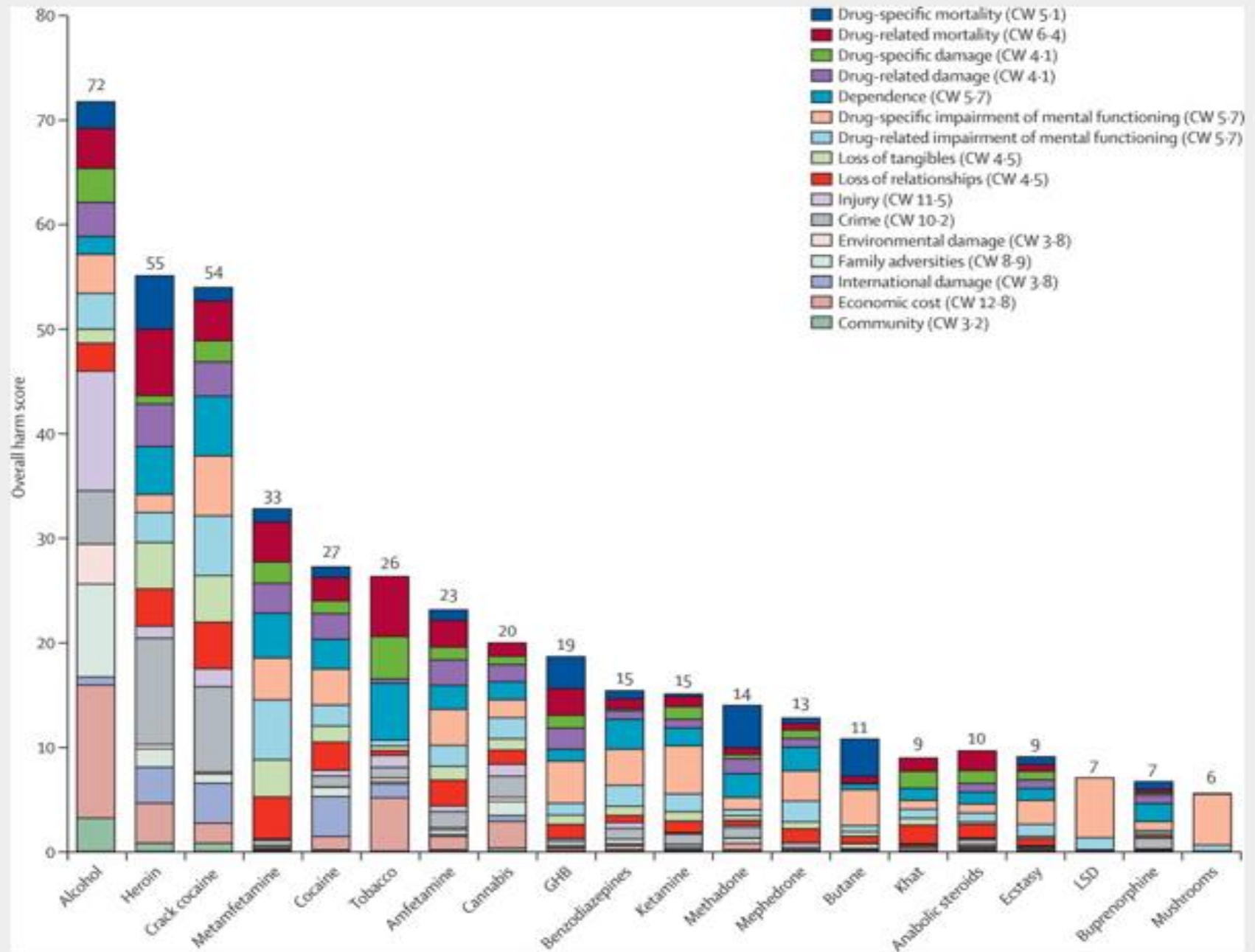
- a) Substance use disorders,
- b) Relationship between trauma and co-occurring disorders, primarily substance abuse
- c) Substance abuse and trauma effects on 1) parenting capacity, and 2) children
- d) Effective intervention & treatment strategies:
How to address substance use disorders in the family (with prevention and treatment) while implementing ASFA

Part I: Understanding Substance Abuse & Its Effects on Parenting

*“If a community values its children,
it must cherish their parents.”*

Bowlby, 1951

RELATIVE RISKS OF VARIOUS SUBSTANCES

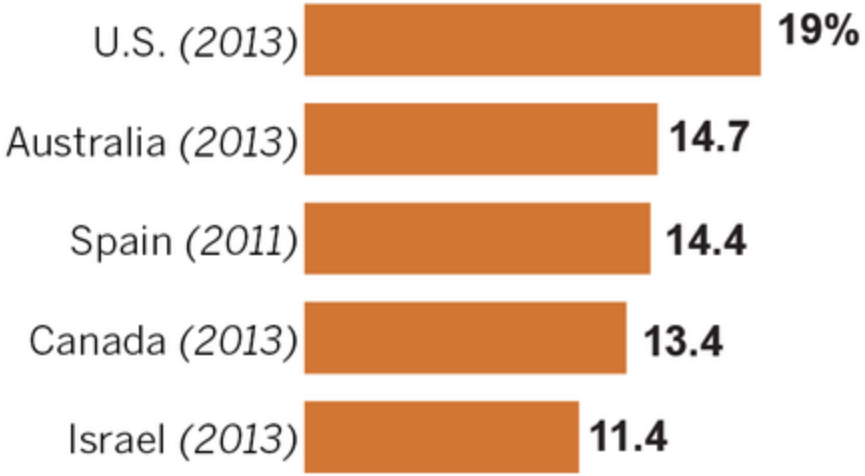


246 million use illicit drugs/yr-10% develop SUDs.
200K die/yr from drug-related deaths.

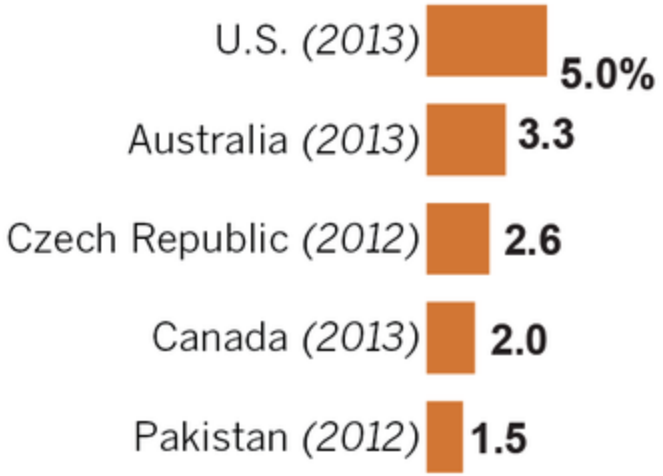
Global drug use

Percentage of adults (generally ages 15 to 64) who have used drugs at least once in the last year in the top five countries in terms of overall drug use.

Any illicit drug use



Prescription opioids



Source: United Nations Office on Drugs and Crime

Lorena Elebee / @latimesgraphics

The Child Protection System Mandate

“...protect the children’s *current* and *future* safety and well-being, while strengthening and preserving the **family unit** - wherever possible...”

THINK INTERGENERATIONALLY

Four “Clocks” Guiding Work with Drug Affected Families

TANF

Limited funding
& Services
(5 yr maximum)

DRUG RECOVERY

Minimum 4-6 mo
9-12 mo usual
+ LT aftercare

ASFA

**If 15 of last 22 mo in
FC, must move to TPR**

In many states earlier

TPR possible:

6 mo, if under 3,

12 mo, if over 3 y/o

CHILD DEVELOPMENT

Variable

Video clip

- Dr. Edward Tronick Still Face Video

<http://www.youtube.com/watch?v=apzXGEbZht0>

How MANY Children are Exposed?

- **Reported Findings of Prenatal Exposure:**
Alcohol: est. 11.2% - 22.8%; Illicit drugs: 4.6% - 10%; Tobacco: 18% - 25%
- **Direct Environmental (in-home) Exposure: 11%**
(8.3 million children) live with at least one parent who is either alcoholic or in need of treatment for the abuse of illicit drugs
- **Social/Environmental “Exposure”: about 100%**
- **GOOD NEWS: NOT ALL DRUG-EXPOSED CHILDREN ARE AFFECTED**

Substance Use by Pregnant Women by Length of Gestation & Est. Number of Infants Exposed

(2003-2004 annual average: approx 4 million births/year)

Substance Used (per month)	1 st Trimester	2 nd Trimester	3 rd Trimester
Any Illicit Drug	8.0% women 327,440 infants	3.8% women 155,534 infants	2.4% women 98,232 infants
Alcohol Use	22.2% women 908,646 infants	7.0% women 286,510 infants	4.9% women 200,557 infants
Binge Alcohol Use	10.6% women 433,858 infants	1.9% women 77,767 infants	1.1% women 45,023 infants

ADDICTION

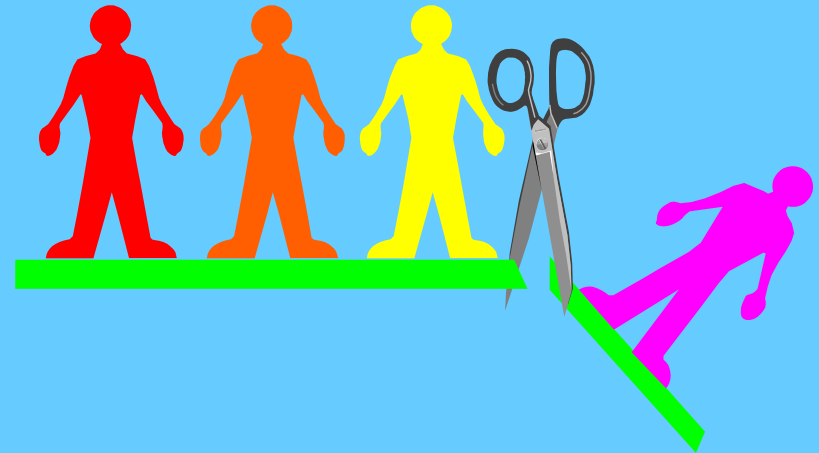
- NIDA/CSAT Definition -

A DISEASE CONSISTING OF A
NUMBER OF BRAIN
CHEMISTRY DISORDERS

Addiction *is related to
pleasure/reward pathway activation by
drugs of abuse and **includes**
maladaptive behavioral response to
neurological dependence*

Continuum toward Addiction: *Use, Abuse, Physical and Psychological Dependence*

- Tobacco
- Alcohol
- Legal & Prescription Drugs
- Illicit Drugs
- Other Behaviors (eg: gambling, sex, internet use, compulsive buying, unsafe driving, etc.)



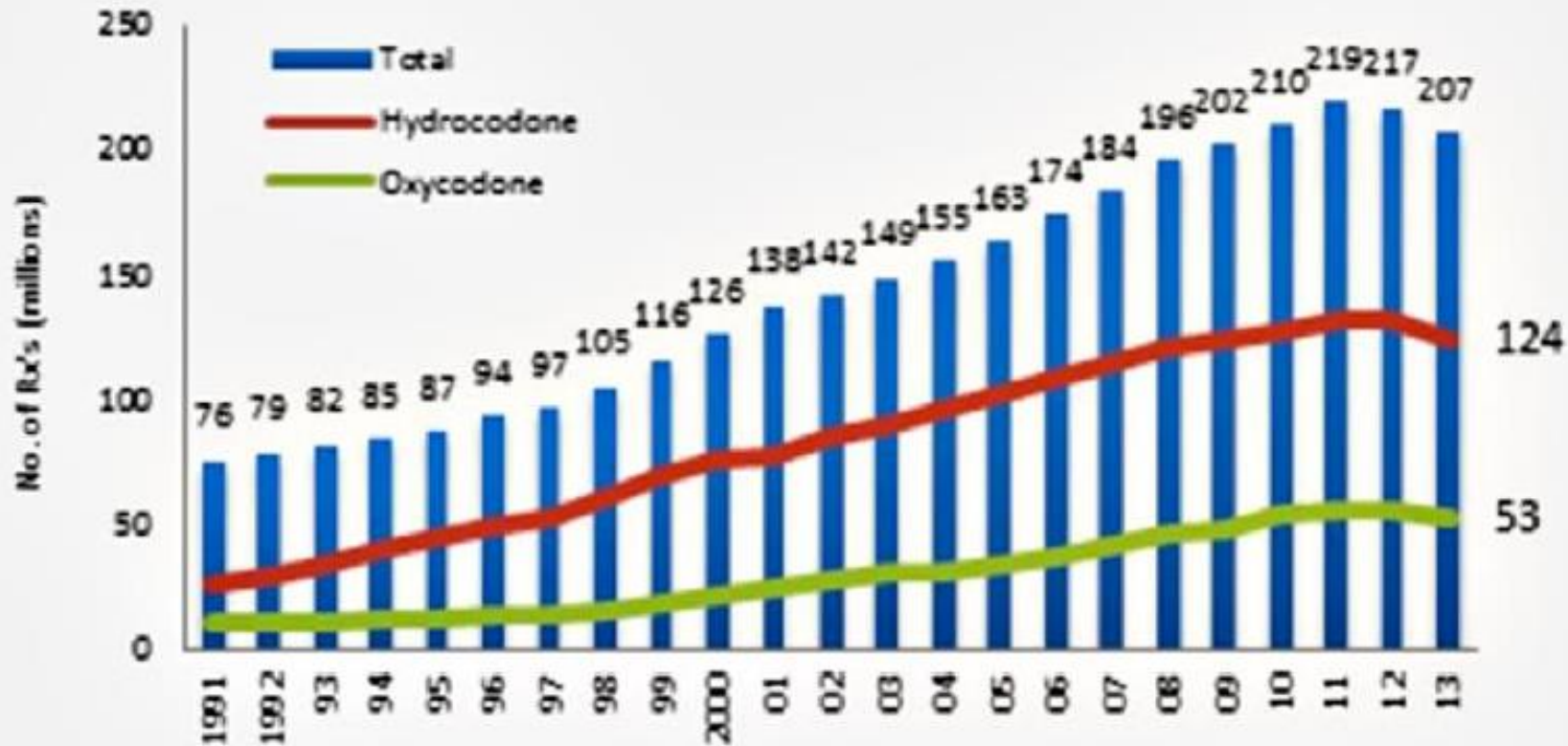
American Society of Addiction Medicine, American Pain Society, American Academy of Pain Medicine – *Recommended Definitions:*

I. **Addiction** is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

II. **Physical Dependence** is a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

III. **Tolerance** is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.

US Opioid Prescription Increase 1991-2013



Volkow – 04/02/2014 - Testimony

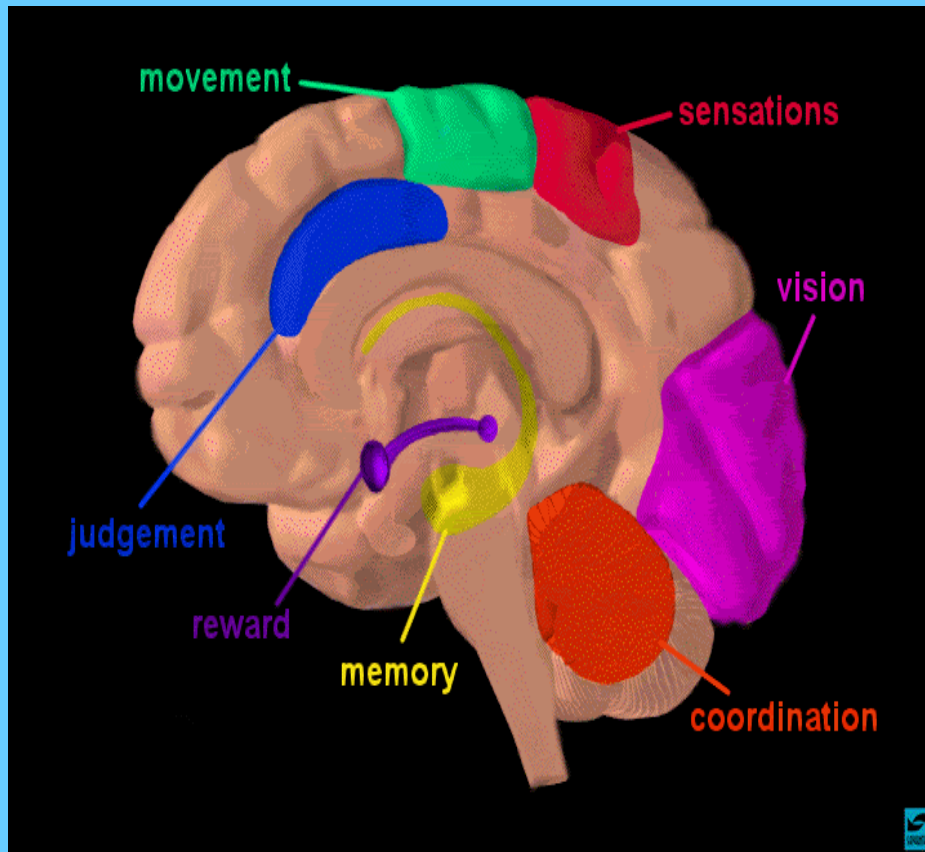
<http://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2014/harnessing-power-science-to-inform-substance-abuse-addiction-policy-practice>

Tolerance & Physiologic Dependence Precedes Addiction

- EG: physical dependence to opioids means that the body relies on an external source of opioids to prevent withdrawal.
- Many substances – ie: caffeine, nicotine, sugar, anti-depressants - can cause physical dependence, it is not a property unique to opioids or alcohol.
- This is a normal adaptive neurologic response to ongoing opiate exposure (which is NOT normal for the brain).
- This physical dependence can be managed more helpfully with Medications (MAT) to enable the client/patient to better focus on the difficult work of overcoming and healing from their addiction.

