SUBSTANCE USE

WORKBOOK FOR COMMUNITY HEALTH WORKERS

TEAM UP SCALING AND SUSTAINABILITY CENTER

TEAM UP SCALING & SUSTAINABILITY CENTER™

Acknowledgements

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TABLE OF CONTENTS

How to Use this Workbook

Goals for this Workbook

- TEAM UP Workbooks are designed to provide a framework for the CHW scope of practice within the TEAM UP Model™ and emphasize three core areas of work:
  - Engagement
  - Education
  - Care coordination
- Each workbook focuses on a developmental or behavioral concern and aligns with training content available in the TEAM UP CHW Foundational Training and the TEAM UP Virtual Learning Platform.
- CHWs can use this workbook to guide their work with patients and families.
- All tasks and activities outlined in this workbook can be coordinated between the CHW and other members of the integrated care team.
- CHWs should collaborate with others on the integrated care team on work outside of their scope.

Adapting this Workbook

- This workbook is meant as a guide and is intended to be adapted to suit each practice's needs while maintaining the CHW scope of practice as defined within the TEAM UP Model.
- Please maintain all acknowledgements to the TEAM UP Scaling and Sustainability Center as the originator of this workbook's content.

A Family Centered Approach to Healthcare

When communicating with and about people with mental health conditions, it is important to understand how they view themselves and to use inclusive language that respects their self-conceptions. Popularized in the 1970s and codified in the Americans with Disabilities Act, people-first language centers on an individual's personhood when describing their health condition. For example, using a people-first approach, a person diagnosed with autism would be referred to as *a person with autism* rather than an *autistic person*.

However, as social values evolve, so does the language surrounding mental health. Some individuals view their mental health condition as an integral part of their identity and prefer an identity-based approach. This perspective emphasizes the sense of belonging that comes from identifying with a community of people who share the same condition. Using this approach, a person diagnosed with autism might prefer to be called an *autistic person* rather than a *person with autism*.

