CHILD ABUSE AND NEGLECT
USER MANUAL SERIES

Protecting Children in Families Affected by Substance Use Disorders

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau
Office on Child Abuse and Neglect

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Protecting Children in Families Affected by Substance Use Disorders

ICF International

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Preface

Each day, the safety and well-being of children across the Nation are threatened by child abuse and neglect. Many of these children live in homes where substance use disorders (substance abuse and dependence) create additional and compounding problems. The child welfare and alcohol and drug abuse treatment fields are working to find effective ways to serve families where this overlap occurs. Intervening effectively in the lives of these children and their families is not the responsibility of a single agency or professional group, but rather it is a shared community concern.

Since the late 1970s, the *Child Abuse and Neglect User Manual Series* has provided guidance on child protection to hundreds of thousands of multidisciplinary professionals and concerned community members. The *User Manual Series* offers a foundation for understanding child maltreatment and the roles and responsibilities of various practitioners in its prevention, identification, investigation, and treatment. Through the years, the manuals have served as valuable resources for building knowledge, promoting effective practices, and enhancing community collaboration.

A number of changes have occurred that dramatically affect each community's response to child maltreatment since the last update of the *User Manual Series* in the early 1990s. The changing landscape reflects increased recognition of the complexity of issues facing children and families, new legislation, practice innovations, and systems reform efforts. Significant advances in research have helped shape new directions for interventions, while ongoing evaluations show "what works."

The Office on Child Abuse and Neglect within the Children's Bureau of the Administration for Children and Families, U.S. Department of Health and Human Services, has developed this third edition of the *User Manual Series* to reflect increased knowledge and the evolving state of practice on child protection. The updated and new manuals are comprehensive in scope, while succinct in presentation and easy to follow, and they address trends and concerns relevant to today's professional.

This manual, *Protecting Children in Families Affected by Substance Use Disorders*, provides a basis for understanding parental substance use disorder and its relationship to child maltreatment. The manual is intended to help child protective services (CPS) caseworkers identify when drug and alcohol use by a parent or other caregiver is a factor in child welfare cases and work more effectively to meet the needs of all family members involved. The manual encourages enhanced collaboration between CPS and alcohol and drug abuse treatment agencies. While CPS caseworkers are the primary audience, alcohol and drug abuse treatment providers may find the manual helpful in building their understanding of child protection issues among the families with whom they work. It also may be useful to other professionals,

such as those working in health care, mental health, child care, law enforcement, and child advocacy.

This manual builds on information presented in other publications in the series, particularly *A Coordinated Response to Child Abuse and Neglect: A Foundation for Practice* and *Child Protective Services: A Guide for Caseworkers*. Readers are encouraged to begin with these manuals as they address important information on which CPS practice is based.

User Manual Series

This manual—along with the entire *Child Abuse and Neglect User Manual Series*—is available from Child Welfare Information Gateway. Contact Child Welfare Information Gateway for a full list of available manuals and ordering information:

Child Welfare Information Gateway
1250 Maryland Avenue, SW
Eighth Floor
Washington, DC 20024
Phone: (800) FYI-3366 or (703) 385-7565
Fax: (703) 385-3206
Email: info@childwelfare.gov

The manuals also are available online at **http://www.childwelfare.gov/pubs/usermanual.cfm**.

Acknowledgments

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Acknowledgment of Prior Edition

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CHAPTER 1
Purpose and Overview

The relationship between substance use disorders (SUDs) and child maltreatment is compelling and undeniable. More than eight million children in the United States live with at least one parent who abused or was dependent on alcohol or an illicit drug during the past year.[1] These children face a heightened risk of maltreatment.[2] One study, for example, showed that children of parents with SUDs are nearly three times more likely to be abused and more than four times more likely to be neglected than children of parents who do not abuse substances.[3]

According to the National Child Abuse and Neglect Data System (NCANDS), in 2006, an estimated 3.3 million referrals were made to child protective services (CPS), representing 6 million children. From this population, approximately 905,000 children were found to be victims of child abuse or neglect. Of the maltreated children, 66.3 percent were neglected (including medical neglect), 16.0 percent physically abused, 8.8 percent sexually abused, and 6.6 percent psychologically maltreated. Additionally, 15.1 percent of victims were associated with "other" types of maltreatment, such as abandonment or congenital drug addiction. A child could be identified as a victim of more than one type of maltreatment.[4] Additionally, while estimates vary, most studies suggest that parental SUDs are a contributing factor for between one- and two-thirds of children involved with CPS.[5]

Overview of the Connection Between Substance Use Disorder and Child Maltreatment

SUDs often affect the way people live, including how they function, interact with others, or parent their children. Studies suggest that SUDs, by impairing parents' judgment and priorities, can influence parental discipline choices and child-rearing styles and have negative effects on the consistency of care and supervision provided to children.[6] The time and money parents spend on seeking out or on using drugs or alcohol may limit the resources available in the household to meet their children's basic needs. In addition, families affected by SUDs often experience a number of other problems—including mental illness, domestic violence, poverty, and high levels of stress—which also are associated with child maltreatment.

Children of parents who have SUDs and who are also in the child welfare system are more likely to experience emotional, physical, intellectual, and social problems than children whose parents do not have SUDs. Additionally, abused and neglected children from families affected by substance abuse are more likely to be placed in foster care and to remain there longer than maltreated children from families not affected by substance abuse.[7]

Note on Terminology

Those working with individuals, families, and communities affected by the use and abuse of alcohol and drugs use a wide variety of terms to describe the same or similar concepts, especially the spectrum of substance use. While some readers may be more accustomed to using the term "substance abuse" to mean any dependence, addiction, or abuse of a substance, this manual uses the term "substance use disorder," which encompasses both abuse and dependence (addiction). (See Chapter 2, *The Nature of Substance Use Disorders*, for more details about the definitions of these terms.) The phrase "substance use disorder" has been adopted by the public health and alcohol and drug treatment fields as less stigmatizing and more reflective of the disease's characterization as a disorder with biological, psychological, and social origins. Some within the child welfare field have also begun to use this term.

Additionally, reliable, consistent, or generalizable data are limited concerning the relationship between substance abuse and the frequency of child maltreatment because researchers often define terms such as "substance abuse" or "child abuse" differently, they collect data from sources that have divergent perspectives, and neither State alcohol and drug abuse treatment nor State child welfare data systems consistently require staff to report information about this overlap. When presenting results of studies, this manual, where possible, uses the same terminology as used in the research description.

For more information about terminology related to SUDs, please refer to the following:

- *National Association of Social Work Standards for Social Work Practice with Clients with Substance Use Disorders* (**http://www.socialworkers.org/practice/standards/NASWATODStatndards.pdf**)
- *Substance Use Disorders: A Guide to the Use of Language* (**http://www.pacdaa.org/pacdaa/lib/pacdaa/Substance_abuse_disorders.doc**), a publication of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

CPS caseworkers and SUD treatment providers also report conflicting pressures that arise from trying to meet concurrently:

- The timeframes required by the Adoption and Safe Families Act to promote permanency for abused and neglected children
- The time required to access open treatment slots
- The time necessary for successful treatment participation
- The developmental needs of children.[8]

These challenges underscore the need for quick and effective screening, assessment, and treatment, if necessary, of SUDs among families in the child welfare system. Further, they point to the need for partnerships between the CPS and SUD treatment systems to support parents in obtaining the services they need, while ensuring the safety and well-being of children.

Organization of the Manual

To assist families experiencing SUDs as well as child maltreatment, CPS caseworkers must recognize and address each problem and their interaction. This manual is structured first to provide CPS caseworkers and other readers with the groundwork for understanding SUDs and their dynamics, characteristics, and effects. The manual then places parental SUDs into the context of child protection

and describes its impact on children, as well as its relationship to child maltreatment. Several chapters are devoted to helping CPS caseworkers understand how to recognize and to screen for SUDs in child maltreatment cases, to establish plans for families experiencing these problems, and to support treatment and recovery, as appropriate. The manual also addresses ways in which CPS and SUD treatment providers can coordinate their work, which is critical to improving outcomes for both parents with SUDs and their children.