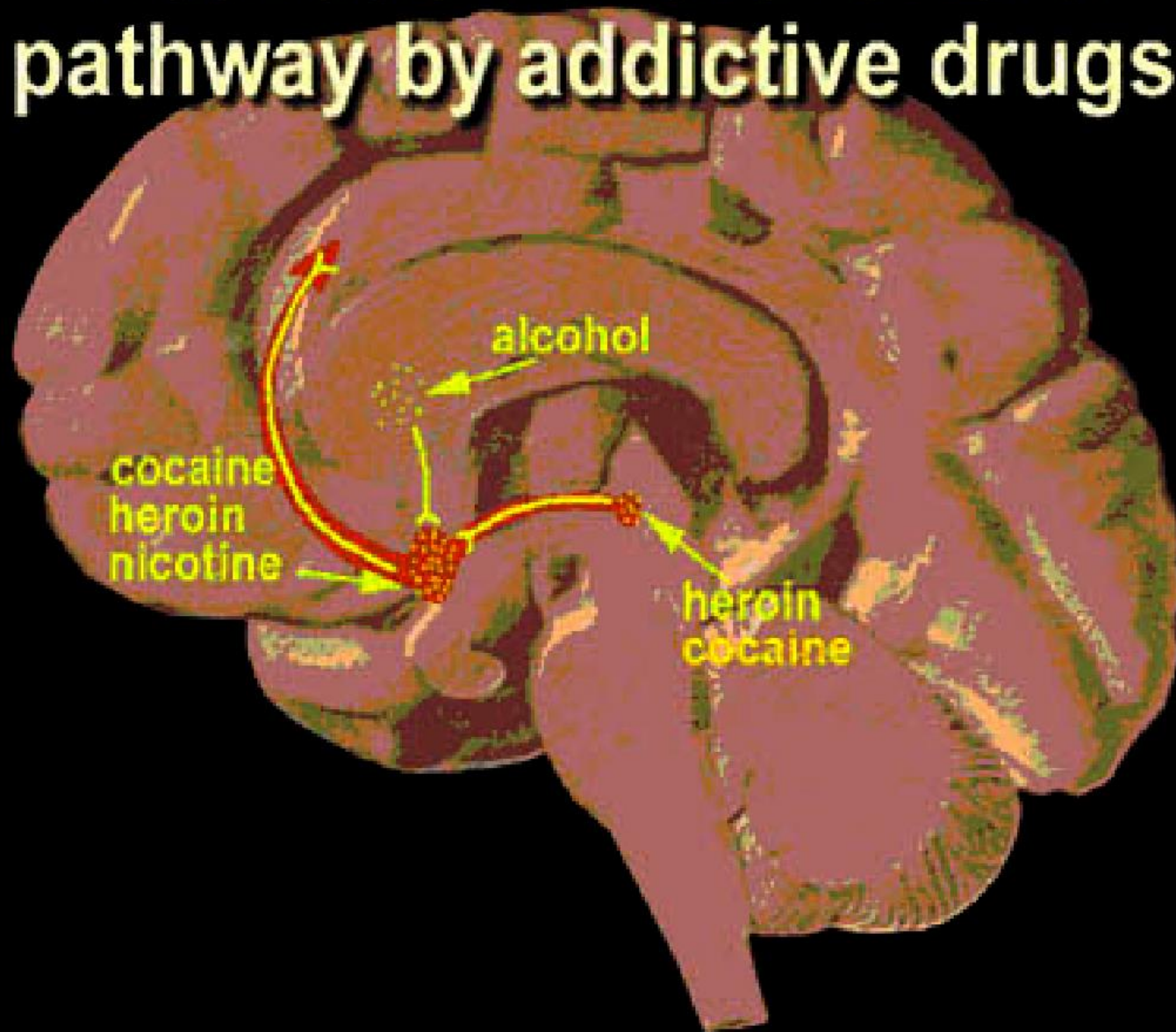
(most people who are dependent do not suffer from addiction)

DOPAMINE REWARD SYSTEM: Essential to Neurologic Reinforcement System



- *Every* substance of abuse has some effect on the limbic (dopamine) reward system
- Dopamine, one of 100+ neurotransmitters, is found in several regions of the brain; is involved in pleasurable feelings, activity reinforcement, movement, motivation, & emotions

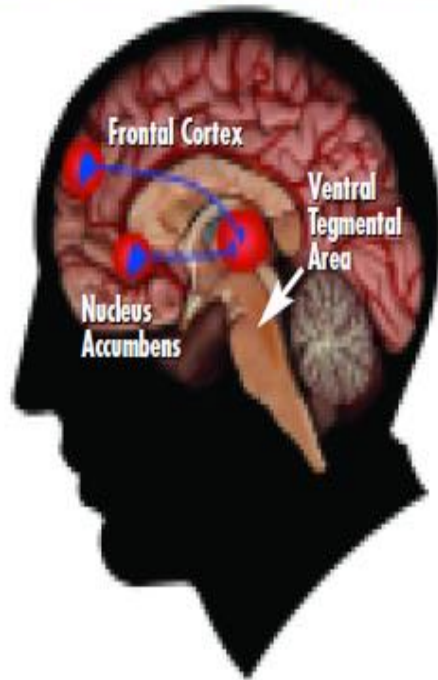
Activation of the reward pathway by addictive drugs



Review of Dopamine Action

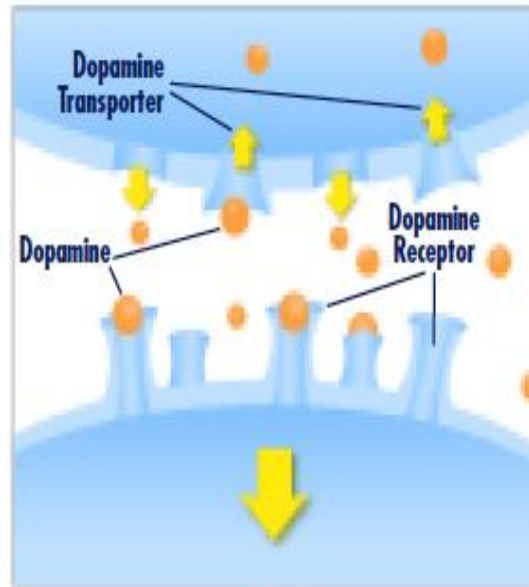
DRUGS OF ABUSE TARGET THE BRAIN'S PLEASURE CENTER

Brain reward (dopamine) pathways

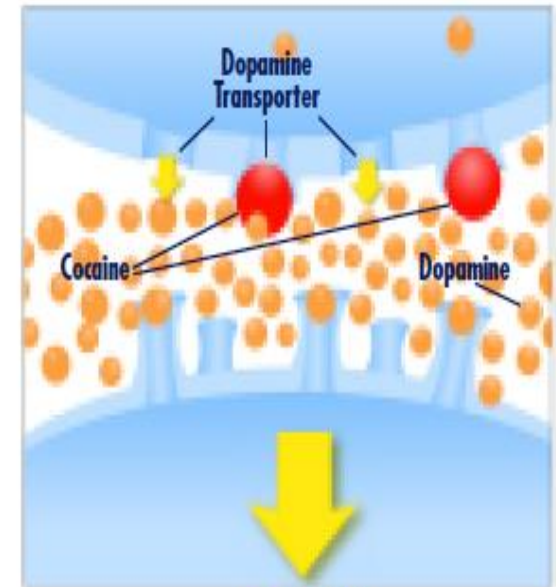


These brain circuits are important for natural rewards such as food, music, and sex.

Drugs of abuse increase dopamine



FOOD



COCAINE

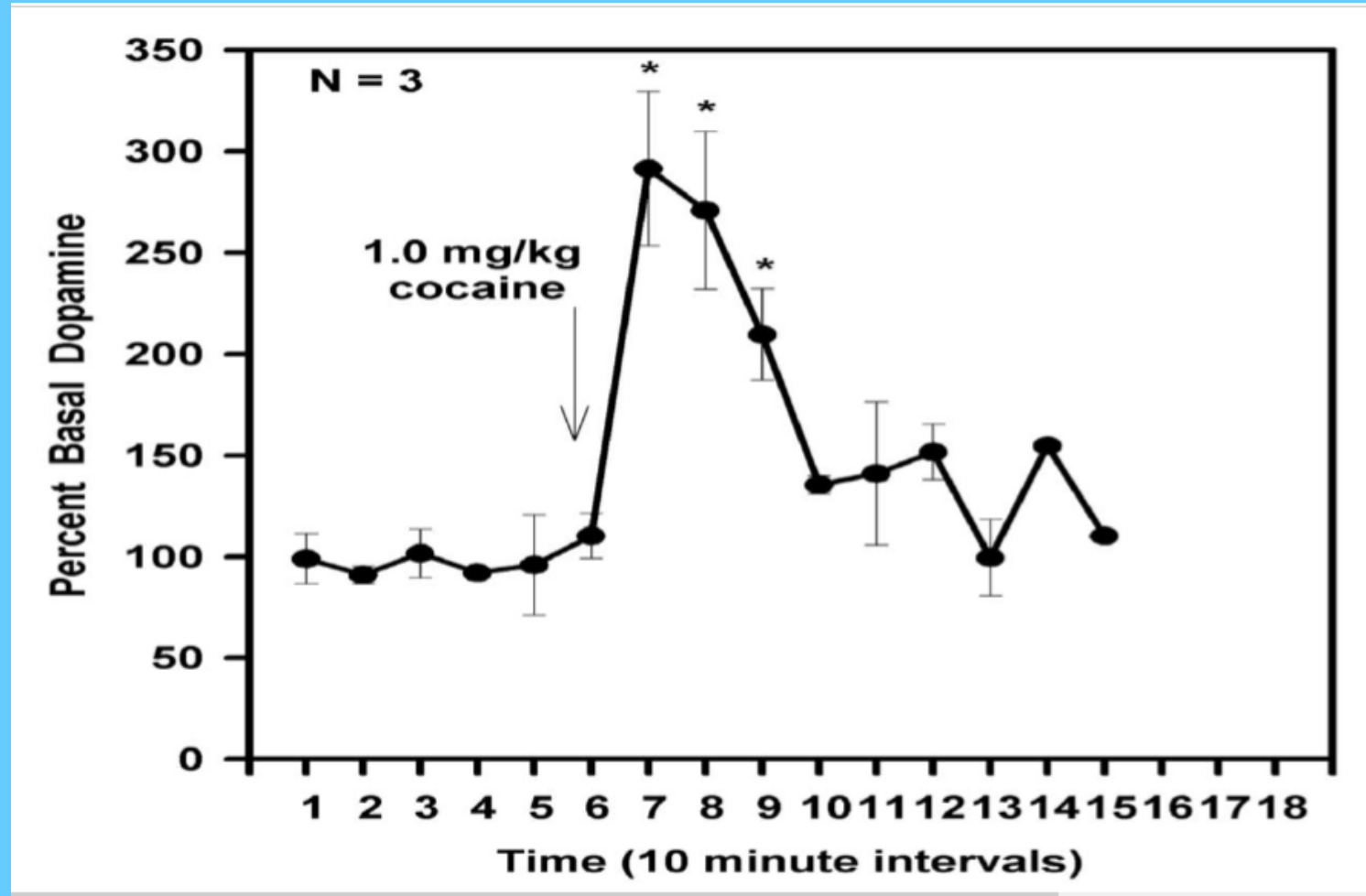
Typically, dopamine increases in response to natural rewards such as food. When cocaine is taken, dopamine increases are exaggerated, and communication is altered.

Methamphetamine in the Brain



Methamphetamine Stimulates Release of Neurotransmitter Dopamine

EG: Cocaine Administration in Awake Squirrel Monkey



Awake Squirrel Monkey



Normal



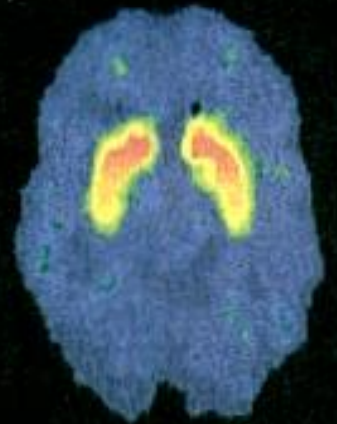
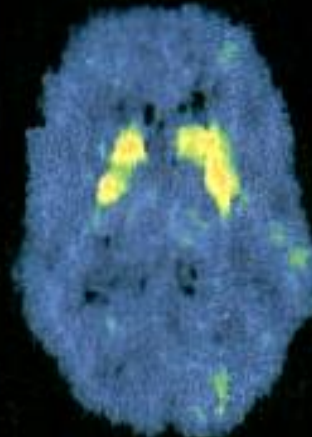
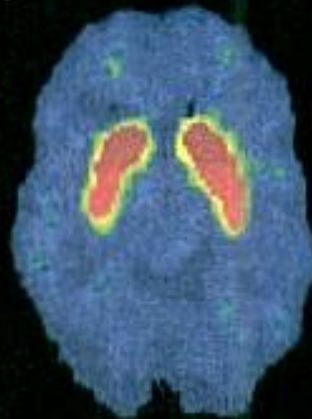
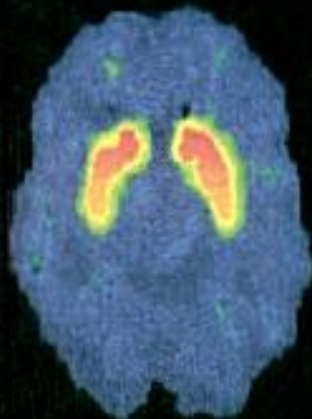
Drug Use



Addiction

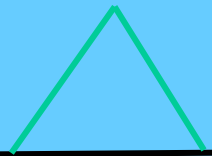


Treatment



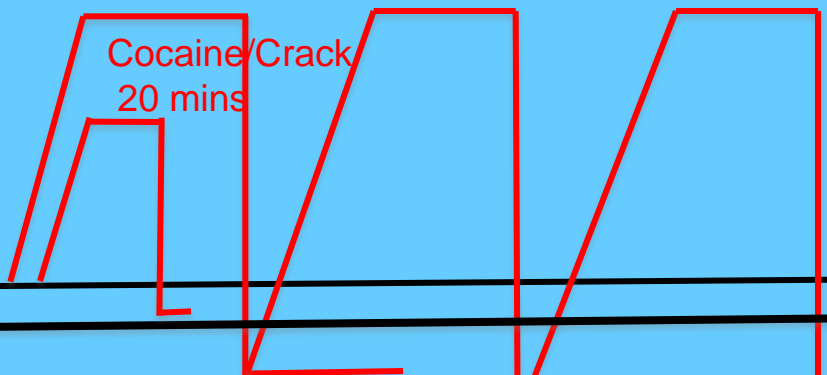
Dopamine

Normal Dopamine release



Meth 10-18 Hours

Cocaine/Crack
20 mins

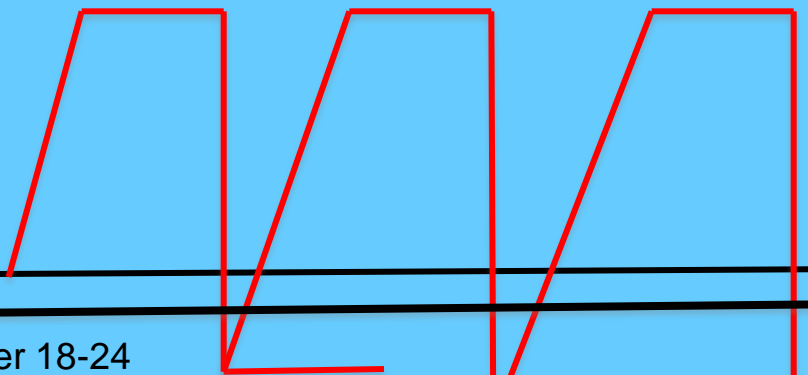


New baseline after 18-24 months of non-use;
Baseline decreases with each relapse.