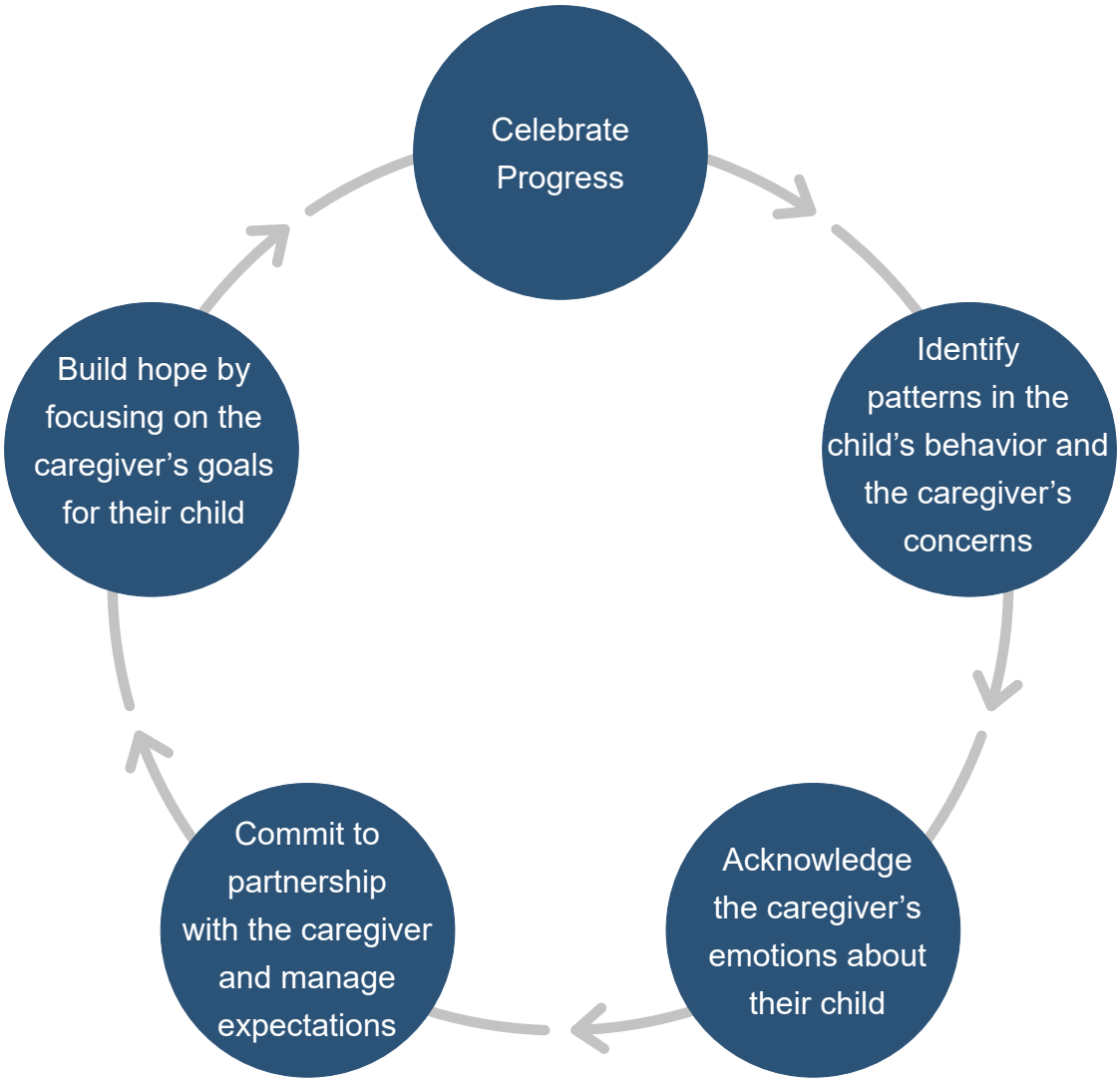
Given the diversity of perspectives on self-identity and language preferences, it is important to be thoughtful and respectful in communication about mental health conditions. While the TEAM UP Center is committed to using inclusive language that honors people's identities, it does not favor using people-first or identity-based language over the other. To be consistent in its content, this workbook uses people-first language to describe conditions impacting children.

Practitioners should equip themselves with knowledge about the range of ways that people identify, but the most direct way to honor preference is to elicit input from individuals themselves. Using a patient- and family-centered approach involves using the terms preferred by the person or people with whom you are working.

Working with Caregivers

When a child is diagnosed with substance use, or begins showing signs of substance use, caregivers may experience a wide range of emotions, including stress, confusion, and grief. It can be difficult to understand or accept, especially if the substance use was not previously apparent. Caregivers may have questions about why the use began, how it is affecting their child, and what the future may hold. They may feel overwhelmed by their child's behavior and uncertain about how to best support them. It is common for caregivers to feel unprepared and that they lack the skills or tools to support their child.

While substance use is often surrounded in shame and stigma, it is important to recognize that substance use is a health issue, not a moral failing. This is particularly relevant when working with patients whose cultural beliefs reinforce stigmas about substance use. It is important to approach children and caregivers with cultural humility and empathy while emphasizing a non-judgmental approach to care.



Core Symptoms

According to the American Academy of Child & Adolescent Psychiatry (AACAP, 2022), children can be exposed to substances from an early age. The average age at which children try marijuana for the first time is around 14, with alcohol use occurring before the age of 12 (AACAP, 2022). Adolescents may begin experimenting with substances for various reasons, including curiosity and social pressure to fit in. Peer influence can be particularly powerful during adolescence, often making risky behavior seem normal or even necessary to belong to a group (AACAP, 2022). While occasional experimentation may seem harmless, substance use can quickly become problematic, leading to issues with physical, cognitive, and emotional development.