Specifically, the manual addresses:

- The nature of SUDs
- The impact of parental SUDs on children
- In-home examination, screening, and assessment for SUDs
- Treatment of SUDs
- The role of the CPS caseworker when an SUD is identified
- Similarities and differences between CPS and SUD treatment providers
- "Putting it all together"—making the systems work for families.

Readers should note that no single publication can address all the intricate factors and interactions related to the connection between SUDs and child maltreatment, but this manual can contribute to an increased understanding of the issues and identify avenues for enhanced services to families. Professionals should supplement it with other information, training, and professional development activities.

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CHAPTER 2

The Nature of Substance Use Disorders

In This Chapter

- The continuum of alcohol and drug use
- Appropriate and inappropriate uses of substances
- Characteristics of addiction
- Why some people become addicted
- Negative consequences of SUDs
- Co-occurring issues

Understanding the nature and dynamics of substance use disorders (SUDs) can help child protective services (CPS) caseworkers in screening for SUDs, making informed decisions, and developing appropriate case plans for families experiencing this problem.

The Continuum of Alcohol and Drug Use

Substance use, like many human behaviors, occurs along a broad continuum from no use to extremely heavy use. The likelihood of an individual experiencing problems stemming from substance use typically increases as the rate of use increases. The continuum for the use of substances includes substance use, substance abuse, and substance dependence or addiction.

Substance use is the consumption of low or infrequent doses of alcohol or drugs, such that damaging consequences are rare or minor. In reference to alcohol, this means drinking in a way that does not impair functioning or lead to negative consequences, such as violence. In reference to prescription drugs, use involves taking medications as prescribed by a physician. Regarding over-the-counter medications, use is defined as taking the substance as recommended for alleviating symptoms. Some people who choose to use substances may use them periodically, never use them to an extreme, or never experience life consequences because of their use.

Substance abuse is a pattern of substance use that leads to significant impairment or distress, reflected by one or more of the following:

- Failure to fulfill major role obligations at work, school, or home (e.g., substance-related absences from work, suspension from school, neglect of a child's need for regular meals)
- Continued use in spite of physical hazards (e.g., driving under the influence)
- Trouble with the law (e.g., arrests for substance-related disorderly conduct)
- Interpersonal or social problems.[9]

Additionally, use of a medication in a manner different from how it is prescribed or recommended and use of

an intravenous drug that is not medically required are considered substance abuse.

Individuals may abuse one or more substances for a certain period of time and then modify their behaviors because of internal or external pressures. Abuse is characterized by periodic events of abusive use of substances, which may be accompanied by life consequences directly related to its use. With proper intervention, an individual with substance abuse problems can avert progression to addiction. At this level of progression, the abusers often are not aware, or if they are, they may not be honest with themselves that the negative consequences they experience are linked to their substance use. With proper intervention, these individuals are able to choose to limit or to cease substance use because of the recognition of the connection between use and consequences. Other people, however, may continue abusing substances until they become addicted.

Substance dependence or addiction is the progressive need for alcohol or drugs that results from the use of that substance. This need creates both psychological and physical changes that make it difficult for the users to control when they will use the substance or how much they will use. Psychological dependence occurs when a user needs the substance to feel normal or to engage in typical daily activities. Physical dependence occurs when the body adapts to the substance and needs increasing amounts to ward off the effects of withdrawal and to maintain physiological functioning. Dependence can result in:

- **The continued use of a substance despite negative consequences**. The individual continues drug or alcohol use despite incidents, such as accidents, arrests, or a lack of money to pay for food because it was spent on drugs.
- **An increase in tolerance to the substance**. The individual requires more of the alcohol or drug to obtain the same effect.
- **Withdrawal symptoms**. The individual needs to consume the substance in order not to experience unpleasant withdrawal effects, such as uncontrollable shaking and tremors or intense nausea.
- **Behavioral changes**. The individual who is dependent:
  - Uses more than intended
  - Spends a majority of the time either obtaining, using, or withdrawing from the use of the substance
  - Cannot stop using until the substance is gone or the individual passes out.

Criteria for diagnosing substance dependence and substance abuse as an SUD have been defined in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (DSM-IV-TR), the American Psychiatric Association's classification index for mental disorders. (See Appendix D, *Diagnostic and Statistical Manual of Mental Disorders Criteria*, for more information on this topic.)

Appropriate and Inappropriate Uses of Substances

Certain substances, when used appropriately, have helpful and even lifesaving uses. Many individuals use various drugs to help overcome physical and psychological problems. Drugs can alleviate cold and flu symptoms, make it easier to sleep, reduce physical or emotional pain, and help overcome feelings of anxiety, panic, or depression. Some of these drugs require a prescription from a doctor to be obtained legally, while others are considered safe enough to be sold over the counter to the public. Although these drugs have many health benefits, many also can be used in a higher quantity or in combination with other substances to produce either a "high" or a numbing effect. Combining these drugs with alcohol or other drugs can intensify their effects and increase risks to the user and to those around the user. Individuals who abuse prescription medication sometimes resort to forging prescriptions, to visiting several doctors who will prescribe the same drug without asking questions ("doctor shopping"), or

to buying stolen drugs. Exhibit 2-1 provides key statistics for commonly abused substances.

Other substances may not have medicinal qualities but can affect users psychologically and physically or lower inhibitions and impair judgment if misused. For instance, some individuals drink alcohol at social gatherings to feel more comfortable talking and relating to others. Being of legal age and drinking alcohol is a commonly accepted practice in the United States. Of course, alcohol often can be misused and can negatively affect events ranging from traffic safety to the ability to care adequately for children.

Exhibit 2-1
Selected Drug Statistics from the National Survey on Drug Use and Health (NSDUH)*

- An estimated 19.9 million Americans, or 8.0 percent of the population aged 12 or older, were current illicit drug users in 2007.** (This figure reflects use of the following drugs: marijuana, cocaine, heroin, hallucinogens, and inhalants and the nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives.)
- The estimated number of Americans who were current users of the following drugs in 2007:
  - Marijuana: 14,448,000
  - Cocaine: 2,075,000 (including 610,000 users of crack)
  - Hallucinogens: 996,000 (including 503,000 users of Ecstasy)
  - Inhalants: 616,000
  - Heroin: 338,000
- In 2007, approximately 6.9 million people aged 12 or older (2.8 percent of the population) were current users of prescription-type psychotherapeutic drugs taken nonmedically, including pain relievers, tranquilizers, stimulants, and sedatives. This includes 529,000 individuals who were current users of methamphetamine, which can be manufactured illegally using existing prescription drugs.
- An estimated 22.3 million Americans aged 12 or older in 2006 (9.0 percent of the population) were classified with substance abuse or dependence. Of these:
  - 3.2 million abused or were dependent on both alcohol and illicit drugs;
  - 3.7 million abused or were dependent on illicit drugs but not alcohol;
  - 15.5 million abused or were dependent on alcohol but not illicit drugs.[10]

* These statistics are drawn from the 2007 NSDUH, an annual survey of the civilian, noninstitutionalized population of the United States aged 12 or older. To see the full results of the most recent survey, visit the website of the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies: **http://www.oas.samhsa.gov/nsduhLatest.htm**.

** "Current users" reflect persons who used the specified drug during the month prior to the NSDUH interview.

Quick Facts on Alcohol Use

- Slightly more than half of Americans aged 12 or older, or approximately 127 million people, reported being current drinkers of alcohol in the 2007 NSDUH. (Current drinkers were defined as having had at least one drink in the 30 days prior to the survey.)
- An estimated 17 million people (6.9 percent of the population) were heavy drinkers. (Heavy drinking was defined as having five or more drinks on the same occasion on at least 5 different days in the past 30 days.)
- Among pregnant women aged 15 to 44, an estimated 11.6 percent reported current alcohol use, and 3.7 percent reported binge drinking. (Binge drinking was defined as having five or more drinks on the same occasion on at least 1 day in the past 30 days.)
- Excessive alcohol use is the third leading lifestyle cause of death in the United States and was determined to be a key factor in approximately 79,000 deaths annually from 2001–2005.
- The U.S. Dietary Guidelines for Americans recommends no more than one drink per day for adult women and no more than two drinks per day for adult men. It also lists several types of individuals—including children, adolescents, and pregnant women—who should avoid alcohol completely.[11]

For more information on commonly abused substances, see Appendix E, *Commonly Abused Substances*.