Little to no dopamine in the body, creates Anhedonia.

Normal Dopamine release



New baseline after 18-24 months of treatment.
Baseline decreases with relapse.

Suppression of dopamine release is adaptive consequence of sustained exposure

Time

Brain Chemistry is Changed in Addiction



- **Neurotransmitter production is “turned off”, receptor sites are “desensitized”, (neuro-adaptation occurs) and in some drugs, re-uptake system is damaged**
- **Client is chemically depressed**
- **External chemical supply needed to address depression and stave off withdrawal**

Brain Chemistry is Changed in Addiction



- Environmental cues trigger need to use
- At next use (relapse), the brain responds differently
- *Relapse Prevention Requires Planning*
- Cognitive functioning is impaired during initial recovery
- Brain recovery takes time (*min. 12-15 months-in the case of some stimulants*)

Brain Changes are Long-Lasting

- The pathways between cue and activation don't go away, rather through disuse a new pathway established to dampen cue/use path
- *Pathway can be (re)activated at any time by use*
- Orienting to use starts outside the central consciousness
--bypassing prefrontal cortex of reasoning/judgement
- *Addictive drugs are 10-20x greater than natural rewards*
- Some synthetic opiates (ie fentanyl) is 80-100x more potent than morphine, but dominated by analgesic and sedative effect versus euphoria.

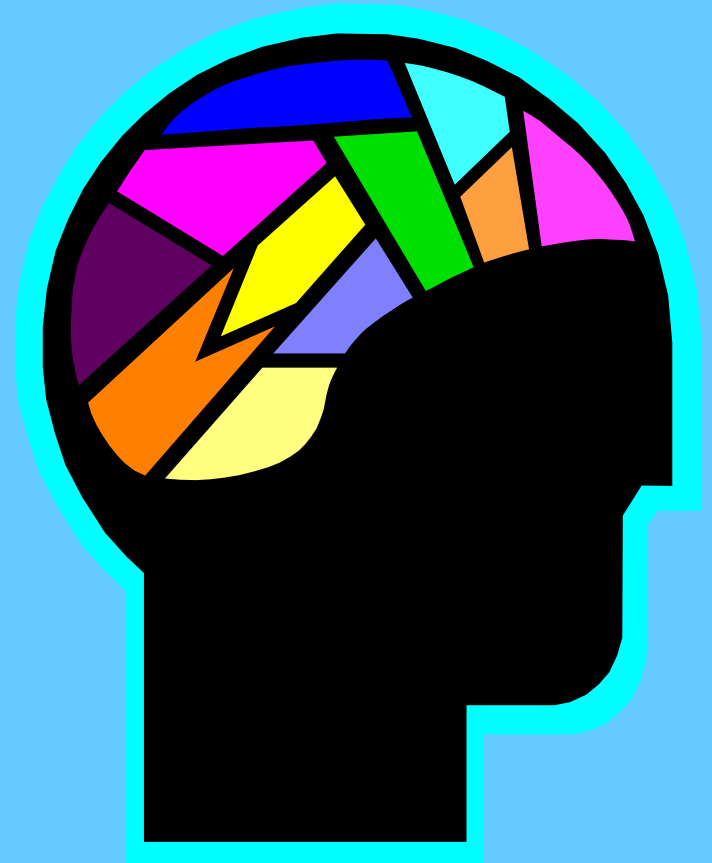
Chemical Dependency: ADDICTION

- **Pathological, compulsive use; loss of control over use**
- **Continued Use, despite negative consequences (DENIAL)**
- **Chronic Disease, characterized by relapse**



Chemical Dependency: ADDICTION

- **Increased Tolerance to drugs of abuse**
- **Withdrawal Symptoms – not necessarily physical - if/when drug use stops**
- **Genetic Predisposition
Intergenerational Family
Patterns**



RECAP check in!

Neurotransmitter levels involved in addictive disorders (eg: dopamine) typically do what after a person has gone through recovery:

- a) seem to return to baseline (pre-addiction) levels
- b) seem to never return to baseline levels
- c) seem to increase above baseline levels

So, recovery implications of this fact include:

- a) a relapse prevention plan must be in place
- b) other mental health issues may emerge when a person achieves abstinence
- c) multiple major relapses may make “permanent” recovery/abstinence difficult
- d) all of the above

MOST FREQUENTLY ABUSED DRUG: ALCOHOL

- **Leading Cause of Mental Retardation in Developed World: FAS & FASD issues**
- **Probably accounts for many psychiatric mis-diagnoses: ADHD, ADD, ODD, Borderline Personality Disorder, etc.**
- **Present with most other abused drugs**
- **Involved in MOST cases of Domestic Violence**



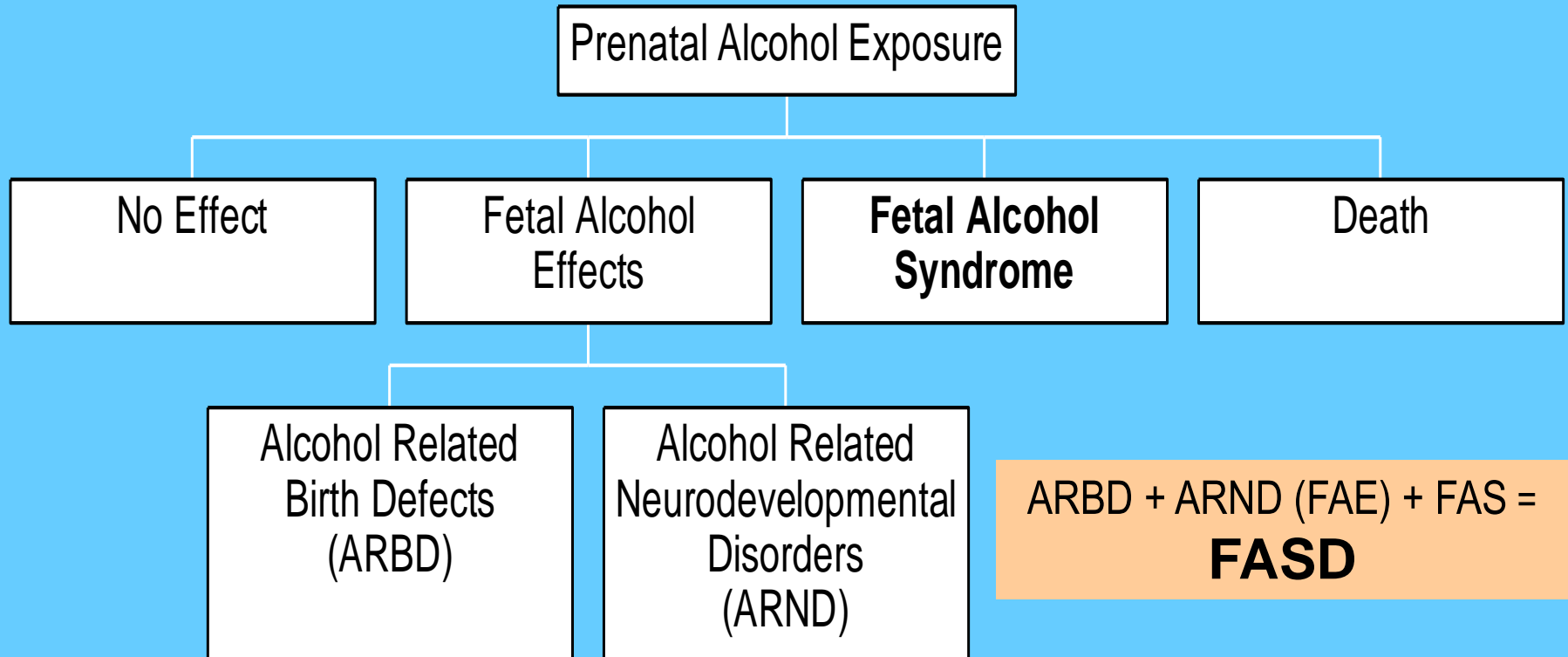
Alcohol Consumption in Pregnancy has Wide Range of Fetal Effects

No Effect; FAE (alcohol related birth defects (ARBD) + alcohol related neurodevelopmental disorders (ARND)), FAS, and Death

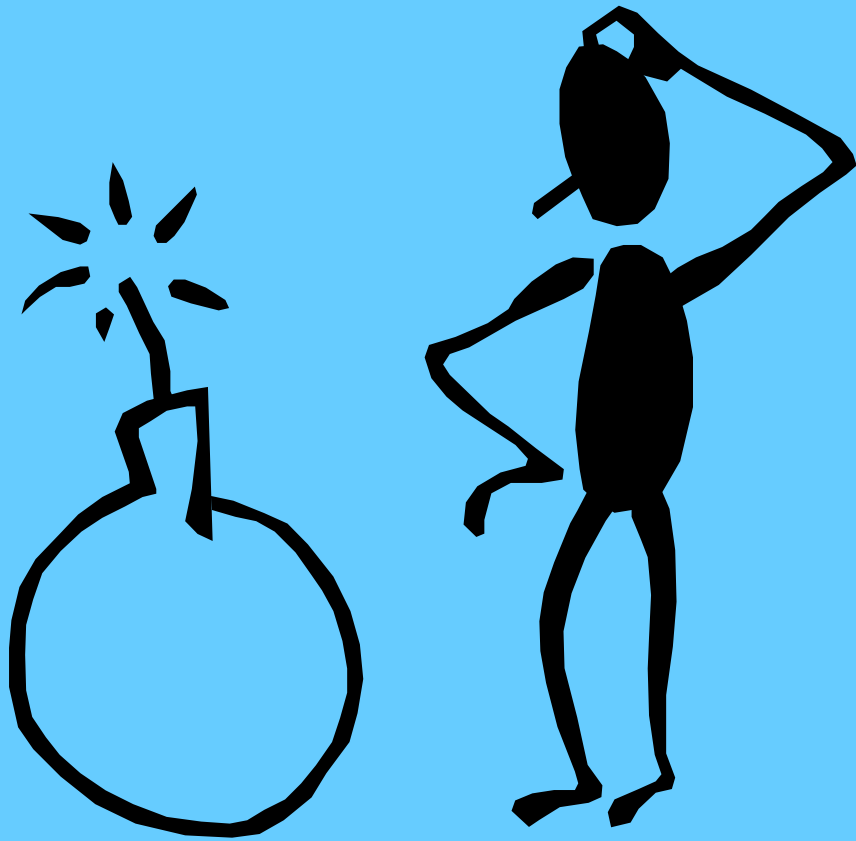
- .5 to 3 infants per 1,000 live births have fetal alcohol syndrome (FAS)**
- 1 in 100 children has a fetal alcohol spectrum disorder (FASD)**
- Low levels of alcohol consumption have been shown to be related to negative developmental sequelae**



Range of Effects: Fetal Alcohol Spectrum Disorders

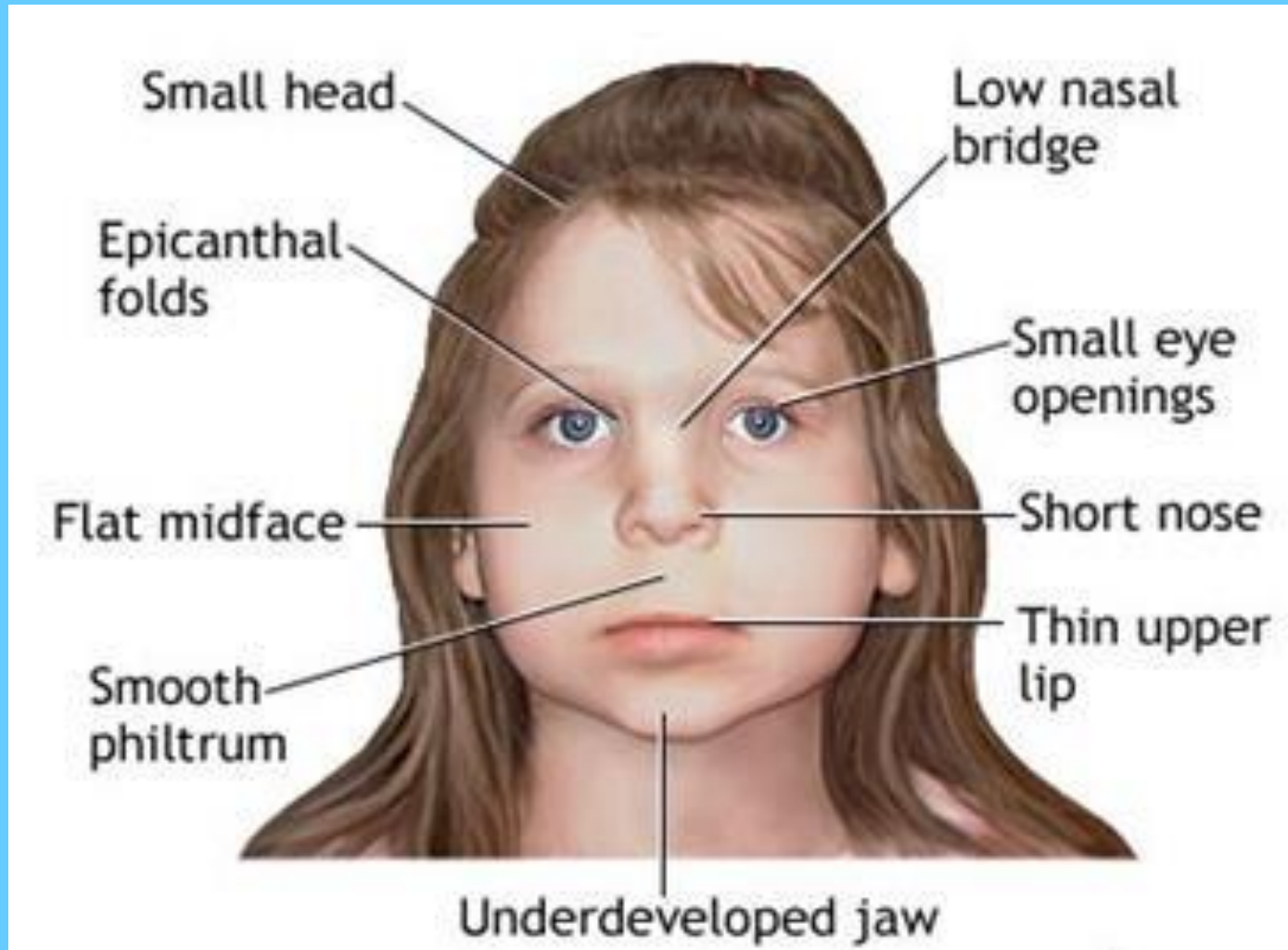


AOD Prenatal Exposure Can Have Lifelong Effects



- **FAS first described in 1973**
- **FAE/ARBD is now more recognized**
- **Increased susceptibility to chemical dependency**
- **Related to many learning disabilities**
- ***MANY* Undiagnosed Adults: some of your clients!**

Example of FAS physical features



FAS Facial Diversity



Discriminating Features

Short palpebral fissures

Flat midface

Short nose

Indistinct philtrum

Thin upper lip

Associated Features

Epicanthal folds

Low nasal bridge

Minor ear anomalies

Micrognathia



People with FAS have average IQ between 60 and 65

Evidence of Prenatal Harm from Substances of Abuse

- But not all drug exposed children are affected equally. Interaction with the environment is important variable.
- Multiple drugs, including alcohol, methamphetamine, and cocaine can cause prenatal brain damage at multiple sites. There is a wide range of outcomes that are not directly dose-dependent. Consequences of dopamine receptors modification is yet unknown.
- Degree and frequency of use, type of drug, timing of use, plus multiple other factors must be considered on case-by-case basis in evaluating appropriate interventions for child – and parent or caregiver
- Children's behaviors, secondary to prenatal exposure, should be considered as a possible risk factor for abuse and neglect and parenting support provided.