Education is key to preventing adolescent substance use. Early detection and intervention can improve outcomes, and it is important for caregivers to recognize the early signs of substance use, which may include the following (AACAP, 2022):

- Changes in behavior
- Friends are using substances
- No longer engaging in activities
- Declining grades

Indication of problematic substance use includes (American Psychiatric Association, 2022):

- Consistent use in the last 12 months
- Using as coping mechanism
- Increased use
- Inability to cut down or stop use
- Great deal of time spent on obtaining, using or recovering from substance
- Interference with school, work and social relationships
- Continued use despite issues with school, work and social relationships

Risk and Protective Factors

Different risk and protective factors contribute to the development of and recovery from substance use. Early intervention, education about patterns of substance use and treatment, and consistent support can help a child recover from substance use.

Common risk factors that contribute to the development of substance use include (American Psychiatric Association, 2022):

- Family history of substance abuse and mood disorders
- Trauma
- Poor caregiver supervision

- Family conflict and harsh discipline
- Low academic achievement and aspirations
- Poor self-esteem Peer acceptance through substance use

Existing mental health conditions such as anxiety, depression, PTSD or ADHD

- Common protective factors include (AACAP, 2022):
- Setting and enforcing clear rules about substance use
- Family bonding (family activities, like eating dinner together)
- Talking about the dangers of alcohol and drug use
- Promoting academic success
- Involvement in community programs

Screening

Children are often first screened through general developmental screening tools like the Survey of Well-Being for Young Children (SWYC), which asks about child behavior, child development, and family questions, Ages and Stages Questionnaire (ASQ), or the Parents' Evaluation of Developmental Status (PEDS) (AAP, 2024).

U.S. Department of Health and Human Services (n.d.) recommends using screening tools, such as the CRAFFT, to assess potential problematic behavior and risk levels for substance use in youth ages 12-21. Information obtained from the CRAFFT can serve as the basis for early intervention and patient-centered interventions (U.S. Department of Health and Human Services, n.d.)

Interventions

Interventions for children commonly involve caregiver active participation, psychoeducation, developmental education and emotion regulation skills, behavioral management and coping strategies, and, when appropriate, directly addressing behavioral and mental health concerns in a safe therapeutic setting. Below are examples of commonly used interventions for children and families.

Outpatient (OP) Therapy

- OP therapy is a common and effective treatment approach for supporting children and families with behavioral health concerns. It is flexible and centers around the patient's and family's needs. Patients are also able to access substance specific therapy in addition or in place of traditional therapeutic services. Therapists are able to support the development of essential skills, such as coping, caregiving strategies, and behavioral plans, to increase and stabilize the patient's ability to function and succeed in the home and other settings.

Children's Behavioral Health Initiative (CBHI)

- CBHI provides children and their families with integrated behavioral health services and a comprehensive, community-based system of care. Services under CBHI include, but are not limited to, intensive care coordination (ICC), in-home therapy (IHT), therapeutic mentors (TM), and in-home behavioral services (IHBS) (Children's Behavioral Health Initiative, 2015).
- While all the CBHI services provide support for children and their families, IHT may be particularly helpful for children with substance use. In IHT, a team works with the child and family to create a treatment plan that targets specific challenges that interfere with everyday life (Children's Behavioral Health Initiative, 2015).

Partial Hospitalization Program (PHP)

PHP is a short-term intensive day program that provides diagnostic and clinical treatment, which includes group and individual treatment. Patients typically attend during school hours, however there are programs that are offered after school hours. Many PHPs are dual diagnosis focused, supporting children with co-occurring substance use and mental health conditions.

Intensive Outpatient Program (IOP)

