Haley Hartle, NAADAC: All right, Everybody welcome to today's Webinar. We're super excited to have the

Haley Hartle, NAADAC: first part of our Specialty Online Training Series, Our new series, incorporating the family into treatment and recovery. Today we have part one endangered children in rural populations, implications for practice.

Haley Hartle, NAADAC: My name is Hayley Hartle, and I'm. The training programs manager here at Nedak. I'll be the facilitator for today's training, and then with me behind the scenes. I have our training and customer care Specialist Alison White, who will be addressing any issues in the chat box.

Haley Hartle, NAADAC: today. We are using Zoom Webinar. So you most of you should be familiar with this by now, but your zoom control panel will look like the one on my screen. The 3 main things to be aware of are the chat box. That's where you can communicate back and forth with attendees.

Haley Hartle, NAADAC: We have our Q. A. Box where you can post any questions for our presenters today.

Haley Hartle, NAADAC: and then the live. Transcript button will enable those close captions for you. So if you have any questions about that, feel free to reach out to myself for Allison, via the chat box, and we would be happy to help get that set up for you.

Haley Hartle, NAADAC: So just a reminder. Every needac webinar has its own web page that looks just like this, where you would have registered this link, that where it says register now will take you over to the Education Center, where all of the content will live. And this is where we will include the access education link for you to watch the on-demand recording of this as well. So If you have any questions about that again, you can always email us at Ce at

Haley Hartle, NAADAC: after today's Webinar. After this live event ends You can navigate to the Ce quiz by clicking on the link in the Thank you, Box. You may need to refresh your page to see that.

Haley Hartle, NAADAC: you also should receive an email. If you were in attendance for the full Webinar, you should receive an email with a link to the Ce quiz. So be on the lookout for that.

Haley Hartle, NAADAC: I mean, if you have any questions on that again feel free to reach out to us.

Haley Hartle, NAADAC: And then now I have the pleasure of introducing our 2 presenters, for today we're super excited to have both of them here. So we have

Haley Hartle, NAADAC: Dr. Drew and Dr. Drew is an associate professor at the University of North Texas, and is regarded for his expertise in creating trauma-informed mental health workforces.

Haley Hartle, NAADAC: has developed and evaluated multiple federally funded trauma-informed training programs targeted at developing clinical skills for rural mental health professionals.
Haley Hartle, NAADAC: In 2014 he founded the trauma-based behavioral health fellowship.

Haley Hartle, NAADAC: He has served on the Council of social work, education, national Task force, where he developed a guide for trauma, informed social work, practice.

Haley Hartle, NAADAC: and his practice. Mockaji serves individuals across the lifespan with challenges in a variety of areas such as addiction and substance, use issues and psychological trauma using evidence based approaches.

Haley Hartle, NAADAC: And then we also have with us Megan Reagan.

Haley Hartle, NAADAC: So Megan is a licensed social worker with over a decade of experience and child serving systems.

Haley Hartle, NAADAC: Reagan has supported various Samsa and hers of funded initiatives, including the development and oversight of an evidence-based trauma treatment program. And most recently co-evaluation and sustainability planning for her, says rural Communities

Haley Hartle, NAADAC: opioid response program in Southern Illinois reagan is trained in multiple trauma, focused modalities, and is a passionate trainer regarded for her expertise on subjects related to trauma, informed care, childhood, trauma, and secondary traumatic stress and workplace resiliency.

Haley Hartle, NAADAC: So now, without further ado, I can turn things over to our presenters. Thank you both so much for being here with us today.

Megan Ragan: We are so excited to be here. Let me get my screen shared, and then

Megan Ragan: Haley, can you just confirm that I am showing the right screen here?

Haley Hartle, NAADAC: Yes, I can see. Okay.

Megan Ragan: perfect, perfect. So, as Haley said, my name is Megan Reagan, and with me we have Dr. Drew, and we are very excited to be talking with you today about a topic that is very important to us, and very much embedded in the work that we're doing in Southern Illinois.

Megan Ragan: So Our objective for today is that by the end of the training we are expecting participants to be able to identify 3 child maltreatment, risk factors associated with parental substance misuse

Megan Ragan: we are also in. We discussing information related to social determinants of health, and how these things really impact families across generations. And then, lastly, we're going to be talking about 3 common barriers that we often see present in rule service settings.

Megan Ragan: So to get us started here. We wanted to give a little bit of background information about our project, and Drew is going to to discuss that.

Dhru Mukherjee: Well, I lots of the insights, data and and our presentation talk, the content of it
Dhru Mukherjee: emerged from a project that both Megan and I are involved, and it is called rural Communities opioid response program. So in our car program. We had received a first in a, you know, a planning grant and an implementation grant.

Dhru Mukherjee: as a part of the planning process, we did a needs assessment of the of the 3 rural counties of southern Illinois, and found out what are the different challenges that folks are facing about the raging opioid crisis that are there in our region.

Dhru Mukherjee: and upon the end of the you know, needs assessment study. We developed a strategic plan and got funded for implementation and the implementation, as you can see in this map that we are. These are the counties that we have.

Dhru Mukherjee: kind of focusing on in the implementation we have, like, identify. One of the main thing was like almost 65% of children who are being referred to child protective services. Where had parental drug connection.

Dhru Mukherjee: The, however, when we try to gather in, you know, secondary data from the child protective Services folks at the State Agency, we realize that sub parental substance, use or substance. Use related reasons for child refereal to child protective services.

Dhru Mukherjee: does not even have a distinct category in Illinois, where data is collected. So you know, substance use parental substance. Use data is a talked under parental neglect.

Dhru Mukherjee: So if you go and look at the data from the child protective services you're going to find that you have to like. There is no way to differentiate between which one are really, you know, parental substance use related.

Dhru Mukherjee: and which are a broad other neglect categories. So you know. So we realized that that was, you know, one of the barriers to our, you know, to our study, you know, providing services. Not only that our needs assessment study also showed.

Dhru Mukherjee: that there was a you know there was a disconnect and fragmentation in, you know, substance use prov provisions, substance, use provider and substance, use related services and child welfare. They are not. There is no refereal system. There is no case management system where parents you know what. Even if

Dhru Mukherjee: parent reunification with child is one of the most stated goal of child welfare, yet the parents are given numbers to call for substance use related services, and usually we have 8 to 9 weeks of weight in those agencies, because these 3 counties are located in a medically underserved and

Dhru Mukherjee: a behavioral health care provider shortage area designated by the Federal Government. So, as a result, the waiting list is very long. Folks who are there are. Most of the behavioral. Health and physical health are funded by a Medicaid and government program rather than commercial insurance, so that the list is very long.
Dhru Mukherjee: and parents sometime fall between the cracks in the sense they would call providers, and there is a long waiting list. The referral PE the the time labs between referral and actual receiving services is 8-9 weeks long, affecting people receiving services.

Dhru Mukherjee: and, of course, as you may know.

Dhru Mukherjee: substance use has a stigma of its own child, you know, being referred to or investigated by child. Protective services have stigma of its own, and those stigma are amplify in a rural community. And so, you know, we we are re realized these barriers

Dhru Mukherjee: and wanted to create some sort of a trauma informed, you know, way of connecting systems as a as our methods. For you know, a community response to opioid addiction.

Dhru Mukherjee: So, as we were doing the implementation, we realized, there are, you know these challenges that I was saying that the substance use pro providers and the network of substances. Providers themselves are fragmented, based on organization, community, mental health and other organizations

Dhru Mukherjee: along with hospital emergencies. All entities, all stakeholders, provider stakeholders who are doing substance use related services, do not have a referral system to kind of share their waiting less clients among each other.

Dhru Mukherjee: There are consortium system of care related funding and pro projects are going on. Yet at the patient level. A referral systems are very rarely used, and you know, data sharing is almost not there, you know. In fact.

Dhru Mukherjee: there is No, there has not been a data sharing agreement with many the substances providing organization, and for a and, of course, child welfare, which is completely in, as you know, isolated from the substance use provider infrastructure in our area. So one of the biggest challenge was system, a fragmentation.

Dhru Mukherjee: and then another was that you know that one of the thing that I, my personal realization has been that

Dhru Mukherjee: we have been focusing on the even. You know the the profile of a person in addiction, who is a a male, a white person, a white male.

Dhru Mukherjee: a young, you know, a and a a a, a, a, a, a, a stereotypical profile of a person who would be most likely to get overdosed. But if you look at the in our studies, and if you you know, we did also like it, qualitative elements in our needs, assessment, focus, group and other.