Effects of prenatal exposure on IQ Appear to Increase with Age

- IQ was roughly parallel at birth in comparison study between exposed and non-exposed children
- By age 7, exposed children's IQs were 4.4 lower on average
- By age 15, the difference had grown to 7.8 IQ points (lower for exposed)
- Special Education referrals were 16% for Exposed, 11% for comparison group

Psychopathology in Drug Exposed Children at Age 11

Measure: DISC Symptom Scores at Age 11	Exposed Mean (SD)	Comparison Mean (SD)	P value =
ADHD	6.28 (5.69)	5.45 (5.44)	.021
Depression	3.34 (3.53)	2.82 (3.14)	.015
Compulsive Disorder	2.31 (2.80)	1.60 (2.18)	.001

Barry Lester, 2004

BOTTOM LINE UPFRONT

- Science & Prenatal Drug Exposure:
There ARE Drug Effects, but NOT
ALL Drug-Exposed Children Are
Affected

There are some behaviors in childhood that are related to substance use in adolescence, that are related to prenatal drug exposure (cocaine & methamphetamine) and environmental adversity

Presence of substance use disorders in parents results in three to fourfold increase in risk of Child Maltreatment:

- 2.7 greater chance of abuse
- 4.2 greater chance of neglect
 - Lack of Essential Food
 - Lack of Hygienic Home & Care
 - Inappropriate Sleeping Conditions
 - Lack of Medical / Dental Treatment
 - Lack of Supervision

The Consequences to Children

- **Up to 40% of incest cases involve alcoholic parent**
- **Abused/neglected children can become:**
 - **angry, antisocial**
 - **physically aggressive, violent**
 - **poor students**
 - **depressed, self-mutilating, suicidal**
 - **future substance abusers**
 - **future child abusers**

Youth Non-Use or Use?

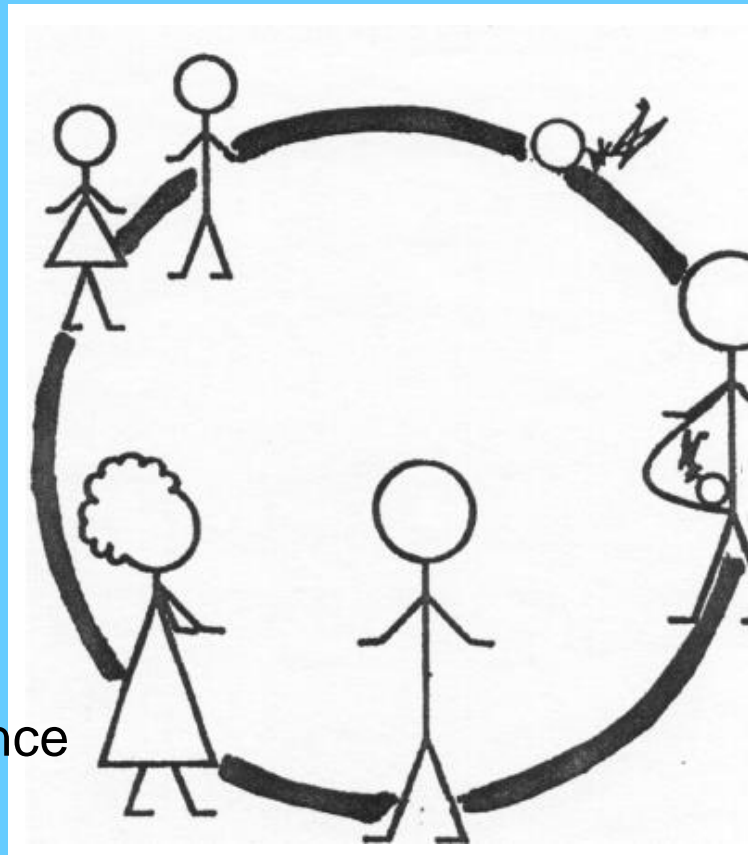
Factors to keep in mind

- **Risk**
 - **Family/Parental Addiction History/Genetics/**
 - **Familial, Ethno- and Socio-cultural, community practices – basically epigenetics!**
 - **Trauma Exposure**
 - **Developmental Competencies, & Interpersonal Experiences**
 - **Environmental Exposures and Access**
- Resilience & Protective Factors**
- Substance abuse or other addictive behaviors; absent or present?
- Modeling & monitoring + supervision; + values; + peers; + school functioning; + education; + spiritual orientation
- Sexual or physical abuse, exposure to violence and traumatic loss –home, community, war
- Emotional regulation, self-efficacy, understanding others, empathy
- Increased marketing of drugs to vulnerable youth populations (ETOH ads, outlets etc)

The Family Disease of Drug and Alcohol Dependence

Children

COA Roles
Neglect and abuse
Biologic vulnerability



Grandma/Extended Family

Drug/alcohol dependence and codependence

Father

Drug/alcohol dependence

Fetus/Infant

Intrauterine toxicity
Neonatal toxicity / withdrawal
Increased muscle tone
Neglect/abuse

Mother

Drug/alcohol dependence and codependence
COA issues
Pregnancy complications

Strong evidence that delaying first use (of any substance) dramatically decreases probability of drug dependence at any time in life

- Prevention programs should begin with families with elementary school children (behavioral problems as early as K correlate with later drug problems)
- Early intervention programs with families and communities show successful reduction and cessation of use and progression to dependence

COMMUNITY/SOCIETY Laws and norms favourable towards drug use
 Availability
 Accessibility
 Extreme poverty
 Anti-social behaviour in childhood

SCHOOL/EDUCATION AND PEERS

Childhood/adolescence

School failure
 Low commitment to school
 Not college bound
 Deviant peer group
 Peer attitudes towards drugs
 Associating with drug-using peers
 Aggression towards peers
 Interpersonal alienation
 Peer rejection



Young adulthood

Attending college
 Substance using peers

FAMILY

Early childhood

Cold and unresponsive mother behaviour
 Parental modelling of drug use

Childhood/adolescence

Permissive parenting
 Parent-child conflict
 Low parental warmth
 Parental hostility
 Harsh discipline
 Child abuse/maltreatment
 Parental/sibling modelling of drug use
 Parental favourable attitudes toward drugs
 Inadequate supervision and monitoring
 Low parental involvement
 Low parental aspirations for child
 Lack of or inconsistent discipline



Young adulthood

Leaving home

INDIVIDUAL

Preconception

Genetic predisposition
 Prenatal alcohol exposure

Early childhood

Difficult temperament

Middle childhood

Poor impulse control
 Low harm avoidance
 Sensation seeking
 Lack of behavioural self-control regulation
 Aggressiveness
 Antisocial behaviour
 Anxiety, depression
 ADHD, hyperactivity
 Early persistent problem behaviours
 Early substance use

Adolescence

Behavioural disengagement coping
 Negative emotionality
 Conduct disorder
 Favourable attitudes towards drugs
 Antisocial behaviour
 Rebelliousness
 Early substance use

Young adulthood

Lack of commitment to conventional adult roles
 Antisocial behaviour



MEDIA

Norms, e.g. advertising
 favourable towards drugs



Adverse Childhood Experiences (ACE) Study Findings

Each ACE increased the likelihood for early initiation of drug use 2 to 4-fold; Individuals with 5 or more ACEs were 7 to 10-fold more likely to be AOD abusers

For 4 successive cohorts back to 1900, effects of ACEs outweigh increased drug access, attitudes towards drugs, and public education campaigns to prevent drug abuse

Retrospective study of 8613 adults re: ACE 10 categories:
Childhood Abuse (emotional, physical, sexual),
Childhood Neglect (emotional, physical),
Household Dysfunction (substance abuse, mental illness, battered mother, incarcerated, overt parental marital conflict)

aces connection

HEALTHY, HAPPY KIDS GROW UP TO CREATE A HEALTHY, HAPPY WORLD.

MAIN GROUPS MY PAGE MEMBERS EVENTS VIDEOS PHOTOS FORUM BLOGS ACESTOOHIGH.COM

This community of practice uses trauma-informed, resilience-building practices to prevent Adverse Childhood Experiences & further trauma.

MEMBERS



[View All](#)



Welcome to ACES Connection
Sign Up
or **Sign In**

LATEST ACTIVITY

Teresa Moore and Tim Clement joined Jane Stevens's group



Community Managers
Groups' community managers develop and exchange best practices to grow and facilitate t
[See More](#) [Sign in to chat!](#)

Vincent Felitti, MD, Director, study, Kaiser Permanente CA

www.acesconnection.com


 SEARCH

A-Z Index **A B C D E F G H I J K L M N O P Q R S T U V W X Y Z #**

Adverse Childhood Experiences (ACE) Study

ACE Home

- About ACE
- Pyramid
- Major Findings
- Questionnaires
- Data and Statistics
- Related Links
- Publications

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. The study is a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego.

More than 17,000 Health Maintenance Organization (HMO) members undergoing a comprehensive physical examination chose to provide detailed information about their childhood experience of abuse, neglect, and family dysfunction. To date, more than 50 scientific articles have been published and more than 100 conference and workshop presentations have been made.

The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. Progress in preventing and recovering from the nation's worst health and social problems is likely to benefit from understanding that many of these problems arise as a consequence of adverse childhood experiences.



- [Email page link](#)
- [Print page](#)

Contact Us:

- Centers for Disease Control and Prevention
 1600 Clifton Rd
 Atlanta, GA 30333
- 800-CDC-INFO (800-232-4636)
 TTY: (888) 232-6348
- New Hours of Operation
 8am-8pm ET/Monday-Friday
 Closed Holidays
- cdcinfo@cdc.gov

Publications by

- [Health Outcome](#)
- [Year](#)

Data and Statistics

- [Prevalence](#)
- [Participant Demographics](#)

<http://www.cdc.gov/ace/index.htm>

Prevalence as reported by participants in landmark CDC/Kaiser
Permanent Adverse Childhood Experiences study ¹

Category	Prevalence (%)
Physical Abuse	28.3
Sexual Abuse	20.7
Emotional Abuse	10.6
Physical Neglect	9.9
Emotional Neglect	14.8

10 ACES Survey Questions

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often... ***Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?*** Yes /No If yes enter 1
2. Did a parent or other adult in the household often or very often... ***Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?*** Yes/ No If yes enter 1
3. Did an adult or person at least 5 years older than you ever... ***Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?*** Yes/ No If yes enter 1
4. Did you often or very often feel that ... ***No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?*** Yes/ No If yes enter 1

5. Did you often or very often feel that ... ***You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?***

Yes /No If yes enter 1

6. **Were your parents ever separated or divorced?** Yes/ No If yes enter 1

7. Was your mother or stepmother: ***Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?*** Yes/ No If yes enter 1

8. **Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?** Yes/ No If yes enter 1

9. **Was a household member depressed or mentally ill, or did a household member attempt suicide?** Yes /No If yes enter 1

10. **Did a household member go to prison?** Yes No If yes enter 1

Now add up your "Yes" answers: _____ This is your ACE Score

Children Under Stress:

Emotionally, Socially, Psychologically, & Physically in High Risk Homes



- Exposure to, involvement with illegal, often dangerous, and socially unacceptable practices and beliefs

- Appearances of and standards of “normality” that differ from societal norm; cognitive dissonance

- Coercive “belonging” & “tribal identity” issues



Children Exposed to Violence in their homes - between parents and others

- 60-70% of Domestic Violence cases are characterized by alcohol & drug abuse
- 80% women in shelter recalled witnessing violence between *THEIR* parents as children
- 85% of children directly witnessed assault in domestic violence incidents with police response



Trauma, Violence, & Substance Abuse

- Children & youth are at highest risk for being victims of violence (3x adult rate)
- Substance abuse, aggression, & trauma exposure are highly correlated
- Trauma exposure also correlates with:
 - substance use with high risk behaviors
 - substance use associated with both perpetration of violence – and victimization
 - substance use related to severe accidental injury/personal loss – ensuing trauma

Variability in Experience of Trauma

- Traumatic experience is filtered through cognitive and emotional processes before it can be appraised as an extreme threat
- Individual differences (in many domains: genetics, experience, social context), means that different people have **different thresholds for what is experienced as traumatic**
- Risk and Protective Factors lead to vulnerabilities and protection to developing clinical symptoms after exposure to extremely stressful situations
- Events such as rape, torture, genocide, and severe **war zone stress** are experienced as and recognized as traumatic events *nearly* universally

Physiologic Response to Potentially Traumatic Events

<i>Arousal & Hyperarousal Continuum (children)</i>	REST ENGAGED	VIGILANCE	RESISTANCE (Crying)	DEFIANCE (Tantrums)	AGGRESSION
<i>Dissociative Continuum</i>	ENGAGED REST	AVOIDANCE	COMPLIANCE Robotic/ detached	DISSOCIATION Fetal Rocking	FAINTING
<i>Regulating Brain Region</i>	NEO- CORTEX CORTEX	CORTEX LIMBIC	LIMBIC MIDBRAIN	MIDBRAIN BRAINSTEM	BRAINSTEM (Autonomic)
<i>Cognitive Style</i>	ABSTRACT	CONCRETE	EMOTIONAL	REACTIVE	REFLEXIVE
<i>Internal State</i>	CALM	AROUSAL	ALARM	FEAR	TERROR

Adapted from Bruce Perry

Perinatal Drug & Early Stress/Trauma Exposures Affect Common Neural Systems – Influencing Vulnerability to Drug Abuse

- Changes in the regulation of the brain's stress response occur from both *adverse external/environmental stress* early in life **and** *internal experiences prenatally*
- Chemicals (eg - glucocorticoids) released during stress *alter* gene expression & influence functions of nearly *all* tissues; their chronic effects can be permanent

Alcohol, Tobacco and Marijuana: “Gateway” Drugs

- Teens who use alcohol and tobacco at least once in past month - 30 times likelier to smoke marijuana
- Teens who use alcohol, tobacco and marijuana at least once in past month - 17 times likelier to use harder drugs

Marijuana

- Has high addictive potential by overactivating endocannabinoid system, but not as high physical dependency effects. Can cause:
 - Mental impairments; high association of mental health problems with addiction
 - Immune system weakening
 - Hallucinations
 - Depression and anxiety
 - Nausea/Vomiting
 - Dry mouth
 - Dizziness
 - Numbness
- Passes through the placenta & causes fetal growth retardation
- Can be a direct trigger for schizophrenia onset among those already at risk for psychosis with family mental health history

Teens & Marijuana Problems

Adolescents who smoke marijuana are at enhanced risk of adverse health/psychosocial consequences, including:

- sexually transmitted diseases and pregnancy,
- early school dropout,
- delinquency,
- legal problems,
- lowered educational & occupational aspirations & achievements.