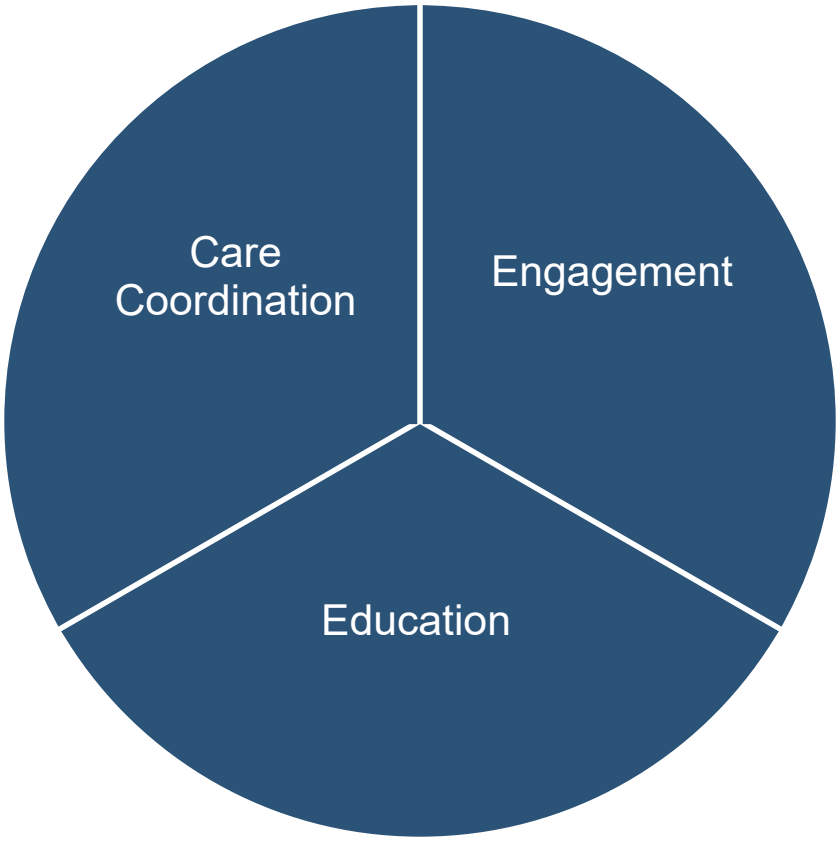
- IOP is considered a step-down treatment from PHP or inpatient hospitalization that provides diagnostic and clinical treatment through group and individual treatment. Patients typically attend IOP for several hours a day a few days a week.

Inpatient Hospitalization

- This is the most intensive level of care for individuals who may be a significant danger to themselves or others. Services are provided in a 24-hour secure hospital setting, and treatment includes group and individual therapy and educational activities. Patients will have their medication reviewed and be watched for safety.
- Patients are admitted to a detox unit for severe substance use that requires detoxification. Upon successful completion of detoxification, patients are stepped down to an unlocked unit or outpatient services.
- In addition to detox units, dual diagnosis programs, such as Motivating Youth Recovery, focus on detoxification and stabilization, which include treatment for both substance use and mental health conditions, known as dual diagnosis, for youths 13-19 (UMass Memorial Health Community HealthLink, n.d.).

Overview of the CHW Role in Substance Use

CHWs within the TEAM UP model specialize within 3 core areas described below to support the developmental and behavioral health needs of pediatric patients at their practice:



Engagement

Engage families in understanding healthy child development, navigating diagnostic processes and pathways, accessing appropriate formal supportive services, and seeking support for parenting stress. This includes outreach to families lost to care or experiencing gaps in care and informal counseling and coaching to promote healthy development, increase access to care and services, reduce stigma, and improve informed decision making for patients, caregivers, and families. Outlined below are some of the ways CHWs can effectively engage with families and caregivers.

Communication Style

- Listening actively
  - Offer encouragement
  - Paraphrase patients' and caregivers' thoughts
  - Observe non-verbal cues and identify emotions
- Asking open-ended questions to allow for more sharing and closed questions to obtain specific details

Motivational Interviewing

- MI is a directive, client-centered approach for eliciting changes in behavior by helping patients and caregivers to explore and resolve ambivalence; this approach focuses on:
  - Collaboration with the patient or caregiver
  - Evoking responses
  - Corroborating the patient or caregiver's autonomy
  - Offering compassion
- MI uses a four-pronged approach to engage with patients and caregivers, called OARS:
  - (O)pen questions: invite others to tell their story without leading in a specific direction
  - (A)ffirmations: recognize patient and caregiver strengths and acknowledge behavior that leads in the direction of positive change
  - (R)eflective listening: is a pathway for engaging others in relationships, building trust, and fostering motivation to change
  - (S)ummaries: apply reflective listening to summarize back what the patient or caregiver shared; can be used throughout conversation