Dhru Mukherjee: And we found that the parents who's with dependent children have a different profile altogether when it comes to usage of, you know, drugs and other substance, you know, addictive substances.

Dhru Mukherjee: and that profile is very different. Our, you know, most of our Federal Government funded programs and communities are looking at a very different profile of a person in addiction. And so
I started increasingly the conceptualizing that a person in addiction and a parent in addiction are 2 different people altogether.

Dhru Mukherjee: because there, you know, the the amount of stigma, the amount of challenges, the responsibilities that you have to navigate

Dhru Mukherjee: are are very different, more more or less. We also found that

Dhru Mukherjee: even if there is overdose, prevention is the long term goal for all of our programs, you know, but there is no overdose data collected, and eventually, because of the challenges of collecting over those data for the fragmentation of system, we also realized that the overdose data collection has been completely even suspended

Dhru Mukherjee: in many of the programs, and most of the overdoses are are very anecdotally recorded in a you know, in in various system.

Dhru Mukherjee: And again, there has not been, any, you know, case management or coordinated services on child removal. Even if 65% of the child removal are connected to parental drug use.

Dhru Mukherjee: So we wanted to increase the access of a system. But if you you cannot increase access of a system. If your the profile of the person in addiction is still very

Dhru Mukherjee: limited in your conceptualization. So we are we. We are trying, we we started acknowledging and psycho educating our stakeholders about the ripple effect of families and how I you know multi-generational families over there. You know, in many many rural areas have

Dhru Mukherjee: drug related issues, and how that ripple effect effect, you know not only the person in addiction, but also their family members, and also children especially, and that needs to be recorded and acknowledged, and services needs to be provided. Gearing towards that.

Dhru Mukherjee: and that lack of understanding is a of of parental profile. We found is a, you know, a major challenge in our area, and we started. Then focusing on mixing these 2 different, you know population, the parents in addiction and the services that are being provided.

Dhru Mukherjee: and and we we found that, you know new perspective to advocate for this population. So, Megan, you can go to the next slide.

Megan Ragan: Okay, so, as you said, all the all the things that we kind of discussed there with challenges to implementation, they're going to be addressed throughout this presentation. But before we get into kind of the the perspectives on a parent and addiction, and looking at that through a trauma informed blends, we wanted to kind of discuss a little bit about

Megan Ragan: what we are talking about whenever we're talking about drug and danger children, and then also, we wanted to kind of define the scope of the the challenge as related to a as in relation to what we're doing.
Megan Ragan: So the first thing here, and we want you to. My computer will work. There we go. We want you to kind of just throw this in the chat whenever you think of a drug endangered child.

Megan Ragan: what pops into your head? What is the the thing that comes to mind?

Megan Ragan: So if you just want to kinda

Megan Ragan: knee-jerk reaction, what comes into your brain. Throw that in the chat. Thank you. So we see, neglect

Megan Ragan: neglected

Megan Ragan: using drugs in their presence. Parents who use drugs around their children basic needs not being met. Poverty present. Oh, it's going very fast.

Megan Ragan: poor environment, high risk of being involved with drugs. A child who is exposed to drugs on a regular basis, left alone at night underage. Yes, all of these things that are are kind of populating the chat there. These are all of the very stereotypical renditions of

Megan Ragan: drug and danger, children that we have in our brain right? And these these are things that you know. Maybe you have encountered in your work. Maybe you have experienced this in you know your personal life, or whatever it is. But this is this is the exact kind of imagery that comes to mind anytime we're talking about what a drug endangered child is.

Megan Ragan: And let me see here a parent that uses map, even if they're not at home. It transfers for the skin to skin contact. Yes, absolutely absolutely so in the chat we're seeing lots of themes related to neglect related to risky behavior of the parents that can also translate to the the kiddos

Megan Ragan: related to potential drug poisoning. You know, oftentimes accidental systemic challenges, trauma, Yes, all kinds of really good information in there, and things where it's spot on.

Megan Ragan: So whenever we are talking about a drug endanger child.

Megan Ragan: we need to know, first of all, that approximately 12% of all children in the United States live with at least one parent with a substance use disorder.

Megan Ragan: So this is something. And this is this again, is just

Megan Ragan: as obviously with statistics. These are just the things that we know right. There is some something that we have ran into a lot. Whatever we're trying to get information related to this work is that oftentimes these things go under reported because there is such a fear of of the system, you know, potentially engaging and removing the child. And we'll get into that a little bit more here in a moment.

Megan Ragan: Another important statistic is that parental substance you misuse, including alcohol, is a contributing factor in child removal from the family home, and more than a third of cases, and this is second only to neglect.
Megan Ragan: So in Illinois. As you said, we we have our child Welfare system does not have a classification specifically for parental substance misuse.

Megan Ragan: We have just the topic of neglect. And then there's a lot of different things that that kind of fall under that heading. But whenever you are thinking of, you know a parent who is using drugs, and a parent who is neglectful. Oftentimes, while there are some similarities, there are also a lot of accentuating circumstances that kind of contribute to one versus the other. So this is just something to kind of keep in mind.

Megan Ragan: another statistic here that, as of April, 2,01547 out of 50 States have laws and child welfare statutes that specifically address the issue of parental substance misuse.

Megan Ragan: So you know. Obviously, the the Government State governments, Federal governments have have realized that this is a challenge, and they have attempted to address that challenge. But from what we have seen, oftentimes the way that that challenge is addressed is more harmful than than it is helpful, especially whenever you're considering the the reunification of the family unit.

Megan Ragan: another. This is the last stat here for this section, but this is a good one, and and it's, you know. Again, it kind of underlines and highlights the importance of really looking at the parents that are in that are that we are talking about here. We're talking about drug and danger, children, and we're talking about parents with substance use disorders or parents who use drugs. It really kind of underlines. You know just how just how prevalent this is this is, and not only that this is occurring, but that when it is occurring, people are not either able to access treatment because of resource shortages, or they are in fear of accessing treatment, because their fear they have fear of ramifications. So approximately 9 out of 10 people struggling with the substance use disorder, do not actually receive treatment, which is, you know, obviously alarming whatever we're thinking about about that in the context, in the context of parents and families.

Megan Ragan: So.

Megan Ragan: whatever we were, we were working on this. I found this, this study here from Goldberg and Bla. And basically it is just talking about kind of the the serious consequences that but serious consequences that come with that can potentially impact parents and children and families that are kind of, you know,
experiencing this substance use challenges. So some of the the risk factors that we know of here is that parental substance use disorders have been consistently linked

Megan Ragan: as a serious risk factor for child physical abuse. We also know that whenever children have parents who use substances, there are increased risk

Megan Ragan: for things like physical, emotional, and psychological trauma.

Megan Ragan: and then kind of breaking it down here into some of the environmental, individual and familiar risk factors that can influence the risk of not just the child being maltreated, but also the risk of poly victimization. So being victimized in more than one way, or being victimized over a period of time. And these are the some of the things that the research has shown, and that we have seen also in our needs assessment and in our work here with our core. So obviously the child and parental ages

Megan Ragan: really impacts the parents and the family's ability to be functional whenever there is kind of the substance, use thing thrown into the mix. Another thing that we've seen is that that social connectedness or isolation, that that parent may experience in relation to their network, their community, their family, whatever it is

Megan Ragan: that also plays a huge role in how successful that parent may be able to function as a parent, while also potentially using substances.

Megan Ragan: And we also have kind of the wild card of intimate partner, violence or domestic violence, this exposure to community violence, all of these things are things that you probably see in your work every single day. And all of these things kind of add an extra level of risk

Megan Ragan: to the potential for child maltreatment. Whenever we're talking about these families that are are, you know, historically, have experienced a lot of adversity. And then, you know. Lastly, we have this idea that

Megan Ragan: geographic location is also a risk factor, and this is something that I thought was really really interesting is we were kind of

Megan Ragan: like looking at this. Research. Research has shown several different studies here, have shown that families are more at risk

Megan Ragan: of potentially being separated. Children are at risk of being removed, and they are at an increased risk of not reaching reunification whenever they live in a rural area versus a metropolitan area. And there there's a few different reasons for that, that, you know. Research has shown. But this also aligns very well with what we have actually seen just anecdotally

Megan Ragan: in our work here

Megan Ragan: through

Dhru Mukherjee: Well, as a Megan was showing, you know, one of the goal of this presentation is also to
Dhru Mukherjee: that usually in child welfare

Dhru Mukherjee: A. You know, and for very good reason children are the focus when it comes to the conceptualization of who is who is a victim.