About 50% of those entering treatment for marijuana are under 25 y/o, have used on average for 10 years with daily use at time of entry, and an average of 6 cessation attempts.

Cannabis dependence is twice as prevalent as any other psychoactive substance in the US – about 4.3% in 1994 (because so many people use it)

Marijuana Edibles: New Problem for Teens and Children



Marijuana Edible RISKS

- **Risks:**
- Legal Retail Store Sales for 21 y/o+ in CO, WA, AK, OR but transported to other states
- One product may contain 4x THC “safe” dose
- Takes up to 4 hours for effects to be felt (unlike smoking) so overdoses more likely
- Variable quantity per product
- No federal agency oversight because not legal
- Increases likely use by children & teens

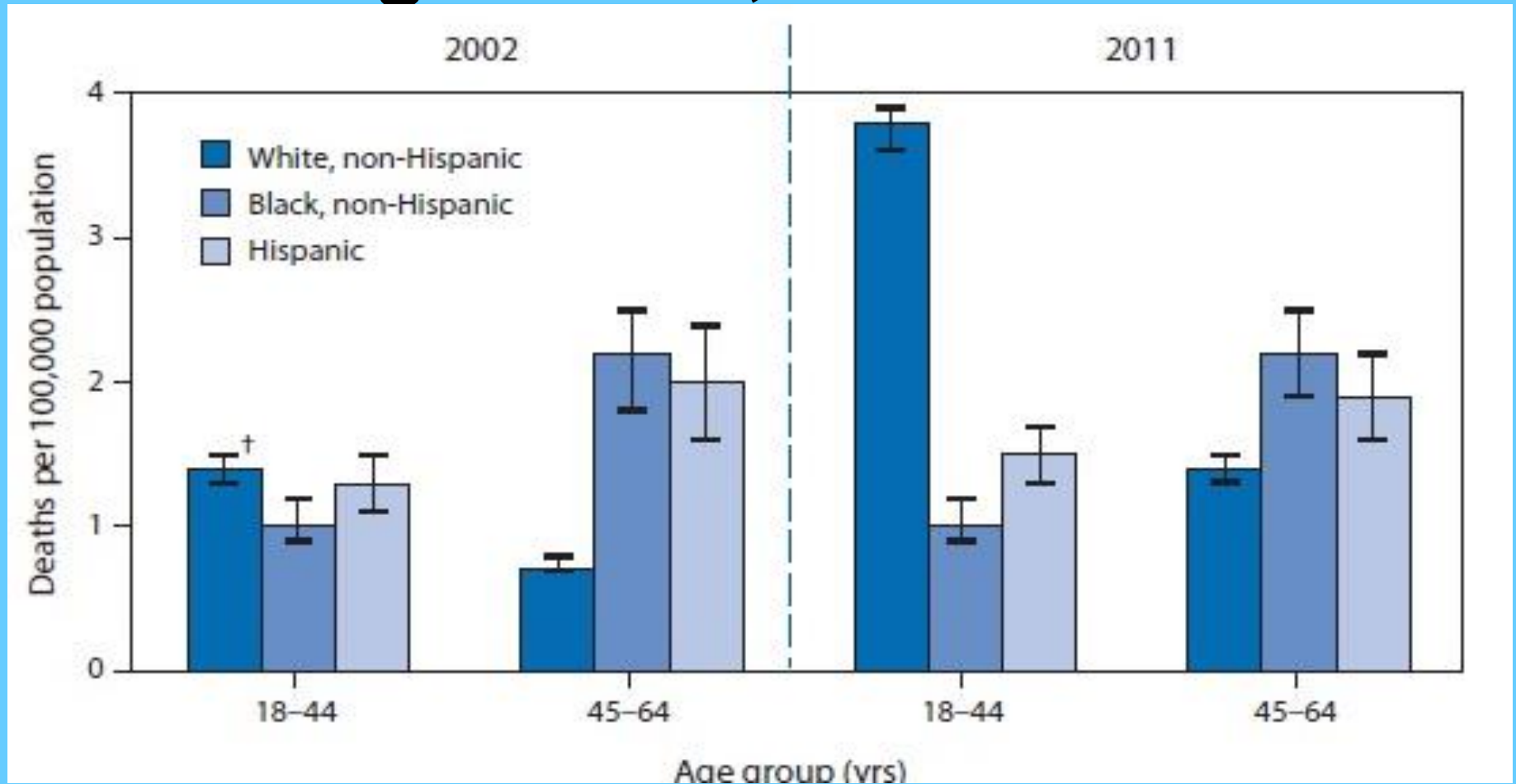
Bath Salts & Spice

- New synthetic drugs containing chemicals related to cathinone; like amphetamine
- Ivory wave, Bloom, Cloud Nine, Lunar wave, Vanilla Sky, White Lightning
- Can have effects like Ecstasy (sociability, libido increase)
- Paranoia, agitation, hallucinations, violence, panic attacks
- Abuse potential similar to methamphetamine
- K2, Fake Weed, Yucatan Fire, Skunk, Moon rocks
- Attach to same receptors as THC; smoked or ingested
- Poison control center increase: elevated heart rate, vomiting, agitation, confusion, hallucinations, cardiac arrest
- Some heavy metal residues and varying chemicals

Anabolic Steroids

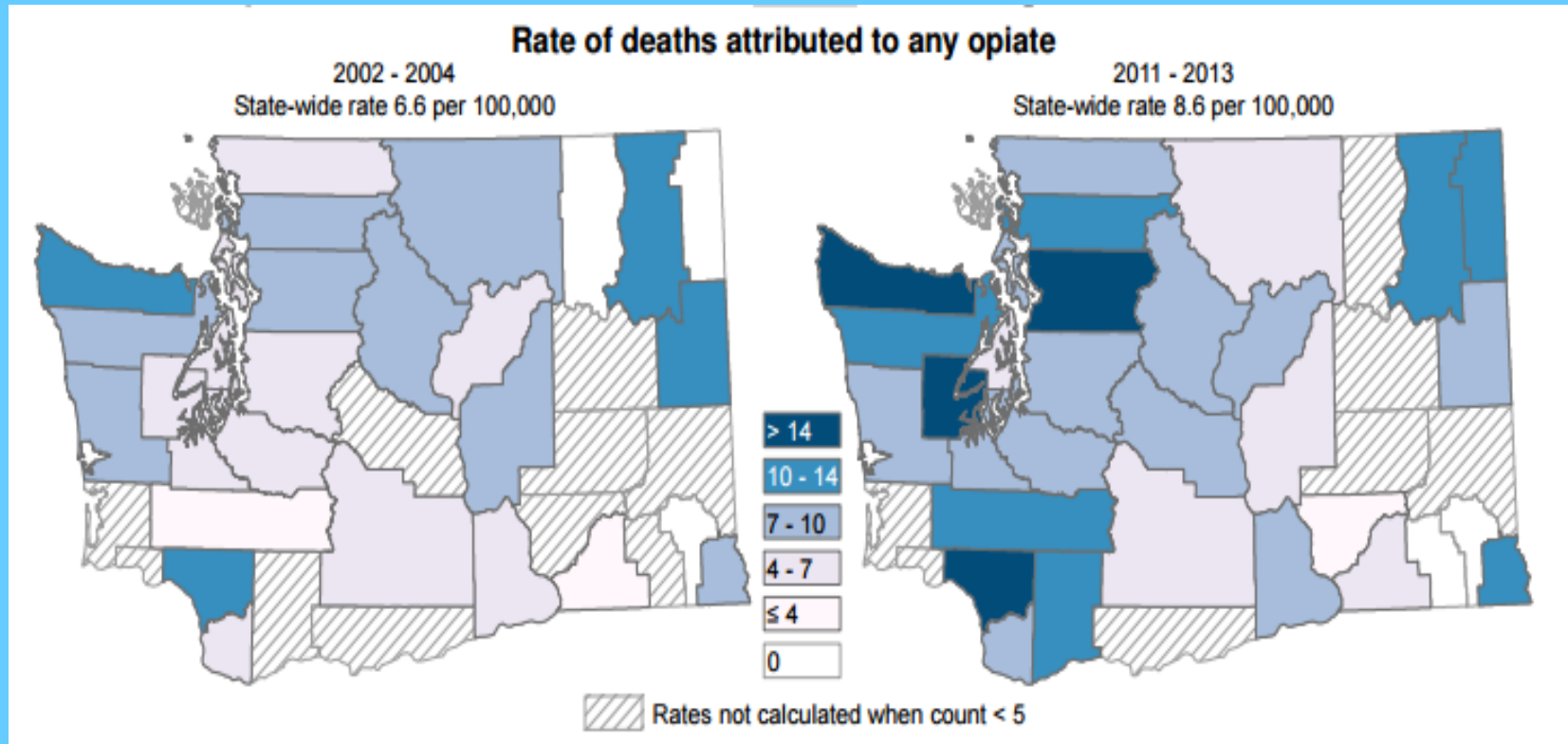
- Generally elevated mood, but also extreme mood swings, manic like behavior that can be violent
- Act on limbic system that influences mood
- Can include irritability, life-threatening depression, when drugs are reduced or stopped
- Impaired judgment, generated by feelings of invincibility
- Most dangerous consequences include impaired kidney function; liver damage, cardiac enlargement, increased stroke and cardiac attack risk due to blood cholesterol changes and elevated blood pressure

US Rates of Heroin-related Drug Deaths, 2002 & 2011

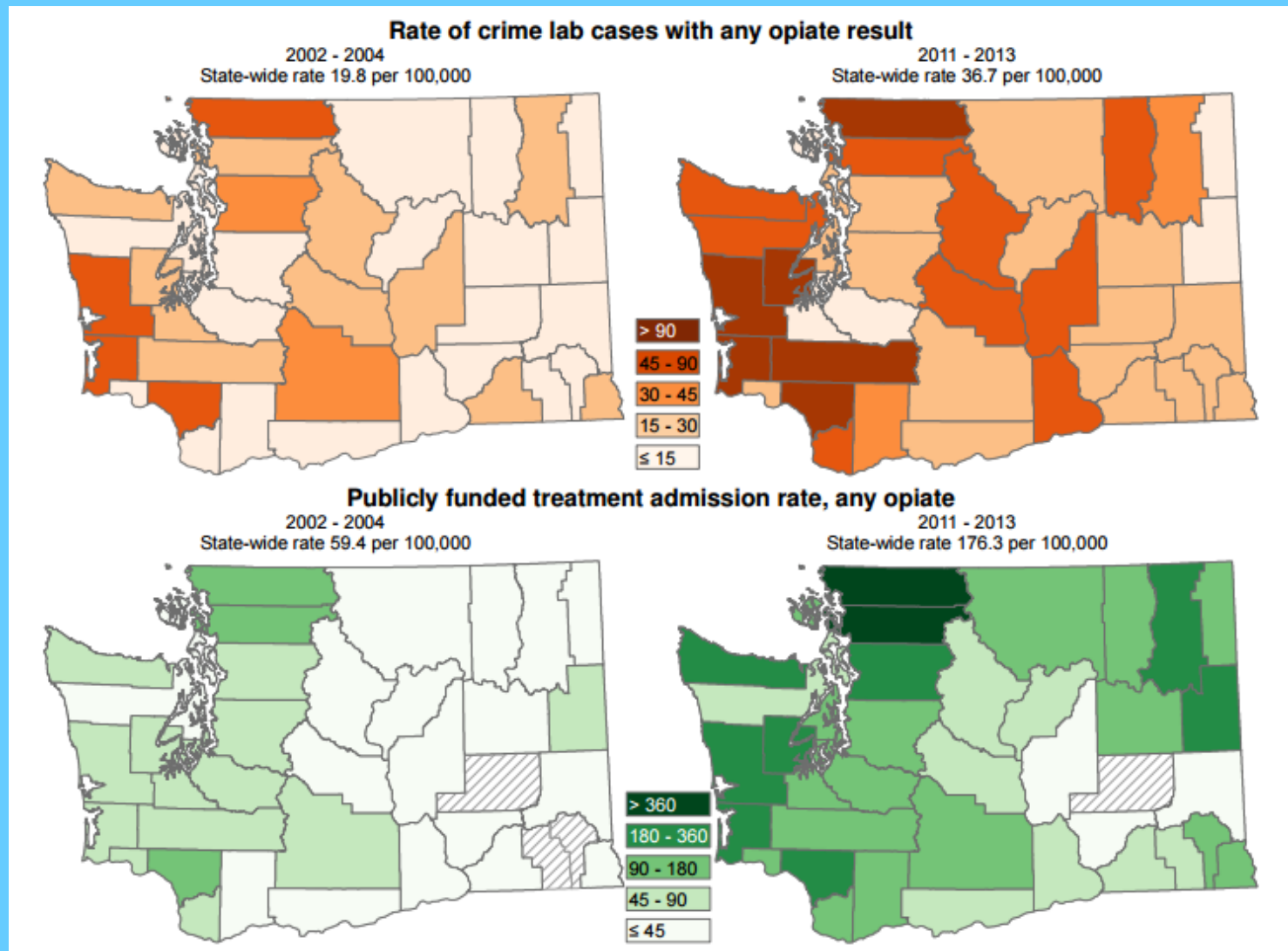


The rates for both age groups of Hispanics and non-Hispanic blacks did not significantly change during the decade.

30.9% overall increase in annual death rate due to opiates Between 2002-04 and 2011-13