With respect to child protection, substance use becomes problematic when it contributes to the harm of children. This can be difficult for CPS caseworkers to identify because the distinction between "normal" alcohol use and problematic use may be blurred and subject to interpretation. (See Chapter 4, *In-home Examination, Screening, and Assessment of Substance Use Disorders*, for more information about identifying SUDs.)

Characteristics of Addiction

Knowing the characteristics of addiction can help inform effective intervention and practice with individuals suffering from SUDs. Characteristics include:

- **Progressive Nature**. A central feature of addiction is a progressive use of a substance, whether alcohol, prescription medications, or illegal drugs. The physical, emotional, and social problems that arise from addiction typically continue to worsen unless the SUDs are treated successfully. If left untreated, addiction can cause premature death through overdose; through organic complications involving the brain, liver, heart, and many other organs; and by contributing to motor vehicle crashes, homicide, suicide, and other traumatic events.
- **Denial and Concealment**. Addiction can be difficult to identify, even for individuals experiencing it. People who are addicted to a substance often engage in elaborate strategies to conceal the amount being consumed and the degree to which the substance is affecting their lives. Another dimension of addiction is that individuals who suffer from it often do not

perceive that their pattern of drinking or drug use creates or contributes to their problems. Additionally, the use of substances may affect their memory or perception of events or of what they have said or done. This lack of recognition commonly is identified as denial.

- **Chronic Disease**. The National Institute on Drug Abuse has defined addiction as a chronic disease, like heart disease, hypertension, and diabetes. Studies have shown alcohol and drug abuse treatment is about as effective as treatments required for these other chronic diseases. Lifetime management of chronic diseases in all cases requires individuals to change their habits and activities and to take precautions that prevent them from relapsing or worsening their condition.

- **Lapses and Relapses**. Lapses and relapses are common features of addiction. A lapse is a period of substance use after the individual has been clean and sober for some length of time. A relapse is not only using the substance again, but also returning to the problem behaviors associated with it.[12]

Addiction is difficult to deal with; many individuals lapse or relapse one or more times before being able to remain abstinent. If lapses or relapses occur, they do not necessarily mean that treatment has failed. They can point the way toward needed improvements in how those individuals are approaching recovery. Most individuals who have lapsed or relapsed can identify, prior to the lapse or relapse, certain situations, thoughts, or behaviors that contributed to the use of the substance.

Why Some People Become Addicted

Many theories and explanations have been proposed to describe the reasons why some individuals become addicted to substances and others do not. Research on the causes of addiction is not conclusive, and multiple factors may contribute to it. Early explanations for addiction included moral weakness, insanity, demonic possession, and character pathology.[13] These explanations, combined with the problematic behaviors that sometimes accompany addiction, have created a serious stigma. Recent research, however, indicates that substance addiction is a brain disease that changes its structure and functioning, which in turn affects an individual's behaviors. Although the initial use of a substance may be voluntary, a person's ability to control future use may be seriously impaired by changes in the brain caused by prior use.[14]

Some research, including adoption and twins studies, has demonstrated a biological and genetic predisposition to addiction, with scientists estimating that genetic factors account for 40–60 percent of an individual's risk of addiction.[15] These studies suggest that an individual's genes play a role in vulnerability to addiction. For example, one study found that children whose parents are addicted to drugs or alcohol are three times more likely to develop an SUD later in life than children whose parents are not addicted.[16] Other research emphasizes a social factor to explain that addictions appear to "run in the family." These studies suggest that children who grow up in families with SUDs may model their adult behavior on what they have seen and known in their familial experience.[17] Risk for addiction can also be affected by gender, ethnicity, developmental stage, and social environment.[18] In other words, both nature and nurture contribute to a person's vulnerability or resistance to substance abuse.

Many self-help groups, such as 12-step programs, consider addiction a progressive illness that is physical, spiritual, and emotional in nature. They believe that individuals who are addicted must admit that they are powerless over the substance; that is, they are unable to resolve the problem on their own and must seek help outside themselves.[19]

Addiction

People who are addicted to drugs are from all walks of life. Many suffer from poor mental or physical health, occupational, or social problems, which make their addictive disorders much more difficult to treat. Even if there are few associated problems, the severity of addiction itself ranges widely among people.

Isn't drug addiction a voluntary behavior? A person may start taking drugs voluntarily, but as times passes and drug use continues, something happens that makes a person go from being a voluntary drug user to a compulsive drug user. This happens because the continued use of addictive drugs changes the brain. These changes can be dramatic or subtle, but often, without treatment, they result in compulsive or even uncontrollable drug use.

How is addiction similar to a disease? Drug addiction is a brain disease. Every type of drug abuse has its own mechanism for changing how the brain functions. Regardless of which drug a person is addicted to, many of the effects on the brain are similar. These may include modifications in the molecules and cells that make up the brain, changes in memory processes and thinking, transformation of moods, and sometimes changes in motor skills, such as walking and talking. These changes can have a significant influence on all aspects of a person's behavior and can cause the individual to do almost anything to obtain the drug.

Why can't drug addicts quit on their own? In the beginning, almost all addicted individuals believe that they can stop using drugs on their own, and most try to stop without treatment. However, most of these attempts fail to achieve long-term abstinence. Research has shown that long-term drug use results in significant changes in brain function that persist long after the individual has stopped using drugs. These drug-induced changes in brain function can have many behavioral consequences, including the compulsion to use drugs despite adverse consequences—one of the defining characteristics of addiction.

Understanding that addiction has such an important biological component may help explain the difficulty in achieving and maintaining abstinence without treatment. Psychological stress from work or family problems, social cues (e.g., meeting individuals from one's drug-using past), or the environment (e.g., encountering streets, objects, or even smells associated with drug use) can interact with biological factors to hinder sustained abstinence and to make relapse more likely. Research studies indicate, however, that even the most severely addicted individuals can participate actively in treatment and that active participation is essential to good outcomes.[20]

Negative Consequences of Substance Use Disorders

Negative consequences from alcohol and drug use, abuse, and dependence generally fall into three categories: loss of behavioral control, psychophysical withdrawal, and role maladaptation.

Loss of behavioral control happens when individuals do things they normally would not do because their inhibitions and reasoning abilities are impaired. Loss of behavioral control can include passing out, having a blackout (i.e., short-term memory loss), behaving violently, leaving children unsupervised or in a potentially unsafe situation, and neglecting children's basic needs.

Psychophysical withdrawal occurs when individuals experience physical symptoms that result from withdrawing from using a substance. Indicators of psychophysical withdrawal include becoming nauseated or vomiting; feeling feverish, hot, sweaty, agitated, or nervous; and experiencing significant changes in eating or sleeping patterns. In advanced cases, withdrawal may include experiencing, seeing, or hearing things that are not there, such as having the sensation of bugs crawling on the skin or having seizures or convulsions. Physical withdrawal, particularly from alcohol and heroin, can be life threatening.

Role maladaptation occurs when individuals cannot conform to what are generally considered their expected roles (e.g., parent, breadwinner). For parents, this can mean difficulties in caring properly for their children (e.g., prioritizing a need for drugs over a child's needs for food and clothing). Other examples of role maladaptation due to SUDs include relationship problems, failure to keep a job, difficulties paying the bills, and criminal activity.

Problems in one area will not necessarily indicate or predict problems in other areas. Someone who experiences regular hangovers from drinking (defined as anxiety, agitation, nausea, and headaches) can experience these symptoms without experiencing a significant loss of behavioral control or role maladaptation. Others struggling with addiction, however, may suffer from all three consequences.