Dhru Mukherjee: you know, in in the in a child is the one needs protection, and that is it completely understandable, that is, you know, established. But what it also does is in oftentimes it is

Dhru Mukherjee: creates a a a very binary categorical idea where the parents are, you, you know, on the other side of the spectrum, where most of the time parents are viewed as perpetrators to neglectful, and you know a. And you know very. You know.

a a value culture, a value system in rural areas are more about. You know where your need to take your personal responsibility, where parents, I feel, are kind of not really focused on. So one of our idea was to look into parent and child as one unit, because if parental reunification is the goal of child welfare.

Dhru Mukherjee: then parent and well being has to be closely linked with when with child victimization, and how parents can be constructively play a role in it.

Dhru Mukherjee: But in our experiences in working, when opioid response and poly substance use response, we found that

Dhru Mukherjee: the stigma around parental child abuse and the stigma about

Dhru Mukherjee: parents using drugs kind of join forces to amplify the stigmatization of the parent population, then

Dhru Mukherjee: helping to understand or connecting down them to seek access. As you may already know, that one of the reasons stigma is one of the reason, one of the biggest barriers in accessing or increase access to services in in in rural areas.

Dhru Mukherjee: And so as this literature that we have put in here showed that, irrespective of whether there is a a actual data of, you know, Increase or per, you know, be the correlation between parental drug use and

Dhru Mukherjee: child being referred to foster care. It has been seen that the collective experiences of the community, that the you know that foster care placements are kind of go up whenever there is a parental substance use official of jurisprudence most impacted by prop problematic substance. Use maybe significantly, more likely to react strongly

Dhru Mukherjee: and reportedly maltreat reported man treatment when substance using involved, regardless of any objective increase in risk. So you’re going to find that whenever that happen, it's not only from the provider Perspective and i'm talking about providers substance, use providers, medical professionals, law enforcement.
Dhru Mukherjee: We find the parents are they re the challenges of parents. Getting services becomes more more more barriers comes in the way, because the perception, the collective perception of of stigma.

Dhru Mukherjee: and and that is what we are fighting, trying to advocate for parents trying to show a different profile of parents, which is, which is non-stigmatized and non criminalized in every in every possible way. The reason for that is, if the stated goal is indeed the child

Dhru Mukherjee: parental re reunification. And if I want to believe that parental reunification goal is formed, not because of saving money, but because of the overall theoretical understanding and empirical understanding that the child for it is the best in their own biological or parental household.

Dhru Mukherjee: If that is our goal, then I think that this parental stigmatization and stigmatization towards substance use the big causes of further, You know, stigmatization of parents profile as well, and that is what we are trying to challenge here. So in the next slide

Dhru Mukherjee: you you see the factors, and we are throwing in statistics here, and we are going to go deeper into understanding the the profile of the parents, and the end of the goal is is that whoever you are, you'll be a provider working with law in the law, enforcement setting, or primary care, setting or integrated care, setting

Dhru Mukherjee: in different urban rural communities. But you have higher appreciation for a parent who is, you know who uses substances

Dhru Mukherjee: a a little bit more after this presentation, you know. See the humanity of them, and trying to get them some help instead of, you know, creating further barrier in their access to care. And a. And you know these statistics that show that

Dhru Mukherjee: parental drug use and alcohol use as a condition of removal has shown, you know, Higher, it's kind of going up in all over the you know. The the statistic shows is going up all over the country, and we have seen that as well.

Dhru Mukherjee: And the next slide shows that factors contributing to the removal and reunification parental drug use as a identifying condition of removal by State. And you know again

Dhru Mukherjee: in in Illinois, when you are you looking at State statistics. But if you look at Southern Illinois. You know we have local statistic providers shown it's a way more than what is reported over here.

Dhru Mukherjee: but all over. It is a very high, but I would also like to tell you that many States do not even collect parental drug use data at the very first.

Dhru Mukherjee: In place, kind of dwarfing the statistics in that regard. So there needs to be much more work done in collecting a separate variable. I you know classification of parental substance use in this regard, and that is the advocacy that we are trying to do

Dhru Mukherjee: from from our experiences. And in this running this project. So
I know again to provide some contacts, like the factors contributing like number of children who are affected you.

Dhru Mukherjee: Again, you are going to find that the the younger the children is the removal. Rates are more because they are perceived to be more dependent, more helpless; and the stigmatization of parents, who of very young children are are way more than you know, and it kind of decreases over the

Dhru Mukherjee: or over over age again. The next slide is the role of parents in child M. Maltreatment and parents are responsible, either directly or indirectly, for 93% of emotional abuse. 92% of physical abuse 60 person, of child abuse.

Dhru Mukherjee: corporal punishment practices parent you know. So what i'm trying to say is, we're doing this to statistics is that there has been a pretty good reason for parents to see parents and isolating parents from a different unit as a perpetrator of things

Dhru Mukherjee: and a parental drug use just adds fuel to that. You know that toxic imagery of parents. But there are social determinants of a drug addiction and social determinants, some child maltreatment as well, and we find that

Dhru Mukherjee: even if family reunification is the goal when parental drug use come in the picture. Many factors that are that would be very different if a substance induced behavior is taken out of the you know, out of the at the mediatory factor.

Dhru Mukherjee: So we wanted to de-stigmatize this and trying to show with statistics that you know they there needs to be some grace here

Dhru Mukherjee: for parents, because the profile of parents using substances is a little different than others, and you know, and we are going to go deeper in some sort of a micro level analysis of things in our in our next slides.

Dhru Mukherjee: But you know I I feel like after next slide. Maybe maybe we can take a little gap, you know. Maybe maybe a little time to have some questions about. You know the way we are

Dhru Mukherjee: kind of identifying the parents with drug use. Population.

Dhru Mukherjee: Yeah, I I think it now would be a good time to do that before we kind of get into the next section here.

Megan Ragan: So if you have questions about things that have been presented, if you, you know, want clarification, if you have questions about anything that that we have said, please feel free to put that into the Q. A. Or the chat. I found out today, as I, as we were preparing for this presentation, that if there is a question in the Q. A. That you think oh, hey, I would really like to have an answer to that, too. You can actually up Vote that question in the in the Q. A. There.

Megan Ragan: So we'll just take a couple of minutes here, and and we want to engage with you, Drew and I both really enjoy talking with our audiences whenever we are talking about this, so please feel free.
Megan Ragan: Share your thoughts, questions, observations, whatever you may have for us, we want to last base for that.

Dhru Mukherjee: And I would also say, and I agree, and I see that in the chat you know there are some. You know how, Matt. I don't Fentanyl, you know a kind of get transmitted, you know, skin to skin provide great risk, and we have like

Dhru Mukherjee: live in many rural areas. Have you, You know, has multi-generational substances problem where you know it is like even culturally a a developmentally accepted phenomena. But, as you can see, here we are taking a very harm reduction approach.

Dhru Mukherjee: That means that the reason we are asking that you know we are not denying. We are not saying that all these statistics about that is like stacked against the profile of a of the parents

Dhru Mukherjee: we are. We are highlighting that, and saying that let's take an harm reduction approach, because without that harm reduction approach towards dealing with parents, we would not be able to

Dhru Mukherjee: have reunification. It would be a paradox. It would be a contradiction if if if our goal is to, you know, use the parental like you. You know, you know parental capital, parental, social capital as a part of a solution of child mal treatment and child separation in our society we need to take a harm reduction, approach to us. The parents understand the factors that lead to parental drug use

Dhru Mukherjee: and and and help, you know, provide home reduction services at prevention, treatment and and and recovery level to parents in a very intentional way

Dhru Mukherjee: for them to, you know, be in a position to kind of change their behavior, and have children back to their custody again. So that was my perspective. All right, Megan. So let's look at the questions, or

Megan Ragan: yes, I am looking so. It looks like as of right now. We do not have any questions in the Q. A. Out. We have one. Okay, here we go. Thank you so much, Michelle. How do you encourage child welfare organizations to support the harm reduction approach when most focus on abstinence based services?

Dhru Mukherjee: Well, yeah, and and that is what we are trying to say it's not just about child welfare. Even, you know. Substances pro prov providers as well, you know, are not very familiar with the whole. The you know the theory of where harm reduction is coming from.