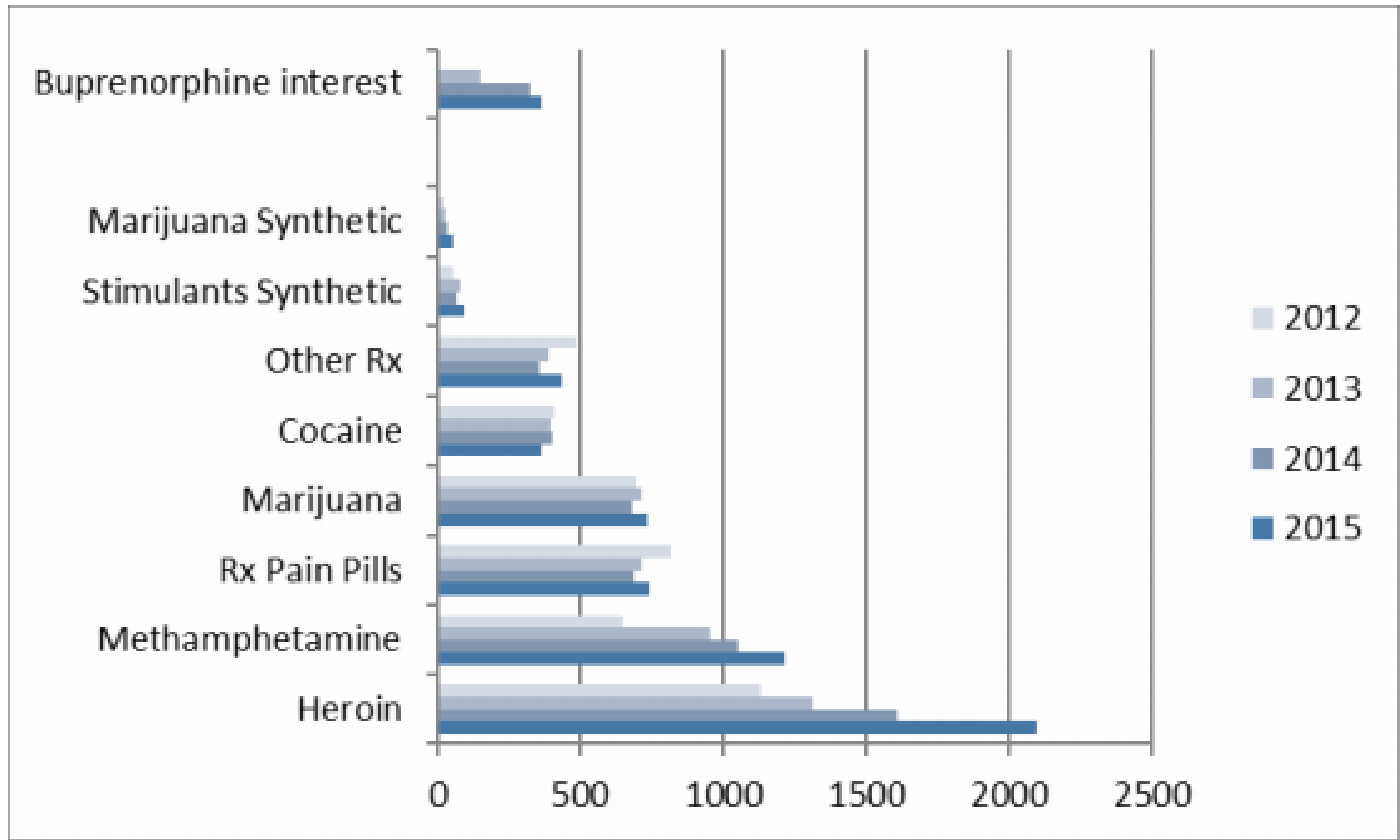


From ADAI-IB 2015-01; UW Alcohol & Drug Abuse Institute April 2015

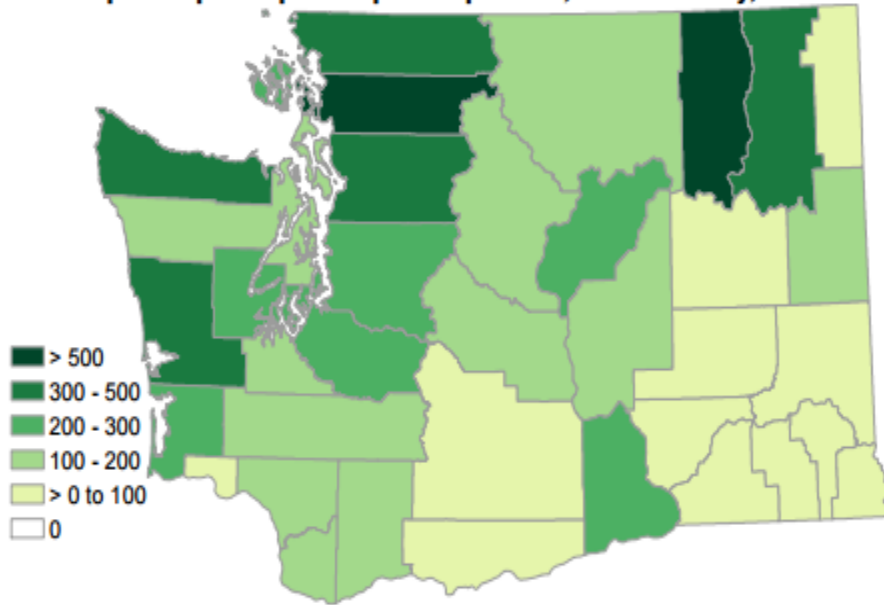


85% Increase in opiates present in crime lab tests
 197% Increase in publicly funded treatment admission rate for opiates

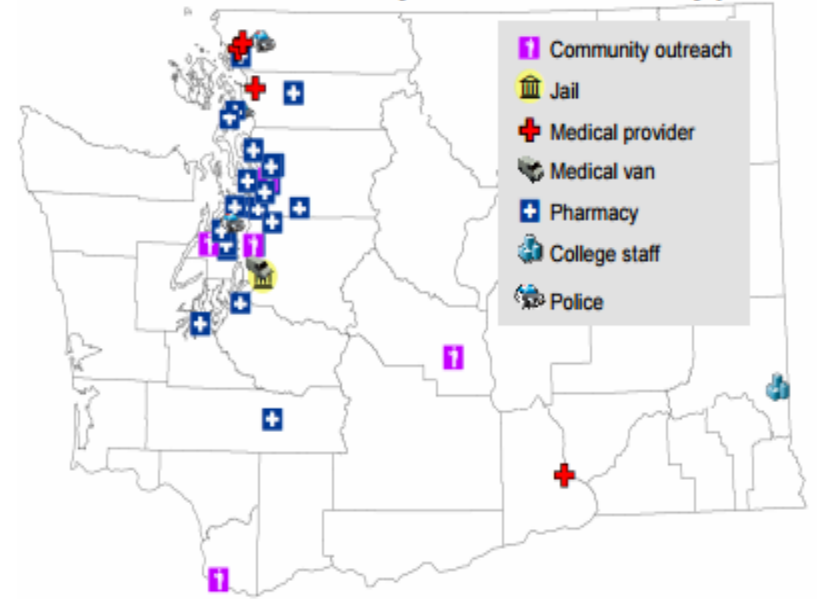
Figure 1. Calls to the Recovery Helpline from King County Residents



Buprenorphine prescriptions per 100,000 in county, 2013



Naloxone distributed to bystanders or carried by police



2013: 15,042 Buprenorphine prescriptions written by 300 out of 500+ physicians authorized to prescribe

2013: 25 Naloxone distribution sites – increasing availability

Opioid Use & Deaths

- 2 distinct but intertwined trends are driving America's overdose epidemic:
 - a 15-year increase in deaths from prescription opioid pain reliever overdoses as a result of misuse and abuse, and
 - a recent surge in illicit drug overdoses driven mainly by heroin
 - Both of these trends worsened in 2014 resulting in more than 47,000 overdose deaths with 10,574 attributable to heroin (opiate) & most others to opioid overdoses
 - Many of these involve illicitly-made fentanyl, a short-acting opioid, that is 50-100x more potent than morphine, often in combination with heroin

Prescription Medications

In 2012 accounted for more deaths than from cocaine & heroin combined

- Abuse increasing;
2000 12-18 y/o p/day
- Cough & cold meds
are most commonly
abused OTCs
(dextromethorphan)
- DXM's similar to
ketamine & PCP
(dissociative) affecting
memory, feelings,
thoughts
- Opioids act on same
sites as heroin
- Overdose deaths
typically are from
polypharmacy – esp
alcohol and opioids
- Risk of stopping
abruptly, not only
withdrawal but other
neurologic &
physiologic symptoms

Methamphetamine Still Poses Threat to Children, Families, & Communities

- Intense, “private” drug culture, characterized by paranoia, irritability, & violence
- Home-based manufacture (“meth labs”) is dangerous BUT decreasing dramatically in prevalence
- DEC (drug endangered children) programs are an important multi-disciplinary approach

CLANDESTINE METH LABS:

Chemical Types & Exposure Outcomes

- Solvents (toluene, xylene, methanol, etc)
- “Meth”, ephedrine, & other stimulant intermediates
- Acids & alkalis (hydriotic & hydrochloric acids, lye) -- burns & internal burns
- Phosphorous, iodine, heavy metals
- Cancer
- Neurotoxicity
- Developmental Toxicity
- Reproductive Toxicity
- Specific Organ Damage
- Acute vs. Chronic

Meth Production

Methamphetamine Synthesis

COOKING

Ephedrine
Hydriodic Acid
Red Phosphorus

Heat

Meth HI
in Hydriodic Acid
Red Phosphorus
"Soup"

Filter

Red Phosphorus "Sludge"
Meth HI in Hydriodic Acid

BASIFICATION / EXTRACTION

Meth HI
in Hydriodic Acid

Sodium Hydroxide

Meth Base Layer
over
Aqueous Layer

Separate

Aqueous Waste
Meth Base

CRYSTALLIZATION

Meth Base

Solvent
HCL

Meth HCL
in
Solvent

Filter

Solvent Waste
Meth HCL Crystals

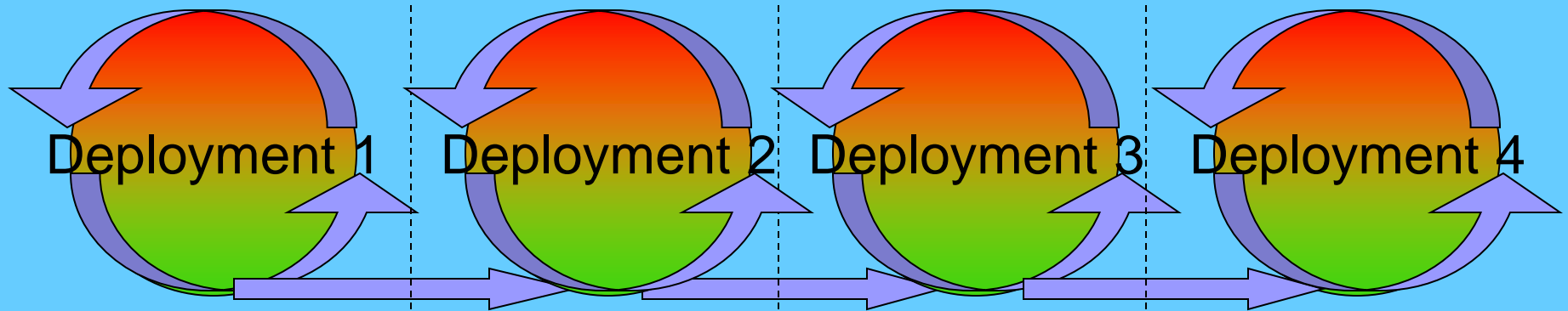
AOD Treatment Protocol Revision Needed due to Significant Overlap of Traumatic Experience & Substance Abuse

- Trauma-related substance abuse treatment protocols must ensure that safety and protection are provided to participants (similar to protocols for children exposed to domestic violence, and physical or sexual abuse)
- Improved understanding of neurobiology suggests that acquisition of safety/security also engages brain “reward centers”
- Relapse prevention strategies for substance abuse must be broadened to include management of trauma and loss reminders, as well as substance abuse triggers

New Population at Risk for Substance Abuse related to Trauma Exposure: Military Service Members, Families & Children

- Parents' wartime deployments have affected an estimated 2 million-plus children since 2002
- Over 44% of US service members are parents
- More than 50,000 military families include two active duty parents
- Preliminary data shows increased marriage and births among military personnel = many new young military families & many blended families
- High rates of prescribed medications for physical pain and psychotropics for military and veteran mental injuries; high risk of complications: additional self-medication & alcohol

Deployment Spiral and Children



Increasing rates of child maltreatment (42% higher during deployments; doubled between '02 and '07 among military families)

Increasing rates of IPV/DV in military/newly veteran families

Deployment Spiral credit to NMFA

Graphics to FOCUS Project



Post-Traumatic Stress

A Newly Recognized Problem: Traumatic Brain Injury (TBI)

- Known as the “signature injury” of OEF/OIF (& even OND), the incidence of various types of TBI may be as high as 50% for combat-exposed troops
- Explosion-related injuries account for 81% of all OEF/OIF injuries
- Emotional regulation problems with anger, anxiety, impulse control, interpretation of communication with others
- Cognitive problems with memory and concentration
- Effects of concussions and "mild" TBI are not immediately apparent and can have long-term sequelae

MTBI = Increased Risk for Addiction

- Within first 30 days, the hazard ratio for drug dependence is 7.7; for Opioid dependence is 6.1; for amphetamine is 4.8; for alcohol is 3.5
- All hazard ratios EXCEPT for ALCOHOL & Opioid Dependence/Abuse decrease over time
- ETOH, drug, nicotine, caffeine, and nondependent abuse of drugs/ETOH were all elevated in 1-30 days; ALCOHOL persisted
- TBI survivors are known to have blunted dopamine systems -

Example Psychiatric Formulary for Deployment

from *Combat & Operational Behavioral Health, Textbooks of Military Medicine*.
Office of the Surgeon General, US Army. 2011

Medications	
Antidepressants/Antianxiety:	Citalopram 20mg, Sertraline 100mg, Prozac 10mg, Paroxetine 20mg, Venlafaxine XR 37.5mg, Venlafaxine XR 150mg, Bupropion XL150 mg, Bupropion XL 75mg, Mirtazapine 20mg
Benzodiazepines	Lorazepam 1 mg tabs, Clonazepam 1 mg tabs, Lorazepam 2 mg injectable
Antipsychotics/Antimanic	Risperidone 1 mg tabs, Quetiapine 100 mg tabs, Olanzapine 5 mg tabs, Haloperidol injectable
Sleep Medications	Trazodone 100mg tabs, Zolpidem 10mg tabs
Adrenergic Agents	Clonidine 0.1mg tabs (for startle, flashbacks in PTSD), Prazosin 1mg tabs (better for nightmares in PTSD), Propranolol 20mg tabs
ADHD Medications	Atomoxetine 20 mg tabs, Methylphenidate or Dexedrine (may want to combine long-/short acting forms)

Part II:

What to do to ethically and effectively implement ASFA

*“If a community values its children,
it must cherish their parents.”*

Bowlby, 1951

**Juvenile/Family Court
Judges Have Unique &
Powerful Role of
Convening Community
& Its Resources**

ADDICTION: MULTI- “SYSTEM” DISEASE

- JUVENILE DEPENDENCY COURT
- FAMILY COURT
- CRIMINAL COURT
- PROBATION/PAROLE
- JUVENILE DELINQUENCY COURT
- **PROBLEM:** *LACK OF CO-CALENDARING & COORDINATED COURT ORDERS & CASE PLANS*
- (Child Welfare, TANF/Work Issues, AOD Tx, Mental Health, Housing, Education – also often involved)

Four “Clocks” Guiding Work with Drug Affected Families

TANF

Limited funding
& Services
(5 yr maximum)

ASFA

**If 15 of last 22 mo in
FC, must move to TPR**

In many states earlier

TPR possible:

6 mo, if under 3,

12 mo, if over 3 y/o

DRUG RECOVERY

Minimum 4-6 mo

9-12 mo usual

+ LT aftercare

CHILD

DEVELOPMENT

Variable

Making Therapeutic Alliances with Parents Makes a Difference

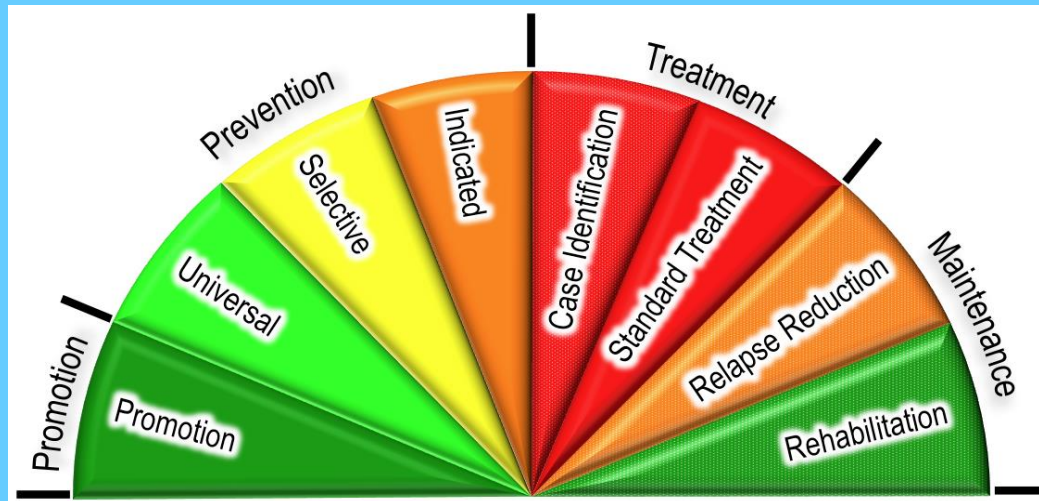
CUSTODY Site	Family Drug Treatment Court	Regular Family Court
Biological Parent(s)	56%	36%
Kinship Care	29%	21%
Foster Care	15%	37%
Institutional Care	0%	6%

Indicated Public Health Interventions

Institute of Medicine (IOM) Taxonomy for Mental Health Interventions
(Mrazek & Haggerty, 1994)

Prevention Interventions:

Target populations with no or subclinical symptoms



Treatment Interventions:

Target populations with diagnosable mental disorders

Three Levels of Prevention Interventions

Universal	Selective	Indicated
Everyone in a population (before or after exposure)	Subgroups of the population at heightened risk (e.g., deployed units)	Individuals identified to be suffering subclinical distress or impairment

Best bang for the buck*

*Feldner, Monson, & Friedman, 2007;
Adapted by Nash & Westphal

Continuum of Alcohol & Drugs in our Families & Community – & Continuum of RESPONSE

- 1) Non-use, Selective Abstinence
 - 2) Experimental Use, Initial Use
 - 3) Responsible Use, “At Risk” Use
 - 4) Situational/Crises, or Binge Use/Abuse
 - 5) Unhealthy Use, Chronic Abuse
 - 6) Chemical Dependency/Addiction
 - 7) Recovery & Relapse
 - 8) “In Recovery”
- 1 & 2) Enhance Protective Factors, Reduce Risk Factors, Provide Prevention/Education
 - 3) Add Early Intervention as needed
 - 4) Add Treatment
 - 5 & 6) Add relapse prevention, trigger cues, trauma reminders as indicated
 - 7 & 8) Add Aftercare, Continuing Care, Boosters

Risk & Protective Factor Domains

Risk Factors <i>(potential problem)</i>	Domain	Protective Factors <i>(potential antidote)</i>
Early Aggressive Behavior	Individual	Self-Control <i>(emotional regulation skill building)</i>
Lack of Parental Supervision	Family	Parental Monitoring <i>(communication skills)</i>
Substance Abuse	Peer	Academic Competence <i>(goal setting & problem solving skills)</i>
Drug Availability	School	Anti-drug Use Policies
Poverty	Community	Strong Neighborhood Attachment

Crossover Youth:

“Indicated” target population

- Dual status children - in both delinquency & dependency systems: est 29% of CW cases also have juvenile justice cases
- 96-98%: youths lack suitable home/family to go to while on or having completed probation
- 95-98%: youths' parents have SUDs
- 87-93%: youths' parents have mental health problems

TREATMENT DEMANDS

- Screening & Initial Assessment (use ASAM criteria) *preferably occurs at court*
- Appropriate Referral (schedule intake appt. within 24 hours) @ Good Quality Tx Pgm
- Continuum of Services (ie: detox, residential, intensive day tx, outpatient, aftercare)
- Allow “Pre-treatment” services
- Use Medication Assisted Treatment, if possible

Medication Assisted Treatment (MAT) is Recommended

Why?