Co-occurring Issues

CPS caseworkers must place SUDs into context with the other problems that families may face. In general, these families have more numerous and complex issues to address than those who are not abusing or addicted to alcohol and drugs. Similarly, child abuse and neglect seldom occur in a vacuum; these families often are experiencing several layers of problems. For both SUDs and child maltreatment, common co-occurring issues include mental and physical illnesses, domestic violence and other trauma, economic difficulties or poverty, housing instability, or dangerous neighborhoods and crime.[21] All of these challenges can constitute barriers to successful participation in SUD treatment and, when addressed, can improve an individual's chances of attaining long-term abstinence. The following sections describe some of the most common co-occurring issues experienced by families affected by child maltreatment and SUDs. The goal is to increase caseworker awareness of the variety of symptoms and factors, particularly those most likely to affect assessment and decisions regarding services for families and children involved in CPS cases.

Mental Illness

SUDS have a strong association with mental illness. In 2007, an estimated 24.3 million adults aged 18 or older had a serious mental illness.[22] (Having a serious mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder during the past year that met the DSM-IV criteria.) Adults with a serious mental illness are much more likely to have used illicit drugs within the past year than those adults without a serious mental illness (28.0 percent versus 12.2 percent).[23]

It is not clear why there is a high correlation between SUDs and mental illness. Three ways in which they may relate to one another are:

- The disorders may occur independently of each other.
- The mental health disorder may place an individual at greater risk for SUDs.
- Alcohol or drug intoxication or withdrawal may result in temporary mental health disorders, such as paranoia or depression.[24]

It is common for either the SUD or the mental health issue to go undiagnosed. In addition, not all mental health problems affecting a parent necessarily will appear severe or profound. As a result, when one issue is identified, it is important to screen for the other. When both are identified, current accepted practice is

to treat both disorders simultaneously, especially with individuals who have serious mental illnesses.

Physical Health Problems

SUDs can cause or worsen physical health problems. For example:

- Alcohol abuse can cause numerous physical problems related to the function of the liver, heart, digestive system, and nervous system.
- Marijuana use is associated with ailments ranging from a burning or stinging sensation in the mouth or throat, to respiratory problems, to an increased likelihood of cancer in the throat and lungs.
- Individuals who inject drugs, such as heroin or methamphetamine, put themselves at risk of contracting infectious diseases, such as HIV/AIDS and hepatitis C, through the sharing of syringes and other injection paraphernalia.

Domestic Violence and Other Forms of Trauma

Trauma can take the form of a physical injury or a painful or disturbing experience that can have lasting effects. It can result from exposure to a variety of events ranging from natural disasters to violent crimes. The consequences of trauma can be significant, affecting the victim on biological, psychological, social, and spiritual levels.

Individuals who have experienced a traumatic event sometimes turn to drugs or alcohol in an effort to deal with the resulting emotional pain, anxiety, fear, or guilt. If the pattern becomes well established, it may indicate that the person has an SUD. SUDs, particularly if they are active over a period of time, increase the likelihood of further exposure to accidental and intentional acts that may result in additional trauma. In addition, individuals who have not experienced a traumatic event, but have an SUD, have an increased likelihood of exposure to events that may then result in trauma, such as being assaulted.

Studies have shown that a high percentage of women treated for SUDs also have significant histories of trauma.[25] Women who abuse substances are more likely to experience accidents and acts of violence, including assaults, automobile accidents, intimate partner violence, sexual abuse and assault, homicide, and suicide.[26]

Alcohol commonly is cited as a causal factor and precursor to adult domestic violence. Research studies indicate that approximately 25 to 50 percent of domestic violence incidents involve alcohol and that nearly one-half of all abusers entering batterer intervention programs abuse alcohol.[27] Despite the evidence that many batterers and victims abuse alcohol, there is no empirical evidence that substance use disorder directly causes domestic violence. However, SUDs increase the severity and frequency

Post-traumatic Stress Disorder

Women who abuse substances sometimes cite continued substance use as a perceived aid in controlling symptoms of post-traumatic stress disorder (PTSD).[30] PTSD is a psychiatric disorder that can occur following the experience or the witnessing of life-affecting events, such as military combat, violent or sexual assaults, or natural disasters. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. PTSD also is associated with impairment of the ability to function in social or family life, including employment instability, marital problems and divorce, family discord, and difficulties in parenting. Research has indicated that women with PTSD are twice as likely to abuse or to be dependent on alcohol and are four times as likely to abuse or to be dependent on drugs.[31] When compared to other traumas, sexual abuse and physical abuse have been found to be associated with the highest rates of PTSD.[32]

of the batterers' violence and interfere with domestic violence interventions.[28] They also contribute to the increased severity of injuries among victims.[29]

Poverty

SUDs cross all socioeconomic lines, but studies show that there is a relationship between poverty and substance abuse.[33] People living in poverty sometimes turn to substances for relief from the anxiety and the stress associated with economic insecurity. Of course, spending money on alcohol or drugs often only contributes to economic problems. Dealing illegal drugs is viewed by some as a source of income and a means of escaping poverty. Unfortunately, some individuals suffering from economic hardship feel that they have little to lose if they get involved in drugs, no matter what the effects are on themselves or their families.

Parents who are distracted by their financial problems may have less energy and attention for parenting. In some homes, the psychological distress of poverty may be directed toward the children. Research has indicated a strong association between child maltreatment, particularly neglect, and poverty.[34] CPS case plans invariably need to address issues related to poverty and establish service plans for families.

Homelessness

In some cases, extreme poverty and other factors may lead to homelessness. Homeless people typically experience several overlapping challenges, including SUDs, mental illnesses, and a variety of physical health problems. Parents with children account for approximately 11 percent of the homeless population, and this number appears to be growing.[35]

Crime

Crime has a strong association with drug use. In the most recent study of its kind, more than three out of every four State, Federal, or local jail inmates previously were involved seriously with drugs or alcohol in some way (e.g., convicted of a drug- or alcohol-related crime, used illicit substances regularly, were under the influence of alcohol or drugs when they committed a crime).[36] Another study found that adults who were arrested for a serious offense were much more likely to have used an illicit drug in the prior year (60.1 percent) than those who were not arrested (13.6 percent).[37] In addition, many individuals in prisons and jails experience multiple, overlapping problems. For instance, research indicates that among inmates with a serious mental disorder, 72 percent have a co-occurring SUD.[38] It often is challenging for these individuals to obtain appropriate services either in prison or upon their release.

Because women are generally the primary caretakers of their children, the increase in the number of incarcerated women over the past decade is particularly relevant to CPS caseworkers. The Bureau of Justice Statistics reports that the female prison population increased from 44,000 in 1990 to more than 111,000 in 2006.[39] One-third of incarcerated women have been convicted of drug offenses, and approximately 65 percent of women in prison report having used drugs regularly.[40] Additionally, 75 percent of incarcerated women are mothers, and two-thirds have minor children, who often are placed outside the home while their mothers are incarcerated.[41]

In response to problems arising from low-level, nonviolent drug offenses, many States and localities have established alternative, less putative programs, such as drug courts, to rehabilitate offenders. (For more information on drug courts, see Chapter 8, *Putting It Together: Making the Systems Work for Families*.)

Methamphetamine Use and Its Impact on Children

Methamphetamine is a powerfully addictive drug, and individuals who use it can experience serious health and psychiatric conditions, including memory loss, aggression, violence, psychotic behavior, and potential coronary and neurological damage.[42] Its use in the United States has become an issue of great concern to professionals working with children and families. In 2007, there were an estimated 529,000 current users of methamphetamine aged 12 or older. Approximately, 5.3 percent of the population reported using this drug at least once in their lifetime.[43] Methamphetamine is also known by ever-changing street names, such as speed, ice, crystal, crank, tweak, glass, bikers' coffee, poor man's cocaine, chicken feed, shabu, and yaba.[44]

As with any children of parents with an SUD, children whose parents use methamphetamine are at a particularly high risk for abuse and neglect. What compounds the problem for children of methamphetamine users is that the drug is relatively easy to make, and therefore, many of these children are exposed to the additional risks of living in or near a methamphetamine lab. During 2005, an estimated 1,660 children were injured, killed at, or affected by methamphetamine labs. In each of the prior 3 years, the number of affected children was over 3,000.[45] The manufacture of methamphetamine involves the use of highly flammable, corrosive, and poisonous materials that create serious health and safety hazards. Children affected by methamphetamine labs may exhibit symptoms such as chronic cough, skin rashes, red or itchy eyes, agitation, inconsolable crying, irritability, and vomiting.[46]

Many communities have Drug Endangered Children (DEC) programs that assist CPS caseworkers, law enforcement, and medical services to coordinate services for children found living in environments where drugs are made. For more information on DEC programs, visit **http://www.whitehousedrugpolicy.gov/enforce/dr_endangered_child.html**.