Dhru Mukherjee: and it is a a and it has a lot to do with stigmatization like If if the phenomena of substance use is stigmatized, you are going to find a opposition to harm. Reduction is very high.

Dhru Mukherjee: Like, For example, we have had in our needs. Assessment found that service providers, medical primary care, as well as behavioral health service providers who are working together in implementing medically assisted therapy, which is a harm, reduction, approach, and providing, you know.

Dhru Mukherjee: person in addiction in our community, with the sobox on, and counseling together, and
many of them have, you know the unexpressed discontent about giving the same sobox on that day prescribe, and and they feel like the you know.

because of the lack of clarity. You know they feel like this is like something of we are distributing drugs. But eventually, when we started taking a disease model and realized that there are some folks, you know everybody has their own journey

Dhru Mukherjee: in a of 2 recovery. You know some folks are good with the, you know. A cold turkey approach, and giving up a behavior just by the determining overnight.

Dhru Mukherjee: and some folks, if they do that, their chances of relapse is high, their chances of overdose is high, like people who try to go through. You know there are lots of good success stories about the you know, alcoholic, anonymous, or the narcotic anonymous a a model, as you may know, but you know there are not a single, but there are lots of empirically supported ideas that if people are.

Dhru Mukherjee: you know the given a hum reduction approach and focus on their functionality instead of their abstinence. And yeah kind of reinforce the value of their functionality irrespective of their usage. That is much more, you know, that contributes way better to the reducing over those statistics than a. You know. Cold Turkey app students approach, but many places in our rural communities because of various reasons.

Dhru Mukherjee: You know there is a stigmatization of harm. Reduction and substances is is high, and therefore you know this whole idea of overnight. We need to change our behavior. It comes from the an internal sense of guilt

Dhru Mukherjee: of relapse. You know we we we feel like, you know. Yeah, we could. We could do it, or, you know, like somebody should do this overnight thing, then only that that person's value is high, and I feel like that is that kind of thinking has contributed, as it's very well established in the literature

Dhru Mukherjee: to 2 substances. And so what but at the same time, I, when we go and discuss and talk about Apps abstinence. And and you know, home reduction approaches.

Dhru Mukherjee: We just wanted to take, you know, take an inclusive approach, and basically do not look down on people who basically take the other view and try to find a some, some

Dhru Mukherjee: a commonality, some overlap between the 2 approaches, and trying to show the person you know the profile of the person as more

Megan Ragan: that with that, with some humanity, then then with stigma, I mean, Megan, you have any thing else to contribute to this? Yeah, I so there, there's an additional question, and I kind of I had a couple of thoughts about it, and it it goes nicely with what you were just saying. So the the other question that we have in the Q. A. Says that from the chart about misplace focused and unaddressed challenges. Are you trying to say that the focus of services has been on drug use, prevention and child removal

Megan Ragan: as opposed to clients center focuses on drug of users and their family. So the first thing that that I want the first thought that I had is that ofentimes whenever we are doing this work.
Megan Ragan: and I spent time working in child welfare, and then I would say that at that time I came from the exact school, thought that you know we prioritize the child over the parent. We protect the child at all costs, which obviously is true right. We we are not saying that what we are saying is that the system has consistently

Megan Ragan: kind of failed parents and failed family as a unit.

Megan Ragan: So it's not about prioritizing the parents needs over the child's needs. It's about prioritizing the family unit as a whole, and addressing these issues that have oftentimes, from what we have seen in these rural areas really been issues for for generations, and we'll we'll get into that kind of in the next section about You know how oftentimes

Dhru Mukherjee: using drugs and substances, misuse and things like that is really kind of a family culture in our area, and especially in like rural communities, and it's something that we have seen a lot. Do you have anything? Yeah, Go as as I agree with I as any phenomena?

Dhru Mukherjee: Not you know there are, we need to be very careful, and therefore, like a more empirical approach, is is better, is like whenever there is a problem or any phenomena. There are interior causes and their exterior causes.

Dhru Mukherjee: There are things that are in the lies in the failure, in the internal locus of control, and there are factors lies in the failure of the external local of control. The problem sometime is that if we assign the the cause of certain things only on one domain.

Dhru Mukherjee: and if I feel like you know, I am, you know there are my poverty that caused by inflation or other macroeconomic factors, that I am not really responsible. It is not because of me, you know, and I

Dhru Mukherjee: I need to understand. And and and it is a very important psych education to understand what are the factors that are beyond? It's very much like the the serenity prayer. What are the factors that are outside of your locus of control? And then, you know, be aware of it, and don't don't blame yourself for it.

Dhru Mukherjee: What are the things that you can do? Because I i'm also not saying that, like I, we are promoting a cod link culture where we are saying, every problem is outside you, and you have nothing to do with it. We are not saying that at all. We are saying it's always a

Dhru Mukherjee: a a continuum of both factors. And if there are factors that you can do, For example, if we know that your access to services is available to you, you have transportation, and you have everything that you can do. But you are not still accessing. For whatever reason we need to understand, so understand the behavior that you can change in your internal locus of control or the interior factors.

Dhru Mukherjee: And there are clinical interventions for that, you know. And then there are, you know, a social determinants of addiction issues that are outside your locus of control and understanding that understanding both the factors is very important, and they go together. The problem of stigma is that sometimes stigma becomes a justification
Dhru Mukherjee: of assigning every responsibility, and putting all the external locus of control factors or exterior factors into the internal of the person and stigmatizing that person. You know, making that person a pariah.

Dhru Mukherjee: You know kind of

Dhru Mukherjee: what what it does is it helps a mask the the community and collective responsibility that comes

Dhru Mukherjee: with addressing access to services at addressing programs, and we are, you know, there are punishment, model and various model, and we sometimes feel like there is a way when we think about like a, you know, a drug abuse, for example. Yes, supply chain is an issue, you know, like we need to stop drugs coming to our community.

Dhru Mukherjee: But some somewhat, you know. Yeah, if but if that is the only solution, you think that's not happening.

Dhru Mukherjee: and if you'd say that well, the only solution to this is sub stopping the supply chain. But you know I would agree with you. 1 2 3 4 time, and I realize that even if you say that you are not able to do it. The supply chain is beyond the it is is still showing up from somewhere.

Dhru Mukherjee: and if that continues my harm, reduction mind would be okay along with as you try. You're trying to throttle the supply chain. Let me also try to improve access to people so that they they get better, and you know they develop resiliency

Dhru Mukherjee: and things like that. So it's a kind of a two-pronged approach to things.

Megan Ragan: Okay, we have One more question, Drew and I I think I think we have time that we could go ahead and answer it.

Megan Ragan: Someone was asking if our research showed a different view of parental substance misuse when a parent is not a member of the dominant culture?

Dhru Mukherjee: Wh how do you? What do you mean by dominant culture first of all. But I would say that

Dhru Mukherjee: you know again, I like the intersectional layering of things. If the parent are not from dominant culture, I think that the stigmatization adds another level to it.

Dhru Mukherjee: you know. But the general stigmatization to substance use to parents who should be feeling guilty for everything goes wrong to their children that that kind of thing is universal.

Dhru Mukherjee: But then there are, you know, there are other intersectional categories. If you add to it, they just create more layers of, you know, challenges.

Dhru Mukherjee: If you're not from the dominant culture. If you're from a gender minority identity, you
know a community. If there are. If you're an immigrant, if you are.

Dhru Mukherjee: you know those are, you know your social support and lots of protective factors that we can cultivate it reduces, and then that in increase your risk factor more. I I just see it more as a as a step wide.

Dhru Mukherjee: You know. You know we in in statistics. Some some time we do step wise a regression that means we add a variable, and see how the the equation on the dependent variable changes very much like that, you know, not dominant culture. Just I would consider that another, you know, a debilitating or a disadvantaged variable, added to that whole challenge.

Dhru Mukherjee: you know, so sure. But in our community we have noticed mostly that the our you know these communities in the rural communities that we have worked in are pretty much, you know, like rural, socioeconomically poor communities. And

Dhru Mukherjee: I feel like there are many, you know, socioeconomic challenges that that come that is like a a and a non-inclusive act as a non inclusive factors as well.

Megan Ragan: Right?

Megan Ragan: Okay.

Megan Ragan: So now we are going to kind of shift into discussing this idea of viewing the parent through kind of a trauma, informed lens, and we would be really remiss if we talked about this without talking about parental adversity.