Problem Solving

- Problem solving is an approach to engagement that seeks to:
  - Increase understanding of the link between current problems, stress, and depression risk
  - Define problems and set concrete, realistic goals
  - Teach a systematic problem-solving strategy
  - Promote behavioral activation with concrete tasks including pleasant social and physical activities
- Problem Solving Education (PSE) is a 7-step method for applying problem solving skills to decrease caregivers' stress, improve functioning, and promote wellbeing; PSE steps include:
  - Exploring the problem
  - Setting realistic goals
  - Brainstorming solutions based on set goals
  - Examining pros and cons of the proposed solutions
  - Choosing a solution
  - Making an action plan to execute solution
  - Reviewing tasks, effectiveness of chosen solution for problem, and reinforcing success reinforcing success

Caregiver Coaching and Support

- Recognize the impact of sociocultural differences on mental health awareness and caregivers' subsequent feelings of frustration, grief, shame, and stress
- Help caregivers work on parenting strategies, structure, reinforcement mechanisms, coping skills, and advocacy for appropriate services
- Emphasize that caregivers' emotions affect children's emotions by:
  - Modeling coping strategies
  - Validating children's struggles
  - Maintaining consistency in disciplinary measures
  - Making themselves accessible to their child
- Empower caregivers to communicate effectively:
  - Describe their child's behavior in specific terms
  - Identify triggers for their child's behavior
  - Provide insight into patterns of behavior (stimulus and reaction)

Supports and Services

- Early Intervention for children under the age of three
- School-based assessments beginning at 2.9 years of age
- Developmental screeners and assessments
- Outpatient services, such as outpatient individual or family therapy based on child's symptoms and family's needs
- School-based services, such as ABA, speech, PT, OT, special education instruction, paraprofessional, and other services based on child's symptoms and needs to support functioning and access to school curriculum
- In-home services, such as IHT, TM and ICC

Education

Educate and offer support to caregivers regarding child growth and development as appropriate including information about symptoms, diagnosis, management, services available for caregivers, family members, and youth, and other resources to promote informed decision-making related to care and to manage parenting stress. This also includes education to support caregiver self-management skills that anticipate and address barriers to accessing services and treatment. CHWs should provide education about:

- Child growth and development
- Common symptoms for developmental delays and appropriate screeners
- EI referral process
- Diagnostic process
- Local options for services

Care Coordination

Coordinate care and assist families in connecting to and maintaining treatment, services, and resources through ongoing collaboration with patients, caregivers, primary care providers (PCP), behavioral health clinicians (BHC), and other care team members.

- Assist with navigation pathways, including pre-diagnosis, diagnostic, and post-diagnosis stages
- Assist with connecting to EI services (see Appendix)
- Assist with initiating CORE evaluation for school-based services (like IEP Checklist in Appendix or 504 Plan)
- Assist with referrals to developmental/behavioral pediatrics (see Appendix)
- Assist with additional outpatient or in-home services, such as outpatient therapy, IHBS, ABA, and ICC

Resources

Substance Use

- Substance Abuse and Mental Health Services Administration (SAMHSA)
- National Institute for Drug Abuse (NIDA) for Teens
- National Institute for Drug Abuse (NIDA) for Parents

Caregiver Resources

- Center for Disease Control (CDC) Positive Parenting Tips Handouts
- American Academy of Child and Adolescent Psychiatry
- Youth & Young Adult Substance Use Services Directory - MA
- MA Bureau of Substance Abuse
- Parent/Professional Advocacy League
- Parenting Stress Line (1-800-632-8188)