CPS agencies have witnessed the effects of methamphetamine use on the child welfare population. In a 2005 survey by the National Association of Counties, 40 percent of CPS officials reported that the number of out-of-home placements due to methamphetamine use had increased in the previous year. In addition, 59 percent of the CPS officials reported that methamphetamine use had increased the difficulty of family reunification.[47]

Because of the dramatic escalation of methamphetamine use and the severity of its effects, further information on the drug and its impact on child welfare can be found throughout this manual. Additional resources are available at **http://www.childwelfare.gov/systemwide/service_array/substance/drug_specific/meth.cfm** and **http://www.methresources.gov/**.

CHAPTER 3
How Parental Substance Use Disorders Affect Children

In This Chapter

- The impact of substance use on prenatal development
- The impact of substance use on childhood development

The lives of millions of children are touched by substance use disorders (SUDs). The 2007 National Survey on Drug Use and Health reports that 8.3 million children live with at least one parent who abused or was dependent on alcohol or an illicit drug during the past year. This includes 13.9 percent of children aged 2 years or younger, 13.6 percent of children aged 3 to 5 years, 12.0 percent of children aged 6 to 11 years, and 9.9 percent of youths aged 12 to 17 years.[48] These children are at increased risk for abuse or neglect, as well as physical, academic, social, and emotional problems.[49]

A predictable, consistent environment, coupled with positive caregiver relationships, is critical for normal emotional development of children. Parental substance abuse and dependence have a negative impact on the physical and emotional well-being of children and can cause home environments to become chaotic and unpredictable, leading to child maltreatment. The children's physical and emotional needs often take a back seat to their parents' activities related to obtaining, using, or recovering from the use of drugs and alcohol.[50]

This chapter discusses how prenatal and postnatal substance use by parents affects fetal and early

A Definition of Child Maltreatment

The Child Abuse Prevention and Treatment Act, reauthorized in the Keeping Children and Families Safe Act of 2003 (P.L. 108-36), provides the minimum standards for defining child physical abuse, neglect, and sexual abuse that States must incorporate into their statutory definitions in order to receive Federal funds. Under this Act, child maltreatment is defined as:

"Any recent act or failure to act on the part of a parent or caregiver, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm."[51]

A "child" under this definition generally means a person younger than age 18 or who is not an emancipated minor. In cases of child sexual abuse, a "child" is one who has not attained the age of 18 or the age specified by the child protection law of the State in which the child resides, whichever is younger.[52]

childhood development. It is intended to help child protective services (CPS) caseworkers understand the behaviors and problems that some children in the child welfare system may exhibit and that hold implications for their potential need for services.

The Impact on Prenatal Development

In 2006 and 2007, an average of 5.2 percent of pregnant women aged 15 to 44 years used an illicit drug during the month prior to being surveyed, and 11.6 percent had consumed alcohol.[53] Nationwide, between 550,000 and 750,000 children are born each year after prenatal exposure to drugs or alcohol.[54] These children often are medically fragile or born with a low birth weight. Some are born prematurely and require intensive care.

Identifying the effects of drugs and alcohol on fetuses has posed challenges for researchers. While there has been some success researching the effects of alcohol on fetal development, securing accurate information regarding the use of illicit drugs from pregnant women or women who have given birth has proven to be very difficult. In addition, women who abuse substances often have other risk factors in their lives (e.g., a lack of prenatal care, poor nutrition, stress, violence, poor social support) that can contribute significantly to problematic pregnancies and births. The sections that follow summarize some of what is known about the effects of substance use on prenatal development.

Pregnancy and SUDs

Women who use alcohol or illicit drugs may find it difficult or seemingly impossible to stop, even when they are pregnant. Moreover, pregnancy can be stressful and uncomfortable. For someone who commonly uses drugs and alcohol to minimize pain or stress, this practice may not only continue, but also become worse. Pregnant women can face significant stigma and prejudice when their SUDs are discovered. For these reasons, some women avoid seeking treatment or adequate prenatal care. Other pregnant women, however, do seek treatment. According to the Substance Abuse and Mental Health Services Administration, 3.9 percent of the women admitted to State licensed or certified SUD treatment programs were pregnant at the time of admission.[55] In another study, pregnant women aged 15 to 44 years were more likely than nonpregnant women of the same age group to enter treatment for cocaine abuse.[56]

The Effects of Prenatal Exposure to Alcohol

Drinking alcohol during pregnancy can have serious effects on fetal development. Alcohol consumed by a pregnant woman is absorbed by the placenta and

Screening Newborns at Birth

Opinions differ about how best to respond to prenatal substance exposure. Some hospitals are reconsidering whether they should test newborns for drugs, and some courts are treating prenatal substance exposure as a public health matter, turning to CPS only if they determine the child was harmed. Decisions regarding whether and when to screen newborns for prenatal substance exposure are beyond the purview of CPS.

Child welfare legislation has provided some guidance regarding how such cases should be handled. The Keeping Children and Families Safe Act of 2003 requires that health care providers notify CPS, as appropriate, to address the needs of infants born exposed to drugs, and requires the development of a plan of safe care for any affected infants. In 2006, statutes in 15 States and the District of Columbia specified reporting procedures when there is evidence at birth that an infant was exposed prenatally to drugs, alcohol, or other controlled substances. Additionally, 13 States and the District of Columbia included prenatal substance exposure in their definitions of child abuse or neglect.[57]

directly affects the fetus.[58] A variety of birth defects to the major organs and the central nervous system, which are permanent, can occur due to alcohol use during pregnancy, though the risk of harm decreases if the pregnant woman stops drinking completely.[59] Collectively, these defects are called Fetal Alcohol Syndrome (FAS). FAS is one of the most commonly known birth defects related to prenatal drug exposure. Children with FAS may exhibit:

- Growth deficiencies, both prenatally and after birth
- Problems with central nervous system functioning
- IQs in the mild to severely retarded range
- Small eye openings and poor development of the optic nerve
- A small head and brain
- Joint, limb, ear, and heart malformations.

Alcohol-Related Neurodevelopmental Disorder (ARND) and Alcohol-Related Birth Defects (ARBD) are similar to FAS. Once known as Fetal Alcohol Effects, ARND and ARBD are terms adopted in 1996 by the National Academy of Sciences' Institute of Medicine. ARND and ARBD encompass the functional and physiological problems associated with prenatal alcohol exposure, but are less severe than FAS. Children with ARND can experience functional or mental impairments as a result of prenatal alcohol exposure, and children with ARBD can have malformations in the skeletal and major organ systems. Not all children who are exposed prenatally to alcohol develop FAS, ARND, or ARBD, but for those who do, these effects continue throughout their lives and at all the stages of development, although they are likely to present themselves differently at each developmental stage. Exhibit 3-1 compares typical childhood behavior at each developmental stage with behaviors and characteristics associated with FAS, ARND, and ARBD.

Exhibit 3-1
Childhood Behavior and Characteristics Associated with FAS, ARND, and ARBD[60]

Developmental Stage	Typical Behaviors or Characteristics	FAS/ARND/ARBD Behaviors or Characteristics
Infants	• Develop mental and physical skills • Bond with caretakers	• Problems with spatial and depth perception, muscle coordination and development, facility with speech, and processing information • Attention deficit disorder • Inability to focus • Possible attachment disorders
Toddlers	• Develop sense of self • Assert independence by saying "no"	• Difficulty exercising self-control, which leads to self-doubt and feelings of inadequacy
5–7 year olds	• Try new things • Meet or exceed academic standards • Learn new social skills	• Overwhelmed with new situations and interactions with other children • Inability to pick up social skills by observation • Problems meeting academic standards
8–12 year olds	• Increased influence of peers • Games become important method of bonding and developing interpersonal skills	• Difficulty remembering rules of games • Lack of remorse in breaking rules • Become depressed and exhibit other behavior problems
Teenagers	• Continued detachment from parents • Development of individual identity • Learn to identify with larger community	• May lack skills to become good community members • Become socially isolated • May find their way to peer groups that engage in high-risk behaviors • May withdraw altogether from groups

More information on FAS is available from the National Organization on Fetal Alcohol Syndrome (**http://www.nofas.org**) and the National Center on Birth Defects and Developmental Disabilities (**http://www.cdc.gov/ncbddd/fas**).