So whenever you are thinking of a family, and you're thinking of all the members of that family unit, the child the parents

Megan Ragan: Oftentimes we see, you know, grandparents, aunts, uncles, things like that all kind of residing with each other, creating this really tight, knit family unit. You would really be doing a disservice if you did not think of

Megan Ragan: each person's experiences, and how those experiences play out and impact the the person's ability to function in the family environment, and also the person's ability to have those relationships that they need to have in order to kind of nurture a. You know, a thriving, resilient child.

Megan Ragan: So I would say, most people in this Webinar. Probably I'm. Making an assumption. But most people have probably heard of Aces adverse childhood experiences just as kind of a recap. These are kind of the core aces that have been studied at great length.

Megan Ragan: If you have not heard of the aces, I definitely encourage you to to look it up. There is a lot of information on the Cdc. About it, but basically it was a study that was done that identified certain experiences that are more likely to lead to negative health and social outcomes later in life.

Megan Ragan: These are kind of the core experiences that were identified, and these are things that
would happen to a person before their eighteenth birthday.

Megan Ragan: So these experiences have been linked with a greater increase in risk of of having some sort of substance use disorder.

Megan Ragan: It's also been linked with issues like increased risk for cancer, increased risk for Co. Pd. And and the thing that I love about the aces is that it really kind of draws a empirical connection between the our experiences and the things that we go through in our childhood, our adolescent years, our our formative years, and then how the rest of our life could potentially kind of play out if there are no sort of mediating factors in there.

Megan Ragan: So whenever we are thinking about parental adversity, and we're thinking about parents who use substances. We have to remember that oftentimes people turn to substances because they are trying to cope with some sort of a of a trauma.

Megan Ragan: That is what has been shown consistently. I forget what the statistic is but it was more than 75 of people who use substances, or who have some sort of substance use disorder, also have report, experiencing some sort of significant trauma in their life.

Megan Ragan: and, as you know, you know, using substances kind of using, though those you know things to dissociate or to kind of, you know, check out from life, that is, I mean it's. It's a it's a coping skill, right? It's maladaptive. It doesn't it doesn't work, and it causes a lot of issues. But it does get the job done.

Megan Ragan: So that is something we have to think about Whenever we're thinking about parents who use substances. This is not just a parent who is completely absorbed in their own experiences and their and what is going on in their world that they're completely, you know, neglecting their responsibilities as a parent or a caregiver. This is, you know, oftentimes a person who is trying to figure out how to move forward through their life in a way that is it painful

Megan Ragan: that is it painful

Megan Ragan: so additional adversities, in addition to kind of those adverse childhood experiences that we talked about oftentimes, in our area, we see substance use as being a multi-generational issue.

Megan Ragan: I cannot tell you the amount of. So I I spent. I spent a lot of time working with teenagers and the amount of times that I have worked with a teenager who was using some sort of substances, and they tell me that you know the first time that I I did, meth. I did it with my mom.

Megan Ragan: or the first time that I smoked marijuana. It was a great experience with my dad.

Megan Ragan: and and this is something that you know it doesn't occur just to kind of you know, the teenagers that i’m working with it probably also happens to their parents. It might have also happened to grandparents. So this is something that we've seen that it. It really is a multi-generational issue and and something that oftentimes is so. It so ingrained in the family culture that it's kind of a an expected thing to happen.
Megan Ragan: Also we see that whenever we have this multi generational substance use in families. There is also not just an increased risk for the parent to potentially, you know, mal treat their child, or you know something like that. But

Megan Ragan: if that parent was raised in that environment, then that parent also was

Megan Ragan: a part of that risk factor, initially as they were the child. So, again this is, you know it's not isolated to just the family, the parent, and the child that we see. Now

Megan Ragan: we also see that domestic violence and substance use correlation. That is a very common connection that we see in our work. And then obviously the the next to last bullet there, probably the most common is this idea of co-occurring mental health and substance use challenges.

Megan Ragan: Oftentimes we so we do a lot of work within our community, and we work with a lot of different individuals from multi multiple sectors. In one of those sectors is law enforcement. And so the thing that we hear most frequently from law enforcement

Megan Ragan: is that whenever they are encountering someone who, you know, appears to be distressed or appears that there's something going on. Oftentimes they're not able to kind of disentangle whether this is a mental health challenge, or whether this is something that's related to substances.

Megan Ragan: So then, you know the person kind of oftentimes unfortunately gets kind of lumped into one category, another, and that ends up being a real disservice that we can't. We can't do something about that sooner rather than later. Usually, when they get into treatment. The person, you know their collision is able to kind of figure that out, but

Megan Ragan: it takes a little bit as as Dr. Drew said it. It takes a while.

Megan Ragan: So some social determinants of rule parenting. This is something that

Megan Ragan: I,

Megan Ragan: This is being a parent in a rural community is an experience all its own.

Megan Ragan: If you have done it, you know exactly what I'm talking about, but people who are parenting in rural communities are at. They have different disadvantages than people who are parenting in more metropolitan communities.

First of all, there is

Megan Ragan: oftentimes a lack of family preservation and a lack of family, support. And there can be a lot of reasons for this. But you know again, oftentimes, whenever we're seeing these challenges in these adversities, they are, They are a multi generational issue. So whenever that happens, you know, family ties, family relationships become broken or they become severed. And then suddenly, you have, you know, a person trying to raise a family in in a vacuum, or, you know, in some sort of
isolation, and we know empirically that that does not work.

Megan Ragan: and we also experience in rural communities a lot of workforce shortages and long wait lists. And so you know, this translates to parents because it it increases the stress that these parents are feeling, you know. Not only am I as a parent? Am I dealing with my own experiences? You know my own trauma, my own, You know possible addiction. Things like that. But not not only all that, but now I can't find a job.

Megan Ragan: you know. If I do find a job. I might have difficulty getting there, because transportation is also an issue that is relevant to rule parenting. Oftentimes in our area it is, it is totally normal to see a very tiny car pull up somewhere, and you know, people and like 5 kids, get out of the back, and parents get out of the front, and we just make it work, you know. But transportation is very difficult, because there's there's a lot of you know. Rural communities are
kind of

Megan Ragan: what up in between a lot of cornfields and and long roads.

Megan Ragan: There's also this inherent economic disadvantage in these rural communities, and also the our our infrastructures that are

Megan Ragan: already not on the same level as I'm. A a metropolitan community are are declining. That's something that we've seen. And then the last one which I think, is kind of the most one of the biggest issues that we have in our area with it being a workforce shortage area. And all of that is, that not only do we not have enough people to provide the resources that people in need need, in order to be successful and functioning, and live their best lives.

Megan Ragan: We also are not able to to train a competent, well trained, well-informed workforce. We try very different. We Try very hard, and Dr. Drew has made a lot of strides in our area doing that, but

Megan Ragan: because we are rule because people oftentimes get trained here, and then they leave, and they go somewhere else. Oftentimes our clinicians or our treatment providers are not able to be trained in you know kind of the the best evidence-based practices for working with with people who are experiencing a substance, use disorder.

Megan Ragan: And then you know all of these things. These are things that

Megan Ragan: everybody, regardless of you know socioeconomic status or experience. These are things that kind of impact. Anyone who's living in a rural community. These are kind of like general experiences of a parent who is parenting in a rural community.

Megan Ragan: But whenever you throw in kind of the the extra factor of parental substance, misuse, then that family and that parent are more likely to be disproportionately impacted by these disadvantages.

Megan Ragan: That is something that we cannot forget. As we're going through this, it's kind of like. Whenever you think of
Megan Ragan: in my mind whenever I think of parents who are using substances. I don't think, really, that everyone is starting at the same starting line. Some people you know, come from very disadvantaged backgrounds. They come from very, you know, multi-generational you know adversity settings.

Megan Ragan: And so we're not all started at the same place. And so that is something that I think we all have to kind of keep in mind. And and you know, really for me, it humanizes the people that we are talking about. It really reminds us that we're human, and this is a human experience that all of us are having.

Megan Ragan: Drew.

Dhru Mukherjee: Well, I would like to, As

Dhru Mukherjee: you know, while highlighting those things. You know, literature has lots of you know, factors that identify parental substance use to many family cultural coping mechanisms and dynamics, and which at the end of the day put the whole.