Because SUDs are chronic, potentially fatal, brain diseases, and medications are available for opiate/opioid addictions!

–Similar to treatment of hypertension or Type 2 Diabetes

•Medications + psychosocial treatment saves & restore lives

USE SPECIFICALLY FOR:

- Intoxication/overdose
- Withdrawal/detoxification
- Abstinence initiation/use reduction
- Relapse prevention
- SUDS sequelae (psychosis, agitation, etc.)

Substances for which Medications are FDA-approved

- Opioids
- Alcohol
- Benzodiazepines
- Tobacco (nicotine dependence)

Substances for which Medications are NOT FDA-approved

- Cocaine
- Methamphetamine
- Hallucinogens
- Cannabis
- Solvents/Inhalants

FDA Approved Medications for SUDs

- **Alcohol use disorder:**

- *Naltrexone* (Revia®, Vivitrol®) – MUST be detoxed before starting; benzodiazepines generally used to support alcohol detox
- *Disulfiram* (Antabuse®)
- *Acamprosate* (Campral®) -helps maintain sobriety among sober

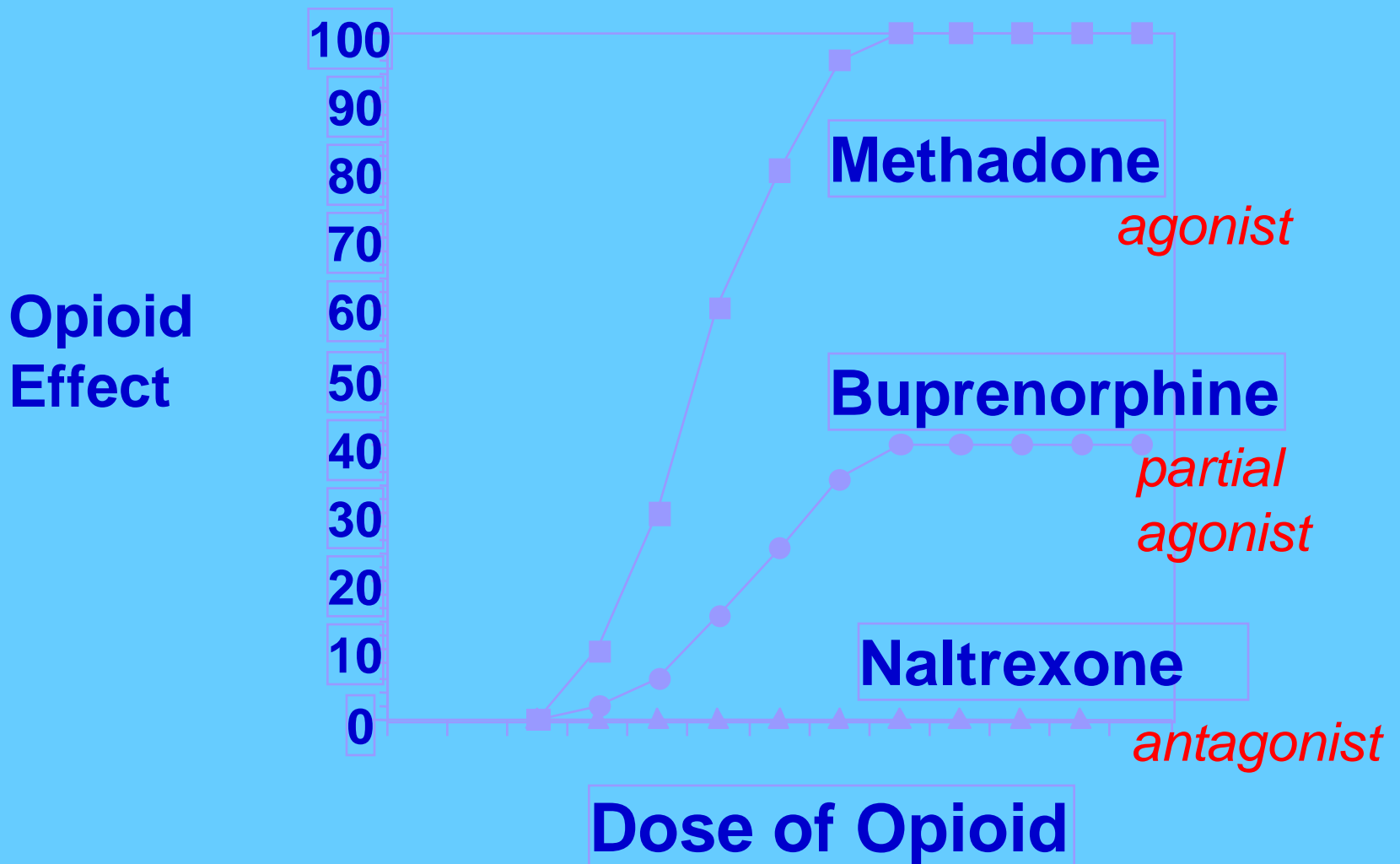
- **Opioid use disorder:**

- *Buprenorphine/naloxone* (Suboxone®) - used to treat/prevent withdrawal and block opiate receptors; has long half-life so is much less addictive; but can cause WD
- *Methadone*
- *Naltrexone* (Vivitrol®) – opiate blocker - must be detoxed for 7-10 days before starting; stops craving & causes no WD

- **Opioid overdose:**

- *Naloxone* (Evzio®, Narcan) blocks opiate receptors; reverse overdose

What is the Difference between Opioid Agonists & Antagonists?



MAT for Opioid Use Disorders

Methadone and buprenorphine are first-line treatment for opioid use disorders

- Methadone better for treatment retention
- Buprenorphine/naloxone more widely available
- Both opioid agonist therapy (OAT) medications consistently and significantly improve outcome versus placebo, no treatment, or oral naltrexone

Extended-release Injectable Naltrexone

- Superior to placebo in double-blind, RCT(trial)
- Further research needed to directly compare to OAT

Due to poor efficacy of psychosocial interventions alone and high mortality associated with opioid overdose, **psychosocial interventions alone are not recommended for opioid use disorders.**

Oral Naltrexone Use in treatment of Alcohol Dependence

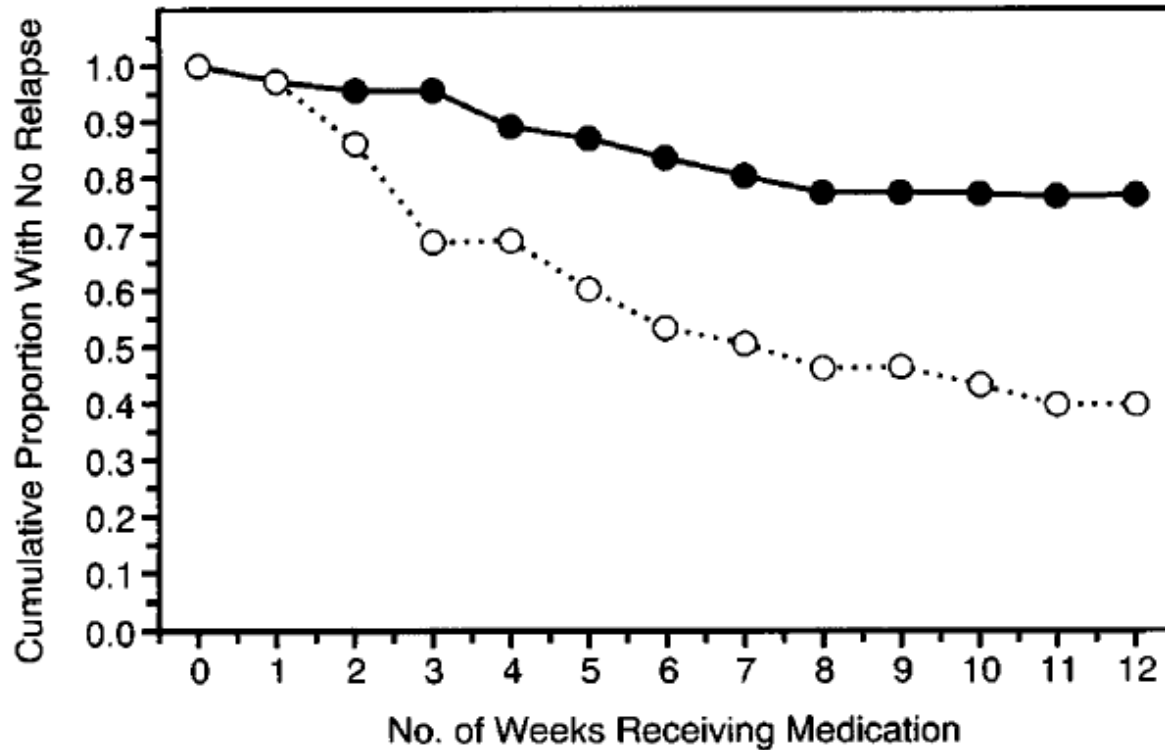
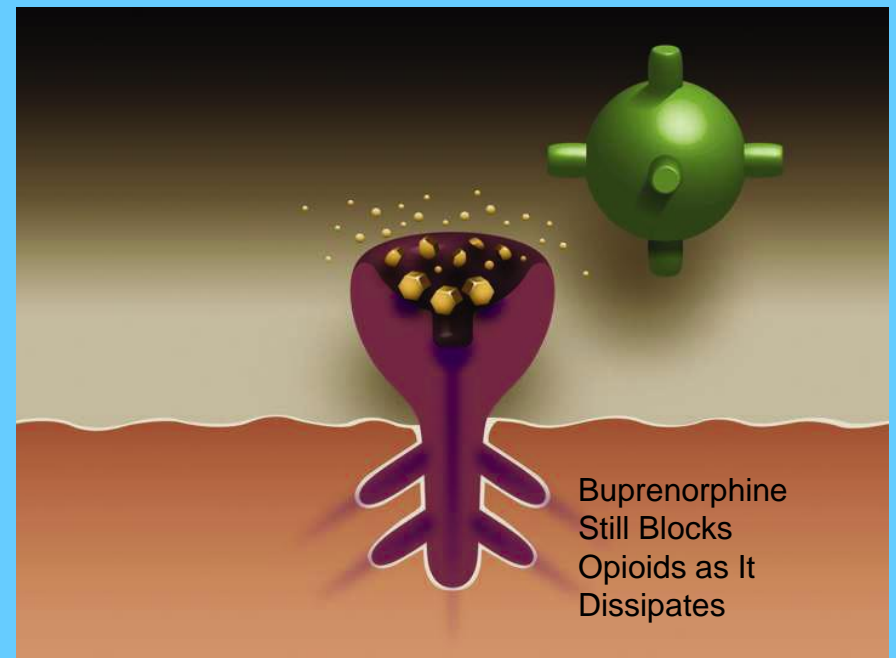
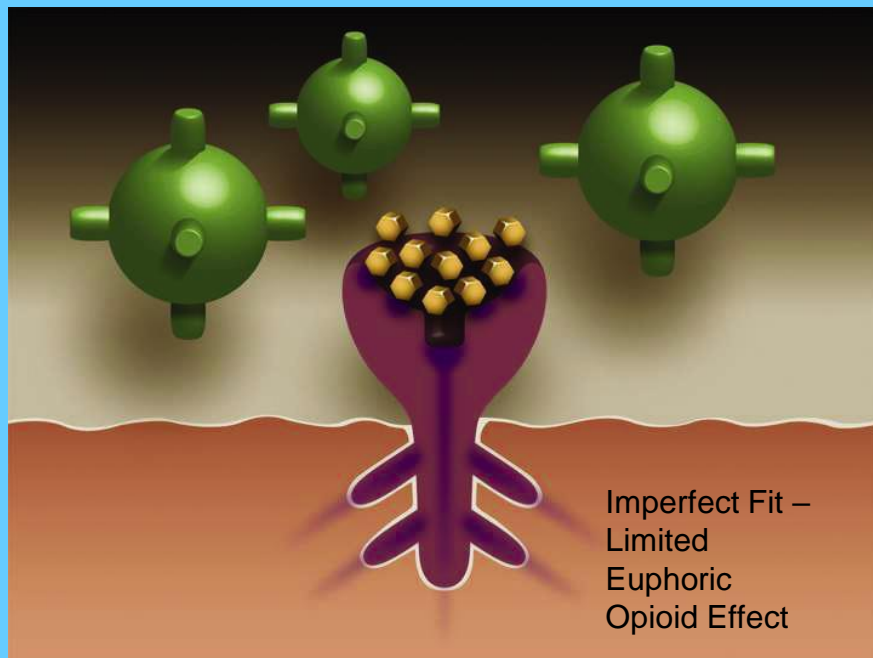
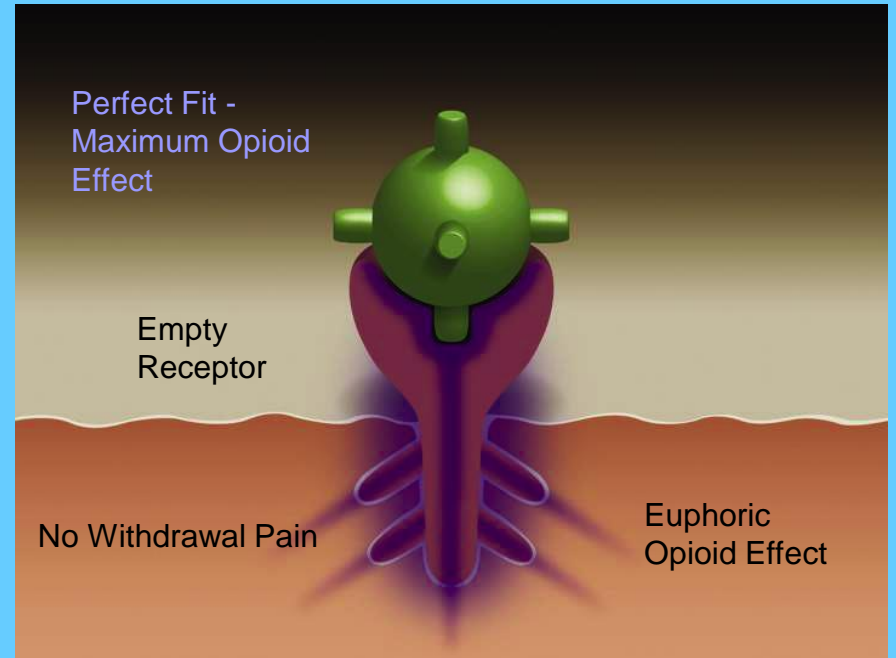
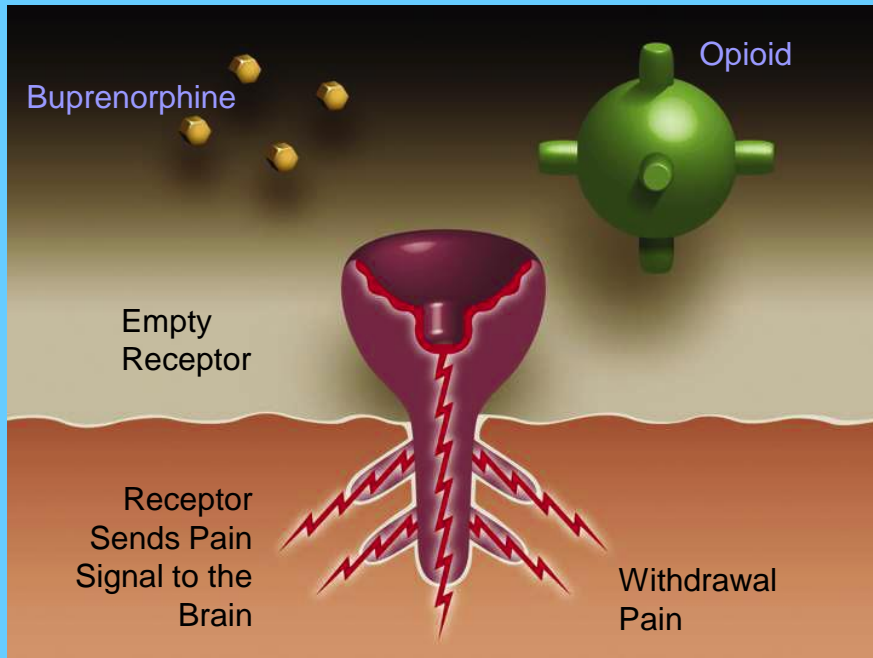