The Effects of Prenatal Exposure to Drugs

Similar to alcohol use, use of other substances can have significant effects on the developing fetus. For example, cocaine or marijuana use during pregnancy may result in premature birth, low birth weight, decreased head circumference, or miscarriage.[61] Prenatal exposure to marijuana has been associated with difficulties in functioning of the brain.[62] Even if there are no noticeable effects in the children at birth, the impact of prenatal substance use often can become evident later in their lives. As they get older, children who were exposed to cocaine prenatally can have difficulty focusing their attention, be more irritable, and have more behavioral problems.[63] Difficulties surface in sorting out relevant versus irrelevant stimuli, making school participation and achievement more challenging.

Pregnancy as a Motivation for Treatment

Given the dangers associated with substance use during pregnancy, women who abuse substances during pregnancy should receive treatment as early as possible. Research has found that women often are more amenable to entering treatment when they are pregnant.[67] CPS caseworkers and other professionals, therefore, should try to use the pregnancy to motivate women to change. CPS caseworkers may not have much opportunity to interact with women who have not yet given birth unless there are other children in the family who have entered the child welfare system.

Once their babies are born, significant changes can occur in the lives of women who abused alcohol or drugs during pregnancy. In the case of babies who test positive for substances at birth, the mothers may experience remorse and sadness over the actual or potential consequences of their substance use, which also can be a motivating factor to seek treatment. If CPS is involved, mothers may admit to enough drug use to explain the positive drug test, but not to an addiction, due to the fear of losing custody of their children. They may comply with treatment requirements in order to compensate for the problems their SUD may have caused their children. Nevertheless, new difficulties may begin when CPS closes the case and the pressure is off the mothers to stay clean. For instance, they may be tempted to use drugs and alcohol again. (For more information on treatment issues, see Chapter 5, *Treating Substance Use Disorders.*)

The Effects of Prenatal Methamphetamine Use

Prenatal exposure to methamphetamine can cause a wide range of problems, including birth defects, fetal death, growth retardation, premature birth, low birth weight, developmental disorders, and hypersensitivity to touch in newborns. Older children who were exposed prenatally to substances may exhibit cognitive deficits, learning disabilities, and poor social adjustment.[64]

Caseworkers should note that methamphetamine users might not be knowledgeable about the potential harm to themselves or to the fetus. Like cocaine and heroin users, methamphetamine users tend to avoid prenatal care clinics.[65] Caseworkers also should be careful of labeling children who have been exposed prenatally to methamphetamine. For example, labeling a child as a "meth baby" can cause the child or others to have lower expectations for academic and life achievements and to ignore other causes for the physical and social problems the child may encounter.[66]

The Impact on Childhood Development

Exposure to parental SUDs during childhood also can have dire consequences for children. Compared to children of parents who do not abuse alcohol or drugs, children of parents who do, and who also are in the child welfare system, are more likely to experience physical, intellectual, social, and emotional problems. Among the difficulties in providing services to these children is that problems affected or compounded by their parents' SUDs might not emerge until later in their lives.[68]

This section summarizes some of the consequences of SUDs on childhood development, including a disruption of the bonding process; emotional, academic, and developmental problems; lack of supervision; parentification; social stigma; and adolescent substance use and delinquency.

Disruption of the Bonding Process

When mothers or fathers abuse substances after delivery, their ability to bond with their child—so important during the early stages of life—may be weakened. In order for an attachment to form, it is necessary that caregivers pay attention to and notice their children's attempts to communicate. Parents who use marijuana, for example, may have difficulty picking up their babies' cues because marijuana dulls response time and alters perceptions. When parents repeatedly miss their babies' cues, the babies eventually stop providing them. The result is disengaged parents with disengaged babies. These parents and babies then have difficulty forming a healthy, appropriate relationship.

Neglected children who are unable to form secure attachments with their primary caregivers may:

- Become more mistrustful of others and may be less willing to learn from adults
- Have difficulty understanding the emotions of others, regulating their own emotions, or forming and maintaining relationships with others
- Have a limited ability to feel remorse or empathy, which may mean that they could hurt others without feeling their actions were wrong
- Demonstrate a lack of confidence or social skills that could hinder them from being successful in school, work, and relationships
- Demonstrate impaired social cognition, which is awareness of oneself in relation to others as well as of others' emotions. Impaired social cognition can lead a person to view many social interactions as stressful.[69]

Emotional, Academic, and Developmental Problems

Children who experience either prenatal or postnatal drug exposure are at risk for a range of emotional, academic, and developmental problems. For example, they are more likely to:

- Experience symptoms of depression and anxiety
- Suffer from psychiatric disorders
- Exhibit behavior problems
- Score lower on school achievement tests
- Demonstrate other difficulties in school.

These children may behave in ways that are challenging for biological or foster parents to manage, which can lead to inconsistent caregiving and multiple alternative care placements.

Positive social and emotional child development generally has been linked to nurturing family settings in which caregivers are predictable, daily routines are respected, and everyone recognizes clear boundaries for acceptable behaviors.[70] Such circumstances often are missing in the homes of parents with SUDs. As a result, extra supports and interventions are needed to help children draw upon their strengths and maximize their natural potential despite their home environments. Protective factors, such as the involvement of other supportive adults (e.g., extended

family members, mentors, clergy, teachers, neighbors), may help mitigate the impact of parental SUDs.

Lack of Supervision

The search for drugs or alcohol, the use of scarce resources to pay for them, the time spent in illegal activities to raise money for them, or the time spent recovering from hangovers or withdrawal symptoms can leave parents with little time or energy to care properly for their children. These children frequently do not have their basic needs met and often do not receive appropriate supervision. In addition, rules about curfews and potentially dangerous activities may not be enforced or are enforced haphazardly. As a result, SUDs are often a factor in neglect cases.

Parentification

As children grow older, they may become increasingly aware that their parents cannot care for them. To compensate, the children become the caregivers of the family, often extending their caregiving behavior to their parents as well as younger siblings. This process is labeled "parentification."[71]

Parentified children carry a great deal of anxiety and sometimes go to great lengths to control or to eliminate their parents' use of drugs or alcohol. They feel responsible for running the family. These feelings are reinforced by messages from the parents that the children cause the parents' SUDs or are at fault in some way if the family comes to the attention of authorities. Sometimes these children must contact medical personnel in the case of a parent's overdose, or they may be left supervising and caring for younger children when their parents are absent while obtaining or abusing substances.

Social Stigma

Adults with SUDS may engage in behaviors that embarrass their children and may appear disinterested in their children's activities or school performance. Children may separate themselves from their parents by not wanting to go home after school, by not bringing friends to the house, or by not asking for help with homework. These children may feel a social stigma attached to certain aspects of their parents' lives, such as unemployment, homelessness, an involvement with the criminal justice system, or SUD treatment.

Adolescent Substance Use and Delinquency

Adolescents whose parents have SUDs are more likely to develop SUDs themselves. Some adolescents mimic behaviors they see in their families, including ineffective coping behaviors such as using drugs and alcohol. Many of these children also witness or are victims of violence. It is hypothesized that substance abuse is a coping mechanism for such traumatic events.[72] Moreover, adolescents who use substances are more likely to have poor academic performance and to be involved in criminal activities. The longer children are exposed to parental SUD, the more serious the negative consequences may be for their overall development and well-being.