Dhru Mukherjee: You know, responsibility on the parents, which is, which is understandable in an extent. But in the next couple of slide I, you know, because I know I had sent, I has spent time in a paraprofessional like Perim and Mothers support group where

Dhru Mukherjee: where someone some of the my parents, literally I overheard them talking about, like you know, when there there is a drug, and you'd say no to a child. You need to say no a. As if it's it is. It is something that was a

Dhru Mukherjee: that they have to do with the with with with an intentionality, because, you know, because in their multi-generational families hardly, They have seen that kind of a you know reinforcement. So you you know, there is. We have all our, we we learn things through our developmental path.

Dhru Mukherjee: and then we lot we. Sometime when we are in in recovery, we we we acquire, you know, new skills and all e, even in our later life. So one of the thing that we want to highlight here is the role of. You know the connection between trauma

Dhru Mukherjee: and stress and and and substance use as a coping mechanism, and looking at the parental substances as a you know, additional factors that kind of contribute to the profile of the parents, and

Dhru Mukherjee: kind of trying to highlight that more in a very clinical way. So when you look at the support system, or you know the the secure base which is kind of the relationship of our attachment pattern. We realize that, par, you know we, we, I I kind of divide that into 3 bases. The first base is a parent's ability to care for themselves and their own needs.

Dhru Mukherjee: as the second base is the parents support network, and the third base is that parents ability to responsibly and appropriately care for their dependent. And when we are talking about these 3 bases as a culture, we take them for granted as if all parents who are our parents.
Dhru Mukherjee: It's pretty obvious to them that they should have access to these 3 bases of support in a, and they should be having secure attachment to these 3 bases to kind of gather that support, and to know the you know kind of nurture their own ability to care for their kids and re rely on their support networks.

Dhru Mukherjee: But I know if we.

Dhru Mukherjee: if we take into the the traumatic stress, the history of trauma into consideration, sometimes even our internal processes, our access to receive support.

Dhru Mukherjee: our even if they are built available, is compromised by our maladjusted coping mechanisms that sometimes you know psychological trauma, childhood drum. And that's one of the reason that we ask for screening our parents with that first childhood experiences, because this gives us a developmental historical picture of If this parents have gone through

Dhru Mukherjee: abuse and try and and you know, traumatic experiences in their developmental stage, that they, even if they have support

Dhru Mukherjee: their ability to care and their ability to access. That support is kind of compromised, and this is what you know where we are going to kind of look into the profile of a parent from a trauma, informed Lance, and look at their maladgestive. T. You know patterns

Dhru Mukherjee: to see how a constructive behavioral health approach can help a parent now to forget about parents. There is something many of you may know about. There is like the the allostatic load which is a way of looking at

Dhru Mukherjee: how

Dhru Mukherjee: we respond to stress. And if you are a person with a a a, an unprocessed trauma in your life at the developmental trauma, then your processing of the stress is, is going to be very different.

Dhru Mukherjee: So if you look at this this chart over here, you know the first column looks at the state of our dependent functioning. That that means that we have a calm state and alert and alarm, fear and terror. These are the state dependent functioning

Dhru Mukherjee: and

Dhru Mukherjee: the dominant brain areas when we are calm is our default. Mode is our prefrontal cortex, our cortex, which is where we are rational. We are responsible. We we nurture, we make intentional behavior, we are able to change our behavior. These are all, you know. If our our the dominant brain, the prefrontal cortex, is at play, then if you look at the moment we go down a step and become alert.

Dhru Mukherjee: then our dominant, the brain activities kind of move from our dominant brain to a up a few notches down in the elevator to our limit system. But still the cortex is functioning. But it's kind of limited system and limits system usually react to things with fear, with anxiety, and and so on.
Dhru Mukherjee: So if you, if, when we are in a calm state, our dominant part of our brain is more rational, and our adaptive, which is the third column on the calm is reflection. That means when we are

Dhru Mukherjee: in our calm state, our reflect, our reflective tendencies are high. Then the fourth column said, adaptive of dissociation, that and so, when we are when something bad happen. But if we are in our calm state.

Dhru Mukherjee: We kind of intentionally a a dissociate to protect ourselves. But we are still, you know, in a position to make decision in a reflective way.

Dhru Mukherjee: Our Our cognition is abstract. That means we don't. We see things underlying things that are not there, but we are in an abstract. You know we are, we are able to think in an abstract way, and if you look at it, our

Dhru Mukherjee: General IQ. Is very high when we are in our calm state of being. That is exactly the reason that as a clinician, whenever a client comes, I we do some grounding exercise to bring their, you know, a parasympathetic nervous system go up and bring some sort of calm next to them, so that their intentional ability of it's intentional behavior and understanding. Go up.

Dhru Mukherjee: But now imagine, if you're in an alert state of being, your limbic system is taking over a, and then your your adaptive tendencies would be to either. You know if you look at the alert and along state is either you can

Dhru Mukherjee: you avoid it? Some some of us avoid, and or some of us get like.

Dhru Mukherjee: but aroused like anxiously attached people, and, you know, avoidantly attached people, people. Some people dissociate, and some people get performative with their anxiety. So in alert and alarm stage. If you look at this 2, you know, on on those 2 rows across the columns you are going to find that

Dhru Mukherjee: limbic system kind of takes over, we have a freeze and flock mentality. Some of us avoid. Some of us are compliant. I know some of us try to comply, and with that anxiety perform. And some of us are, you know, dissociative tendencies we avoid.

Dhru Mukherjee: and we are in, you know, emotional in our you know, in our cognition, our our ability to it. It think through things irrespective of our emotion. Kind of reduces. Our IQ overall falls.

Dhru Mukherjee: Now you go down to the fear element, and you're going to find that

Dhru Mukherjee: the elevator goes down beyond your limbic system in your bread, in your brain STEM where it's. It's the most like the reptile area of your brain. The the earliest part of your brain development is the the brain STEM area, and the fear and terror is where it goes beyond the the limbic system and goes to your brain STEM. Then you have.

Dhru Mukherjee: and that fear gives you. If your dissociative kind you are going to run away from that fear flight, flight. If you are anxious type and your performances are not working, you will start fighting.
Dhru Mukherjee: You will start like you know. Try to protect yourself. You see that’s the ultimate anxious behavior. And then you, if your adaptive style is dissociate again, you're going to fly. You're going to paralyze you'll be catatonic. But if you are anxious, your dissociation level at a terror level is that the ultimate dissociation is fainting.

Dhru Mukherjee: So we start dissociating from our mind. We start dissociating by being, you know, at higher level. It become catatonic. It's like trying to stay away from the reality, and then everything falls apart, you lose complete control of your external environment.

Dhru Mukherjee: You faint, you collapse, and that's also a a fainting itself is a dissociative tendency, and if again a in terror. We are reflexive. Our cognition has completely gone. We are not thinking about anything. We are depending on.

Dhru Mukherjee: Our reflexive evolutionary tendencies to, you know, survive our we don't realize that when we start running our legs started running before our mind tool to our like to run. You know, if it's completely dependent on that. Our brain kind of got suspended overall IQ. The ability to

Dhru Mukherjee: way options and make a critical decision is very low. Now, this states i'm not. You know I the only thing I want you to look at this chart and think

Dhru Mukherjee: this is not like we happening to different type of people under different type of traumatic situations. This happens to us every day when I get up in the morning, and everything is fine. I'm in a calm state, as workload goes at the day unfolds. You know my my brain activity move from my cortex to my limbic system. I find myself making a lot of emotional decision as the day unfolds in the evening.

Dhru Mukherjee: I am way more limbic in the evening that i’m in the morning that maybe my pattern, and you know. So it the decisions i’m making, and a way late when there's less sugar in my mind in in my brain, and when i’m like tired and exhausted with one stress and the other, you know, loading.

Dhru Mukherjee: adding to my allostatic load, and the more stress, the more the ability to stay calm reduces, and you go down in a in the downstairs brain of your of your mind. So when you are parent, if you look at from this, you know, you know.

Dhru Mukherjee: additive, a a model of stress. A person in addiction who is not married doesn't have any dependency

Dhru Mukherjee: is single, has a job or doesn't have a job, but have parents supporting them? That person's level of stress is only the substance use that causing them stress or causing them. They cope, or whatever the they may have childhood trauma, and then maybe some other stuff that causing them stress. And they're coping. But if you are a parent.

Dhru Mukherjee: and you know a a and i’m not talking about in any extreme circumstances. Even now, if you're a parent without a substance, use problem.