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Appendix

Individualized Education Plan Checklist

Individualized Education Plan (IEP) Checklist			
	KEY TASKS	**DATE COMPLETED/ TEAM MEMBER**	**TIMEFRAME**
REFERRAL STAGE			
	Engage family to confirm consent to refer		
	Provide education on school district and referral process		
	Support caregivers with writing “letter” requesting school assessment		Within 5 days district notifies caregivers and provides consent form for testing
	Get release signed		
	If child in EI, coordinate with EI provider		
	Support caregivers with gathering records, e.g., DBP assessment, IFSP, etc.		
	Place follow up call within a week to confirm caregiver signed and returned consent form		
ASSESSMENT STAGE			
	Provide education on evaluation process and remind caregivers to provide IEP Team with important documents, e.g., DBP assessment, IFSP, etc.		Must be completed within 30 days of district receiving signed consent
	Ensure caregiver understands when and where assessment will take place (note that assessments usually occur in the child’s school or if not already attending school, a school within the district)		
	Address anticipated logistical barriers for completing assessment		
	Help reschedule assessment if necessary (note that waiting periods for next available dates may be long)		

Individualized Education Plan (IEP) Checklist			
	KEY TASKS	**DATE COMPLETED/ TEAM MEMBER**	**TIMEFRAME**
	Ensure that child will be tested in all areas of suspected disability, e.g., speech, physical, cognitive, etc		
	Follow up with family and EI provider 3 days before scheduled assessment to review questions, concerns, and important documents have been given to the district		
ELIGIBILITY DETERMINATION			
	IEP Team eligibility meeting was or will be scheduled after completion of assessment. A completed evaluation report can be requested 2 days before the scheduled meeting.		Must occur within 45 school days of receiving signed consent
	Schedule a follow up visit to review evaluation report together. Asist caregivers in understanding assessment results and preparing questions for determination meeting. Determine if it would be beneficial for CHW to accompany caregiver at the meeting.		
	At the meeting, the IEP team will discuss findings from assessments and determine disability and how it negatively impacts access to educational programming.		
	If eligible, the Team will recommend services, goals, and delivery options for proposed IEP. Caregivers will receive a hard copy in the mail.		IEP must be developed and sent to caregivers within 30 days of determination meeting
	If not eligible, caregivers may request a 504 plan or informal support plan		
ACCEPTING PROPOSED IEP			
	Assist caregivers in reviewing proposed IEP		
	Ensure services are clear and goals are defined with measurable outcomes and time components.		

Individualized Education Plan (IEP) Checklist			
	KEY TASKS	**DATE COMPLETED/ TEAM MEMBER**	**TIMEFRAME**
	Provide education on caregiver's options (accepting in full, accepting in part, or rejecting in full). It is recommended that caregivers accept at least parts of the IEP they agree with to avoid delays in child receiving services.		
	Obtain copy of IEP and document in EMR		
IEP Reviews			
	Provide caregivers with education on review schedules and options		
	IEPs are reviewed once every year		
	Re-evaluations occur every 3 years, or sooner if there are other concerns, needs, or information		
	Caregivers may request the team convene at any time if there are concerns		

Early Intervention (EI) Referral, Assessment and Services Checklist

COMMON CHALLENGES IN SUPPORTING FAMILIES WITH SCHOOL SERVICES

Initial Connection:

- It is crucial to ensure caregivers are aware of educational rights and the school navigation process.
- It may also be helpful to explain the difference between medical and educational diagnoses, as well as the most commonly identified disabilities in school settings. It's important for caregivers to understand that having a diagnosis does not automatically mean a child will qualify for an IEP. The IEP Team must determine whether the disability impacts the child's academic access and performance.
- If a child is found not eligible, this is an opportunity to collaborate with school and families to find creative solutions that would best serve the child. It may also be helpful to address caregivers' concerns through other lenses, such as cultural factors that may influence their decision-making process.

Special Circumstances:

- Manifestation determination – if a child with an IEP or 504 plans has been suspended for more than 10 days, from school, transportation, or other programming, for misbehavior there should be a meeting to determine if it is due to the child's disability.
- At the manifestation determination meeting, the Team must answer 2 questions:
  - Is the conduct a direct result of the district's failure to implement the IEP?
  - Does the conduct have a direct and substantial relationship to the disability?

If the team answers yes to either of these questions, then it is a manifestation of the disability. The Team must answer no to both of these questions for a determination of the behavior not being a manifestation of the disability.