Child Abuse as a Precursor to Substance Use Disorders

Many people view SUDs as a phenomenon that leads to or exacerbates the abuse or neglect of children. Research also suggests, however, that being victimized by child abuse, particularly sexual abuse, is a common precursor of SUDs.[73] Sometimes, victims of abuse or neglect "self-medicate" (i.e., drink or use drugs to escape the unresolved trauma of the maltreatment).[74] One study found that women with a history of childhood physical or sexual abuse were nearly five times more likely to use street drugs and more than twice as likely to abuse alcohol as women who were not maltreated.[75] In another study, childhood abuse predicted a wide range of problems, including lower self-esteem, more victimization, more depression, and chronic homelessness, and indirectly predicted drug and alcohol problems.[76]

CHAPTER 4

In-home Examination, Screening, and Assessment of Substance Use Disorders

In This Chapter

- In-home examination
- Screening
- Assessment

The previous chapter described some of the effects of parental substance use disorders (SUDs) on children, but how does a child protective services (CPS) worker determine if SUDs exist in the family? This chapter discusses in-home examinations, SUD screening instruments, and SUD assessments, including their methods, benefits, and limitations, and how caseworkers can incorporate them into their practice.

In-home Examination

An in-home examination includes observations by the CPS caseworker of the people and the environment in a home. When visiting a home as part of an investigation, the caseworker should check for the following indicators of possible SUDs:

- A report of substance use is included in the CPS call or report
- Drug paraphernalia (e.g., a syringe kit, charred spoons, a large number of liquor or beer bottles)
- The scent of alcohol or drugs
- A child or other family member reports alcohol or drug use by a parent
- A parent appears to be under the influence of a substance, admits to having an SUD, or shows other signs of addiction or abuse (e.g., needle marks).

This list can be used pre- or post-screening and can be incorporated into every home visit.[77]

Screening

Screening is the use of a simple, and usually brief, set of questions that have been validated (i.e., tested to show that they accurately indicate the presence of an SUD). Results are easy to interpret. Generally, individuals who are not trained SUD treatment providers use the instruments.

The goal of screening is to determine whether a family member requires further evaluation for SUDs.[78] CPS caseworkers can use screening as a part of their standard home visits or family assessments. This section describes the importance of screening, sample screening instruments, benefits and limitations of screening instruments, and what to do when an instrument indicates an individual may have an SUD.

Signs of Methamphetamine Use and Manufacture[79]

With the increased use of methamphetamine, first responders are now more likely to work with clients who are users or manufacturers of this drug. The following information can assist them in identifying methamphetamine use or manufacturing.

Signs of possible methamphetamine use include:

- Increased breathing and pulse rate
- Sweating
- Rapid/pressured speech
- Euphoria (an exaggerated feeling of well-being)
- Hyperactivity
- Dry mouth
- Tremors (shaking hands)
- Dilated pupils
- Lack of appetite
- Insomnia or lack of sleep
- Bruxism (teeth-grinding)
- Depression
- Irritability, suspiciousness, paranoia
- Visual and auditory hallucinations
- Formication (the sensation of bugs crawling on the skin)
- The presence of white powder, straws, or injection equipment.

Signs that methamphetamine is possibly being manufactured in a home include:

- Laboratory equipment (e.g., flasks, rubber tubing, beakers, large amounts of coffee filters)
- Large quantities of pills containing ephedrine or pseudoephedrine (e.g., certain cold medicines)
- A chemical odor
- Chemicals not commonly found in a home (e.g., red phosphorous, acetone, liquid ephedrine, ether, iodine, phenylacetone [P2P])
- Unusually large quantities of household chemicals (e.g., lye, paint thinner)
- Chemicals usually found on a farm (e.g., anhydrous ammonia)
- Residue from the manufacture of methamphetamine (usually of a maroon color) in bathtubs, sinks, toilets, or on the walls
- Containers used for purposes not originally intended (e.g., glass milk or beer bottles with unfamiliar liquids)
- No visible means of income
- Unusual security precautions (e.g., extra locks, barred or blacked-out windows, expensive alarm systems).

Safety Issues When Encountering a Suspected Methamphetamine Lab

First responders should use extreme caution and seek assistance from law enforcement, fire/rescue personnel, hazardous materials crews, or other appropriate individuals or groups if they are visiting a home that has a suspected methamphetamine lab because these homes may have:

- Individuals under the influence of methamphetamine or other drugs and/or who may be armed
- Defense systems, including explosive devices and other booby traps
- Vicious animals
- Dangerous and volatile chemicals.[80]

First responders who enter a methamphetamine lab that has not been properly ventilated and cleaned—or who are not properly equipped to avoid exposure to chemicals (i.e., have respirators, protective clothing)—may experience shortness of breath, coughing, chest pain, dizziness, vomiting, lack of coordination, burns, and, in some cases, death. If first responders do come into contact with possibly dangerous chemicals, they should wash the exposed skin with liquid soap and water or, depending on the type of chemical exposure, a chemical solution. They also should remove contaminated shoes and clothing. First responders should be knowledgeable about agency protocols for the evacuation, decontamination, and health screenings of children and others found at the home, including which, if any, of the child's possessions (e.g., medications, eyeglasses) should be retrieved from the home and how they should be decontaminated.

First responders who determine they are in a home that has a suspected methamphetamine lab should immediately leave the residence, taking care not to:

- Touch anything in the lab
- Turn on or off any electrical switches (e.g., lights)
- Eat or drink anything
- Open, move, or sniff containers with suspected chemicals
- Smoke anywhere near the home.
- Alarm or act in a way that could be perceived as aggressive by others in the home (i.e., suddenly running from a room, pushing someone aside), especially suspected methamphetamine users, who may experience paranoia and extremely aggressive behavior.[81]

Importance of Substance Use Disorder Screening

Screening for SUDs should be a routine part of CPS investigations, risk and safety assessments, and case planning and monitoring. Evidence of SUDs may not be noticeable upon initial investigation, but may emerge over time as caseworkers develop relationships with a family or notice that family members are unable to participate in program activities. Given the prevalence of SUDs among families involved in the child welfare system, CPS caseworkers should consider screening during all stages of the case.

CPS caseworkers understandably may be uncomfortable discussing SUDs with family members who already feel threatened because of being under investigation for child maltreatment. Abuse and addiction are not always visible, and family members are likely to be reluctant to disclose activities that may be illegal or that could further jeopardize custody of their children. As described in Chapter 2, *The Nature of Substance Use Disorders*, SUDs often are masked by other problems, such as mental illness or domestic violence, and can be overlooked if those other problems

General Home Visit Safety Tips

Families experiencing multiple issues (e.g., SUDs, mental health problems, domestic violence, criminal behavior) can make it more dangerous for CPS caseworkers going into homes to investigate cases of child maltreatment. While on a home visit, caseworkers should remember the following safety tips:

- Ensure that the CPS supervisor knows the time and place of the appointment and the expected time of return.
- Dress appropriately and in a manner that blends into the community.
- Walk close to buildings or close to the curb in an effort to have at least one safe side. Stay away from bushes, alleys, and dark corners, if possible.
- Know the route in and out of the area by examining a map or by talking with others beforehand. Do not wander or appear lost or confused.
- Park as close to the home as possible and in a way that helps ensure an easy exit. Keep the car keys in hand while entering and exiting the home so they are easily available.
- Be aware of your surroundings at all times. Enter and leave homes carefully, noticing doors, windows, neighbors, loiterers, and anything or anyone that may be a risk to safety.
- If unsure of the safety or surroundings of the location, move to another spot by suggesting taking a break or getting a cup of coffee and finish talking there.
- Attempt to keep a clear path to an exit.
- Be aware of dogs that may pose a threat.
- Follow intuition and take action if feeling afraid or threatened. Leave the home or call 911 if necessary.
- Have access, if possible, to technology that may assist with safety issues (e.g., GPS systems, cell phones).