Dhru Mukherjee: you are going to find that you have additional State stressors just because of kids.
Dhru Mukherjee: If you have one kid, you have additional stressor. You have 2 kids. You have. You have more stressor. You have 3, you have more. You have then 2 dogs. You have further stress. You have to think about like, okay, before I even travel what? Where? Who is going to look after these dating people static elements

Dhru Mukherjee: right? So lots of stress to cater to them. To you know the more dependent the the you know, these people are the the stress level. Go up. And then, along with that with any normal person, you have stressors at your work stressors because of external factors, like inflation going up, and you know, ability to purchase. Go down, and all that.

Dhru Mukherjee: So you know, if you look at this whole thing, we are always. It's a spectrum. We are not always in our calm state. We are always moving back and forth, depending on how the day unfolds for us.

Dhru Mukherjee: And from that this perspective I would say that you know a parent in a rural area with multiple children and drug addiction and lack you know and and multiple multi-generational families, invalidating their drug addiction as a maladjusted coping mechanism going on.

Dhru Mukherjee: You are always in your alarm and fear state and If you have unprocessed trauma. You know your coping mechanism is immediately some sort of man adjusted coping mechanism.

Dhru Mukherjee: They're reducing your ability to stay calm or access your prefrontal cortex, your functional IQ. Your cognition, and you are more emotional. more your decisions that you cannot. Your ability to separate facts from emotions, facts from frictions, reduces the more stress. Go up.

Dhru Mukherjee: So from this stress cadence perspective. If you look at it, you're going to find that the parents in addiction are having, you know, to deal with the lots of stuff that we think any normal human would be dealing with, but they're compromised by their

Dhru Mukherjee: a not only their stress. But if they have unprocessed trauma developmentally from their childhood that add to that, and then they are dissociative. They, you know they have man malad jut to mal adjusted coping mechanism that further leads and make them vulnerable

Dhru Mukherjee: to cope with substances for which you did. They don't have to go anywhere. And so again we have another. You know. This is one kind of theoretical perspective that I we we kind of encourage you to view the the problem with the the population with the profile of the parent web. And then another thing is that the more

Dhru Mukherjee: a a you know, less traumatized, a a bringing. You have your ability to. You know our resilience is that there is more stress. But I am able to kind of.

Dhru Mukherjee: you know. Put some of the stress away and take one stress at a time and address it, and that ability that resilience develops also developmentally from the way you are, You're growing up as a child. And so we have this concept that you know resilience. It's all about our window of tolerance.

Dhru Mukherjee: The more our allostatic lows go up, our stressor, go up our unprocessed trauma. Pile up our window of tolerance.
Dhru Mukherjee: You know the bandwidth of it reduces it Doesn't mean that you know I I If all this stuff you if you're investing on yourself. If you're if you're aware of these things, then, even if there are more stress, your your resilience is how your window of tolerance is higher.

Dhru Mukherjee: But if it is not, then you are going to, you know, have a more anxious, you know, like hyper arousal way of looking at things which is basically a hyper arousal. It's a Ptsd symptom of one kind where you are easily overwhelmed. You react things. You kind of you're reactive. Your you show your anger.

Dhru Mukherjee: you know. Behavior of, you know, problematic behavior. Go up like fight, and you know your hyper vigilant all the time. High energy and a kind of manic state, and kind of trying to cope with that Don't know what to do with it, if you already associative kind and a hyperousal state. That's also a way of live

erez agmoni kind of, you know, bumping off from the window of tolerance where you kind of dissociate and your depression. You freeze, you give your you know your your sense of self is full of shame, and

Dhru Mukherjee: you become passive and withdrawn any shutdown. These are the 2, you know, way of kind of coping with it, where the element of trauma, childhood, trauma, developmental thing, access to support having the support is not enough, you know there's lots of things that contribute to the access to support.

Dhru Mukherjee: And if you look at this stigma doesn't help stigma, only reinforces the trauma more and more. And therefore you

Dhru Mukherjee: parental drug use. When we look at from this trauma-informed lens from this trauma in from perspective. We we do feel like the image of a parent. The way that is prevalent in the literature is one of the biggest perpetrator of child abuse there that there is.

Dhru Mukherjee: It's kind of to start getting shifted, you know. You cannot expect parents to be stigmatized by everything, and then also access the services and take care of their affairs, because they are going to be always in that allostatic state

Dhru Mukherjee: where they would not be. And you know that the dysfunction will continue at the systemic level, and the blame will continue to be poured on at the individual level, which is the problem which is the biggest cause of fragmentation of everything, and the problem versus given. If all this money we pour in interventions.

Dhru Mukherjee: So of all the populations of people who use drugs, possibly the most stigmatized that we have seen in our world communities apparent with the with, with the dependent children who are also parents. In addiction. Therefore, parents in addiction as a term as opposed to practice, we person in addiction. We are also trying to popularize.

You know there are stigma that are explicit.
Dhru Mukherjee: that that in the comm that it persist in the community. Sometimes they persist in law, enforcement, and child welfare, then a stigma that is implicit, that came out in our needs assessment, even from providers that were supposed to help them. Pro. You know the pro provide services, because if we bring people to services and their skill, their internal, ex internalized stigma do not go away, and it is very important to make the space secure for providers to bring those stigma out and not hide them, because if they hide them, they're going to compete.

Dhru Mukherjee: their relationship with the client and bring them out in their supervision session. Bring them out and able to talk and process, and that is a better way of going about this, you know. So we

Dhru Mukherjee: we are planning in our project to, therefore do a a a stigma study of some sort, and so that at a provider level of both primary care, behavioral health and substance use providers at at prevention, treatment, harm, reduction, and recovery. You know a spectrum to see their stigma and and try to address this, that more information, the more thing we bring into you into a collective consciousness. Individual consciousness.

Dhru Mukherjee: the more stigma reduces with more understanding and more normalization, which you call like gradual exposure of things that is true in any clinical intervention.

Dhru Mukherjee: and that's the only way to reduce the stigma. So we are kind of working with the, you know, to to to understand, and the landscape of stigma in our provider and community level, right and

Dhru Mukherjee: and trying to kind of create a image of that parent identity. So, Megan, now you can move on to the next one.

Dhru Mukherjee: So

Dhru Mukherjee: And now, having said that, how we you know this understanding of parents in addiction, that you know how, if we can make that understanding happen. How would that change our? You know

Dhru Mukherjee: our approaches, and one of the thing before we go anywhere? I would like to say that I love the idea of how using the recovery lens all across the board, because recovery lens gives us.

Dhru Mukherjee: you know, has a grace in embedded in it. You are always in recovery, and your relapses are not necessarily stigmatized, and costs show. Sh showed as a as a

Dhru Mukherjee: as a failure. And so we we are trying to kind of bring the recovery lens across, you know, out even in other aspects of our community responses to health and behavioral health in general, so that there is grace, and there is lack of stigma if we are all in the process and journey of recovery.

So the next slide me. And then.

Dhru Mukherjee: so, if you look at, you know historically the Child Abuse Prevention Act of 1,974 and comprehensive addiction, Recovery Act of one to 2,007, 16,
Dhru Mukherjee: and 2,018, and the American rescue plan 2022. This American rescue plan is the one that funded and lots of opioid response program. We have the Recovery Act of 2,016, a Sorry, 2,018. The Family First Prevention Act also funded. You know, community response to opioid.

Dhru Mukherjee: A. You know, a a a problem in the rural areas. But if you look at most of all these acts

Dhru Mukherjee: that addressed recovery had a aspects of children involved in it. If you, the way they conceptualize the problem is very much looking at.

Dhru Mukherjee: you know, improving access improving access, for whom

Dhru Mukherjee: this typical person in recovery, not a parent not looking at the ripple effect of that person, as if the person who is in addiction, is isolated from everything that the rel relation on landscape of his life.

Dhru Mukherjee: So, seeing a person as an Adam seeing a person as somebody somebody who is in addiction dealing with his own problem and his problem with that that person's problem is not having a ripple effect in the family and in the children.

Dhru Mukherjee: You know it it. That conceptualization of the clientele is what we are challenging. Again, the even if harm reduction. You know, services have been funded during in these acts, but the explanation of how, where harm reduction is coming from. There is no training. There is no pre training being done.

Dhru Mukherjee: and you know. So and mostly we looked at like reducing supplies and looking more or more of the mainstream issues than looking at the the problem from the different sides where you know the

Dhru Mukherjee: where where the deep system can literally, you know, address some of these problems. So so, Megan, you have any other things to say, or maybe move on to the next one, because maybe we have.