Fig 2.—Relapse rates (as defined in the text) for the naltrexone hydrochloride- (closed circles) and placebo-treated (open circles) groups across the 12 weeks of the study.



Advantage of Buprenorphine: Office or Pharmacy-based Treatment Settings



John Doe Health Clinic
 John Doe, M.D.
 LIC #: 12345678A • DEA #: AB1234567
 NPI #: 12345678B
 200 Riverside Industrial Parkway
 Portland, ME 04103
 Tel: (207) 307-7717 • Fax: (207) 893-0177

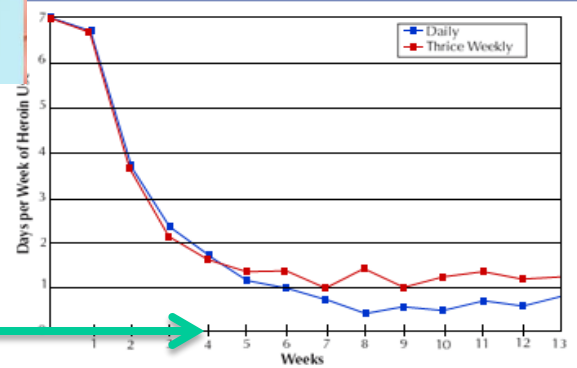
Name: _____ DOB: _____
 Address: _____ Date: _____
R
 Label
 Refill: _____ times PRN NR
 _____ M.D. _____ M.D.
 Product Selection Permitted Dispense as Written

SCRIPT# 1000

SAFETY FEATURES: COLORED VOID BACKGROUND, MICROPRINT LINES, IMPRINT EMBOSS PROTECTION, REVERSE IN DROP OFF, THERMOCHROMIC INK • ON BACK, ARTIFICIAL WATERMARK, COIN REACTIVE INK

- Medical office visit
- Retail pharmacy
- Chronic treatment

Daily or Thrice-Weekly Buprenorphine Doses Yield Similar Declines in Days of Drug Use



Patients in treatment for opioid addiction received either daily or thrice-weekly doses of buprenorphine. Both groups showed reductions in reported days of heroin use during a 13-week treatment program.

ALCOHOL MAT

- Extended release injection of Naltrexone associated with reduced mortality & hospital readmissions for alcohol dependence
- Overall, alcohol MAT improves outcomes at small to moderate rate
- None is consistently better than another depending on individual's case
- All clients do better when supervised and with counseling

When to Consider Medications for SUDs

Ensure case client is assessed for:

- Severity of Concomitant Medical Illness: Patient's ability to tolerate medication?
- Pregnancy: opioid therapy should be offered to pregnant opioid/heroin addicts; medications that can be associated with adverse physical effects should be avoided (e.g. naltrexone, disulfiram (Antabuse))
- Phase of Recovery: Medications for medical withdrawal or medication to assist with maintenance of abstinence following withdrawal

ASSESSMENT: Special Note

- **Employ Cultural Sensitivity**
- **Use standardized Tool; ie: Addiction Severity Index (ASI):**
- **Use standardized Placement Criteria; ie: American Society of Addiction Medicine (ASAM) Placement Criteria**
- **Ensure (& Monitor) Ongoing and Re-assessment & Commensurate Case Plan Adjustment (FDTCs: good idea!)**

TREATMENT DEMANDS CONTINUED

- Relapse Prevention Planning
(MUST be built-into Tx & After-Care Programming from beginning)
- Re-assessment & Case Plan Adjustment
- Integrated/Wraparound Services that feature *Habilitation; not only Rehabilitation*

Principles of Effective Treatment

per National Institute on Drug Abuse (NIDA)

- No single treatment is appropriate for all (***Screening and Assessment***)
- Appropriate treatment must be readily available (***Timely Placement***)
- Effective treatment attends to multiple needs; not just drug abuse (***Case Management /Wrap-around services /"Habilitation"- not just Re-hab***)
- Treatment plans must continually be re-assessed (***Assessment/Tx Adjustment***)
- Possible drug use during Tx must be monitored (***Random Drug Testing***)
- Recovery is long-term process & may require multiple Tx episodes (***Opportunity to Succeed***)



Principles of Effective Treatment

per NIDA

- Adequate time in Treatment is critical (***Appropriate Placement/Retention***)
- Counseling & other behavioral therapies are critical for all (***GOOD Tx***)
- Medications are critical element for some (***Medical & Psychiatric Care***)
- Dually diagnosed clients must be treated jointly (***Coordinated Services/Case Management***)
- Tx does NOT need to be voluntary to be effective (***Court Ordered/Drug Court***)
- Relapse is often part of recovery (***Relapse Prevention Planning/Aftercare***)



MAT Implementation Checklist

http://www.integration.samhsa.gov/clinical-practice/mat/MAT_Implementation_Checklist_FINAL.pdf

Assess The Treatment Environment	
● Which treatment programs in your state/area currently use medications in the treatment of addictions?	
● If there are no programs in your state/area using medications in addiction treatment, why not?	● Are there attitudinal problems?
	● Are there Medication cost concerns?
	● Are there Implementation cost concerns?
	● Are there state regulations and policy barriers?
● Who will provide the leadership to address these barriers?	● How do you plan to assess which treatment programs are most likely to work with you (i.e., early adopters) to adopt medication assisted treatment?
● For treatment programs that use medications, how do you access physicians? Are they:	● Full or part-time staff members?
	● Contracted?
	● Affiliated with a primary care clinic?
	● Affiliated with or embedded in a health center/FQHC?
● Do health centers and other providers have an appropriately trained integrated care team available?	
● Are any treatment programs co-located with health centers? If so, where are they specifically located? If there are none, what do you need to do to have medical care and behavioral health care provided on the same site?	
● What can you do to support the development of networks of treatment providers that include both primary care providers and addiction treatment programs?	
● Are there any comprehensive treatment programs in your state that include primary care within an addictions treatment program? Is the primary care program co-located and under different management or part of the addictions treatment program? How can these different organizational structures serve as models for other addictions treatment programs?	
● How will you work with medical and non-medical clinicians to assure that counseling services accompany use of medications in addictions treatment?	

Implementation:

Which medications to use? For which patient?

Use the MAT CHECKLIST to Determine:

- Is there a methadone provider in the county?
- Is there a buprenorphine provider? Reimbursement?
- Is there coverage/reimbursement for selected medication?
- What is the patient motivated for?

- *...any type/choice of MAT is likely to be more effective than none*
- To date, no well-defined criteria **dictate** which medication should be used for which patient.
- A specific assessment must be done with each patient.

**In Juvenile Court Context
Parent's Treatment Plan **MUST ALWAYS**
be Designed with Clear Implications for Child(ren)
& Parent-Child Relationship in Mind**



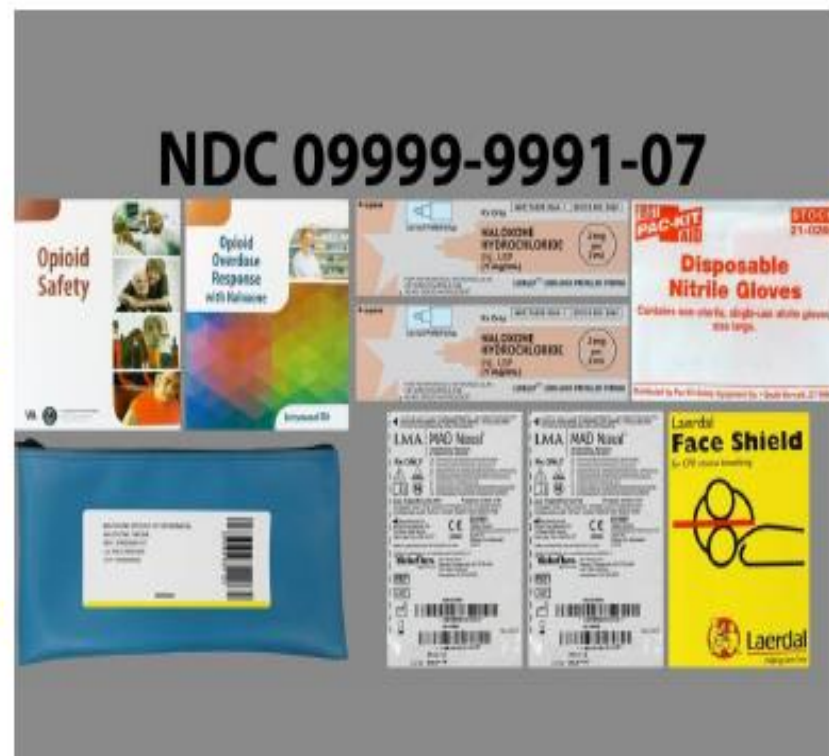
- Parent's Case Plan **MUST** Incorporate Child-Parent Relationship Issues Throughout
- Child's Case Plan & Implementation Requires Close Attention & Should Include Parent – whenever possible

Naloxone Rescue Kit Contents

Naloxone Rescue Kit IM

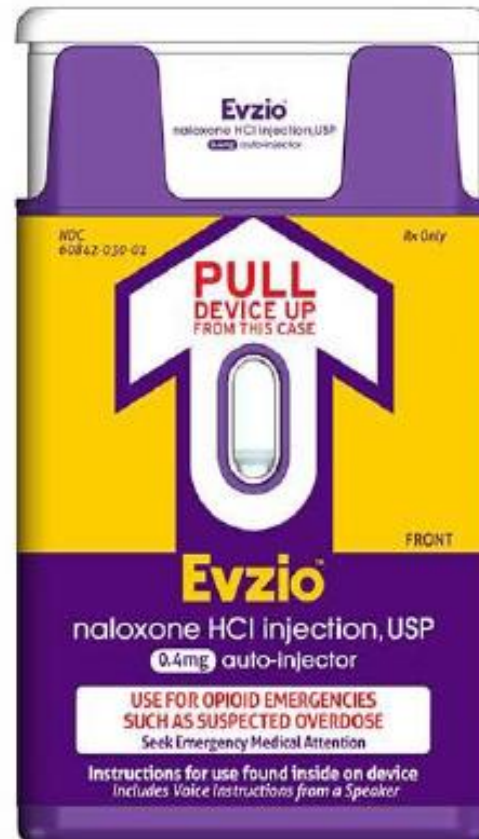


Naloxone Rescue Kit Nasal



Naloxone auto-injector (IM or SC) fast-tracked by the FDA for emergency treatment of opioid overdose for administration by laypersons – (opioid blocker)

Evzio®



WHAT TO LOOK FOR in AOD Treatment Programs

- Acceptance Rate
- Comprehensive, Gender-Specific Services that Include Children in Case Plan
- Retention Rate
- Graduation Rate
- Duration & Quality of After-Care Services
 - Participation Rate
 - Sobriety Rate

Specific Ways to HELP:

Take Away Messages

- 1) STRENGTHEN & SUPPORT PARENT-CHILD RELATIONSHIPS** to prevent separation due to substance abuse
- 2) MAINTAIN PARENT-CHILD RELATIONSHIPS** during necessary separation (due to substance abuse issues or treatment needs)
- 3) REBUILD PARENT-CHILD RELATIONSHIPS** during re-unification and family re-integration

Family Maintenance and Reunification Services

- Counseling
- Parent education
- Child care training
- Anger management classes
- Day or Residential substance abuse TX
- Random drug toxicology testing
- Respite care
- Supervised visitation
- Transportation assistance

Reasonable Efforts to Strengthen or Reunify Family

- Family-centered drug TX services
- Specialized TX programs for women
- Intensive “family preservation” services (safety & stability issues)
- Counseling services
- DV services
- Out of home respite care
- Emergency housing
- Client transportation
- Parent skills training
- Peer group counseling and support
- Teaching homemaking skills
- Emergency \$ assistance
- Government aid programs

Weighing Reunification

- *Best Interest of Child*
 - child(ren)s' age(s),
 - parent/caregivers' drugs of choice,
 - support network in place,
 - relapse history & prevention plan,
 - parental insight,
 - past history.

Characteristics of a Good Case Plan

Simplicity

Specificity

Accountability

“Do-ability”*

*ASSESSMENT!!!!!!!!!!!!

Inability to Comply Is Different than “Non-Compliance”

Good Initial & Ongoing **Assessment**
Is Essential to Distinguishing Difference

Adequate Adoption Preparation & Support Services

- Services must be provided to:
 - Fost-Adopt Families (concurrent planning)
 - Foster children being placed for adoption, both pre- and post-adoption,
 - Post-Adoption Families (all members)
 - Post-termination parents* & family members

Findings from 5-year Follow-Up Court Study:

Ten dozen drug-abusing women were the mothers of 887 children under juvenile dependency court supervision in Los Angeles County (KW 1999).

--Even when/if TPR occurs, many parents may remain/return as CPS clients; Tx & health services must be available.

For Further Resources

- Go to www.samhsa.gov, www.nida.nih.gov, www.findtreatment.samsha.gov, www.csap.samhsa.gov, & (csat)
- Go to www.cwla.org or www.nacoa.org
- Call NCADI or access online at www.kap.samhsa.gov for FREE TIPs Series, & “Screening & Assessment for Family Engagement, Retention, and Recovery” DHHS Pub. No. (SMA) 07-4261. @ 800-729-6686 (eg: #33 “*Treatment for Stimulant Use Disorders*”, #42: “*Substance Abuse Treatment For Persons With Co-Occurring Disorders*”, etc.)
- HBO Addiction DVD (available for \$25 via SAMHSA, Amazon, etc.)
- Book: Strengthening Family Resilience, Froma Walsh, 2006.

For further information

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