Megan Ragan: Yeah, we have. We have about 12 min left, and I know we want to make sure we can grab questions at the end. So

Megan Ragan: these are. These are our last 2 slides, and these are about some different trauma informed approaches to family recovery that that we have seen Drew. Do you want to kind of kick us off, and then i'll jump in where I have. We are increasing the screening and trying to like gather information. Like

Dhru Mukherjee: you know it is. And gathering information about, you know the a. A. Stigma so that we w in one of our pro by expansion of the program we are doing parental classes.

Dhru Mukherjee: We, I have introduced a case management for parents who have children referred in the child protective services. The case management is going to look into data such as ease of use. That means how.
Dhru Mukherjee: after the parents has been given that number or their child, you know, refer to the has a
contact with chart protective services.

Dhru Mukherjee: What is the time lapse between that incident and the parent actually receiving some sort
of substantive service, and that usually is 9 to 10 weeks. And and if the parents is doing a loan, and most
of the time they don't follow up. But we are trying to see introducing this intervention where a case,
management

Dhru Mukherjee: and and coordination, making sure that the parents are actually receiving the services,
reduce the ease of use time, and that will have a positive response in the parents recovery. So that was the
hypothesis with which we are going and providing that case management to parents. We are working with
a child, you know, training, child welfare, workforce.

Dhru Mukherjee: child protective services, investigator, workforce both at the government, as well as the
contractual community who work in a child welfare, a a and and law enforcement, and trying to highlight
these aspects of parent. You know the the profile of parent in in addiction
to bring about an a and highlighting gathering information about the social determinants of addiction as
well, and taking the health approach. Health lens, trauma informed lens, and

Dhru Mukherjee: the the the disease model of addiction to counter some of the stigmatized, you know.
Ways of thinking is also it's something that we have widely adapted in our communities. Megan.

Megan Ragan: Anything else you

Megan Ragan: and that they are able to use these family-centered approaches and their practices. So I
want to say that that is, that is fantastic, Kristen. I I love to hear that this is being done, and I know Drew
does, too. These are some things that we have come across in in the literature, in our practice, just kind of
in, like a wide scan of all the different

Megan Ragan: things that pertain to practice with the specific population. These are some of the common
components that that create a successful environment for for families to recover as a unit rather than to
be be separated.

Megan Ragan: So some of these you'll notice the the thing that I love about them is that a lot of the things
are are done on a very voluntary harm. Reduction kind of basis

Megan Ragan: that, you know. Services are offered on a voluntary basis. People can, you know, use them,
utilize them whenever they want to. No one is required to do services, and these are all kind of
components of primary prevention programs. So these are programs that can, and programs and activities
that can be put into place

Megan Ragan: prior to and hopefully kind of heading off this involvement with child protective services
with families who experience substance, use.

Megan Ragan: So services are voluntary, services are centrally located and easily accessible, and the
services align with the community values and the norms and the culture that are represented in the community. This is a big one. Bullet Number 4 services operate independently of the government. So this for me, is something that's very important, because it kind of helps to

Megan Ragan: sort of sidestep some of the fear that that parents and families may have, and kind of seeking these preventative services, if we are not connected with any sort of government entity, but rather where you know a group of

Megan Ragan: community members that are coming together to kind of, you know. Put these services in place to try to support the people that that live and work in our in our area.

Megan Ragan: Services are also offered, and this is very important, Obviously, in a very normalized and non stigmatizing way. Recovery. That recovery length that Drew mentioned is kind of woven throughout all of these that you know, things like this are things that happen, and all part of some people's human experiences, and that doesn't mean that you know we have to completely just, you know, disband the family, and and come from at it from this very punitive lens.

Megan Ragan: also the the next to last bullet that the services include very concrete support. So this is. This is one of the things, and we actually just had a conversation last week with one of our colleagues about this.

Megan Ragan: that whenever we are working with people who who have some sort of substance, use disorder, or people who are using substances, Oftentimes we really miss the opportunity to kind of provide this sort of stability, whether it's economic stability, food, assistance, housing, assistance, childcare employment, whatever it is, all of these things are are different pieces and components of prevention and and family recovery that cannot be ignored.

Megan Ragan: whenever these are ignored. That we are, you know, not really addressing one major lingering piece of that. That parents, you know, all static load, whatever a parent feels that they are able to, you know, put food on their table that they're able to have appropriate housing that you know they are contributing, and if they are able to provide these supports for their their children and their families. It it really gives this this

Megan Ragan: intrinsic sense of purpose that that we're. If we miss that we are doing a disservice here

Megan Ragan: through thoughts.

Dhru Mukherjee: Well, again, the importance is doing more screening and bringing about.

Dhru Mukherjee: you know, like more of a I would say, that we training opportunities for providers. Sometimes we have many providers who are providing like client and services, but they need to have more training, and at the at the B 2 B services for

Dhru Mukherjee: to to be able to appreciate the you know the challenges of the new phenomenon, like, you know, we started about talking about social determinants of health and social determinants of a a addiction only in a recent time; and many of our providers, you know, do not have a clear clear
understanding. So

Dhru Mukherjee: a it includes, including, you know, Macro level factors into the screening, you know, is is very important, and I think that that is what

Dhru Mukherjee: we are trying to do a. And addressing the system. You know it's systemic fragmentation, and there are some other systemic challenges that contribute to fragmentation as well. That is kind of also cause challenges for parents to seek services that we are trying to address.

Megan Ragan: and with that

Megan Ragan: we would like to take any remaining questions that anyone have we has. We we have about 4 min left in this Webinar, and obviously we really this is the subject that we're very passionate about. So I have included both of our email clear at the bottom of this slide and feel free to reach out and talk with us. We love to hear about what everyone else is doing and learn about. You know what is working for you, what is working for you and your community, your practice.

Megan Ragan: we just this is a subject that we're very passionate about, and we're also very passionate about learning more and expanding our base of knowledge.

Megan Ragan: So, Hayley, I would like to hand it over to you at this time, unless we have any questions. Come in.

Haley Hartle, NAADAC: Yes, absolutely thank you both so much. That was amazing. I'm glad we got to answer some questions earlier on, so I will. I will do some wrap up slides if we don't have any other questions.

Haley Hartle, NAADAC: and then, in the meantime, before we close out the Webinar, If you all have any last minute questions, put those in the Q. A. Box, and then we'll be sure to send those to you both, and then we can post the answers.

Haley Hartle, NAADAC: So, getting a lot of positive feedback in the chat, everybody saying this has been super useful than you both. So that's awesome. This is a fantastic Webinar, just a reminder for you all about the Ce. Process. So if you were in here for the full training. You should get an email about a minute or 2 after the training ends.

Haley Hartle, NAADAC: be sure to check your spam. It could go into there, and that should give you a link to the Ce quiz. You can also access it from the live event page like the one on my screen.

Haley Hartle, NAADAC: and you may need to refresh your page

Haley Hartle, NAADAC: to get access to that, and then a couple of additional upcoming webinars that we have. We do have part 3 of our Peer Support Series. That's a free Webinar series that we're doing. I'm. On April 20, seventh.

Haley Hartle, NAADAC: and then on Friday. May fifth is the part 2 of the same series. So we are looking
forward to hearing from a couple of more presenters for that one, and then part 3 on May tenth.

Haley Hartle, NAADAC: and then just a couple of reminders about the benefits of joining me back by joining Nadak as a member. You have immediate access to over 320 Ce. And those are included as an exclusive benefit.

Haley Hartle, NAADAC: and that is all I have. So if you, Megan or Dr. Drew, have any last minute thoughts that you wanted to share great. If not, we will let everybody be on their way.

Dhru Mukherjee: Well, I think that many of our participants are doing very important work, and you know I I feel like we are all bringing our experiences in the field, and I really appreciate each and every one of you trying to make it make the increase the protective factors in our communities.

Haley Hartle, NAADAC: Awesome. Well, thank you. Yes, any last minute. Thoughts from me, Megan.

Megan Ragan: I don't believe so. No, thank you. We have. It's been our privilege to to share this information with you. You all are doing such amazing work, and we are happy to support it.

Haley Hartle, NAADAC: Awesome. Well, thank you both so much for taking time out of I'm. Sure you're very busy days to be here with us, and a couple of people posting in the Q. A. Thank you again, and we will let everyone be on their way. Thank you so much. Have a great day. Everyone.