In cases where drugs and alcohol may be an issue in the family or the surrounding community:

- Go to the home with another caseworker or law enforcement officer, particularly if the home is in an area known for drug dealing.
- Know the local signs that indicate a drug deal is occurring. In such situations, do not enter the home without law enforcement personnel.
- Be aware of homes or other living environments that may be used as a clandestine drug factory. Do not attempt to investigate such places alone, and immediately contact the police or sheriff if such a lab is suspected. Anyone without proper training and protective gear should stay at least 500 feet away from any suspected laboratory. The following are signs of a possible lab:
  - Strong or unusual chemical odors
  - Laboratory equipment, such as glass tubes, beakers, funnels, and Bunsen burners
  - Chemical drums or cans in the yard
  - A high volume of automobile or foot traffic, particularly at odd hours
  - New, high fences with no visible livestock or other animals.
- If one or both parents appear to be intoxicated, high, incoherent, or passed out, ensure the safety and supervision of the children. Once that has been accomplished, it is appropriate to reschedule the appointment. It may be appropriate to call the supervisor for guidance.[82]

are more apparent. The opposite also can be true; an SUD may mask other problems, such as domestic violence or disabilities. Moreover, addiction often is characterized by denial, and family members may not recognize that they have an SUD. For example, they may feel that their drinking is within an acceptable range or that their marijuana use is not problematic.

Screening is just one of many approaches used to identify SUDs. It is not completely accurate nor will it work all the time (i.e., not all positive responses will demonstrate an SUD, and not all negative responses will rule out a disorder). CPS caseworkers should also rely on additional techniques, such as observation, medical histories, reports from family members or friends, or arrest records. Nevertheless, using a brief screening instrument takes little time and provides an objective method for caseworkers to use in opening a discussion about sensitive issues. In this way, screening becomes part of a continuum of activities aimed at addressing families' problems with SUDs.

Sample Screening Instruments

Ideally, screening instruments used by CPS caseworkers should be brief, easily administered,

Exhibit 4-1
Sample Screening Instruments for Substance Use Disorders

The CAGE Questionnaire (amended for drug use)

C Have you ever felt the need to **C**ut down on your drinking or drug use?

A Have you ever felt **A**nnoyed by people criticizing your drinking or drug use?

G Have you ever felt bad or **G**uilty about your drinking or drug use?

E Have you ever had a drink or used a drug first thing in the morning to steady your nerves or get rid of a hangover? (**E**ye-opener)

Scoring: If the answer is "yes" to one or more questions, the responder should receive a formal alcohol and drug assessment. Answering "yes" to one or two questions may indicate alcohol and drug-related problems. Answering "yes" to three or four questions may indicate alcohol or drug dependence.[83]

UNCOPE

U Have you spent more time drinking or **U**sing than you intended?

N Have you ever **N**eglected some of your usual responsibilities because of alcohol or drug use?

C Have you ever felt you wanted or needed to **C**ut down on your drinking or drug use in the past year?

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

P Have you found yourself thinking a lot about drinking or using? (**P**reoccupied)

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

Scoring: Two or more positive responses indicate possible abuse or dependence and a need for further assessment by an SUD treatment provider.[84]

inexpensive, and capable of detecting a problem or condition when it exists. Two screening tools available for CPS caseworkers are the CAGE and UNCOPE questionnaires, which are shown in Exhibit 4-1. These quick screens should be used with other information and observations.[85] For a list of screening instruments, see Appendix F, *Commonly Used Screening Instruments*. A sample instrument is available in Appendix G, *State of Connecticut Department of Children and Families Substance Abuse Screening and Information Form*.

Benefits and Limitations of Screening Instruments

Screening for SUDs is harder and requires more skill than screening for other problems among child welfare populations, such as barriers to work or stress. This is because SUDs often are characterized by stigma and denial and frequently involve illegal activities. Although screening instruments can provide useful information, they are not without flaws. Without informed interpretation and communication of their results, these instruments will not be effective. It is important to understand both the benefits and the limitations of screening instruments in order to use them properly.

The benefits of screening instruments include the following:

- Instruments provide a consistent structure for caseworkers to use in interviewing family members.
- Instruments can provide a starting point and context for further discussion and service planning.
- Instruments offer parents a chance to disclose an SUD and give caseworkers a chance to refer the parent to an SUD treatment provider for assessment.
- Screening instruments allow caseworkers to weigh an individual's responses to estimate whether SUDs might be a problem.
- Many instruments are widely available and accessible.
- Several instruments have been empirically tested for validity (i.e., the instrument is accurate) and reliability (i.e., the instrument is consistent).
- Many instruments take little time to administer and are not difficult to interpret.[86]

The limitations of screening instruments include the following:

- Screening instruments have been tested and found valid with a variety of populations, but every instrument may not be appropriate for every population. For example, some instruments may have been tested in settings where individuals go for health care and treatment, but not in public agencies or in situations where families know they risk losing their children. Before using a particular instrument in a CPS setting, it is important to check the literature regarding the appropriate use of that instrument.
- Screening instruments rely on self-disclosure. Even the best instruments administered under optimal circumstances will yield valid information only to the extent that families respond honestly.
- Denial is a characteristic of SUDs, and because of this, family members may not understand or acknowledge that their pattern of substance use represents abuse or addiction.
- Information obtained from the screening alone will be of little benefit unless it is part of a continuum of identification, assessment, and treatment.

Instruments are only one technique that caseworkers should use in exploring SUDs with family members. They should complement rather than replace other techniques to identify SUDs. Additionally, instruments are not always correct. If a caseworker suspects an SUD, but the screening instrument

does not indicate a problem, the caseworker's best judgment always should take precedence.

What to Do When a Screen Indicates a Substance Use Disorder

If the results of a screening instrument or an in-home check indicate that a parent may have an SUD, the CPS caseworker should take the following steps:

- Ensure that the parent receives an SUD assessment from a qualified SUD treatment provider.
- If an SUD is present, address it in the case plans for both the parent and the child.
- Ensure that a qualified professional assesses the child for the impact of parental SUD or for the possibility of the child's own use of substances.
- Coordinate service plans with the treatment professional.[87]

Even if an SUD initially has been ruled out as an important factor in the family's case plan, the caseworker should reassess if the family is not making progress in dealing with other issues. An unidentified SUD can hamper a family's progress for years.

Assessment

Once screening indicates that an individual may have an SUD, an assessment is the next step in a continuum of activities to address the problem. An assessment is a detailed evaluation used to determine whether treatment is needed. If so, then the assessment is

Drug Testing Parents

Physical drug testing of parents for evidence of substance use brings to the surface complicated and interrelated issues of public policy, science and technology, and ethics. Drug testing of adults has different goals in different contexts. For example, parole and probation officers use drug testing to monitor compliance with the conditions of parole and probation; employers use them to make hiring decisions; and alcohol and drug abuse treatment programs use tests to assess whether a person is complying with the treatment plan. Parents involved with CPS who are known to have an SUD are likely to be tested as part of their alcohol and drug abuse treatment or to meet court requirements. CPS may rely on the results of drug tests to inform decisions about providing services or reunification, or they may consider drug testing as a means of determining if there is an SUD. Whichever way drug testing is used, it is important for CPS caseworkers and administrators to understand the following uses and limitations:

- Drug tests do not demonstrate patterns of drug use or demonstrate if a person is abusing or is dependent on substances. Test results simply indicate the recent use of a substance and, for some substances, the amount used.
- Common drug tests do not provide accurate information about alcohol use because alcohol metabolizes quickly and is not detectable after approximately 8 hours.
- Whether drug use is detected by tests depends not only on the drug used, but also on other factors such as the characteristics of each drug, an individual's metabolism, and the cut-off levels established by the agency requesting the test or the laboratory analyzing it.
- Drug tests are typically physically invasive procedures, which raises questions about an individual's right to privacy.
- Individuals may be afraid to discuss problems if they believe they will be tested.
- Positive results from drug tests require that there be qualified and trained staff available to initiate careful and sensitive follow-up discussions with family members.[88]

utilized to design an appropriate treatment or service plan. Assessments should include various aspects of family living, such as housing, health issues, child behavior problems, and family strengths. In general, only professionals who are trained in administering assessments and in interpreting their results should conduct them.

Importance of Sharing Information

Ideally, the CPS caseworker and the SUD treatment provider who is conducting the assessment will share information. Information from the CPS caseworker about the case provides the context for the assessment. Likewise, results from the assessment can assist the CPS caseworker in developing a comprehensive and coordinated service plan. The caseworker should provide the following information, if available, to the SUD treatment provider along with the referral:

- The family member's arrest history related to substance use
- The condition of the home when home visits were conducted
- A history of SUD treatment participation by the family member
- Any other SUD-related information.

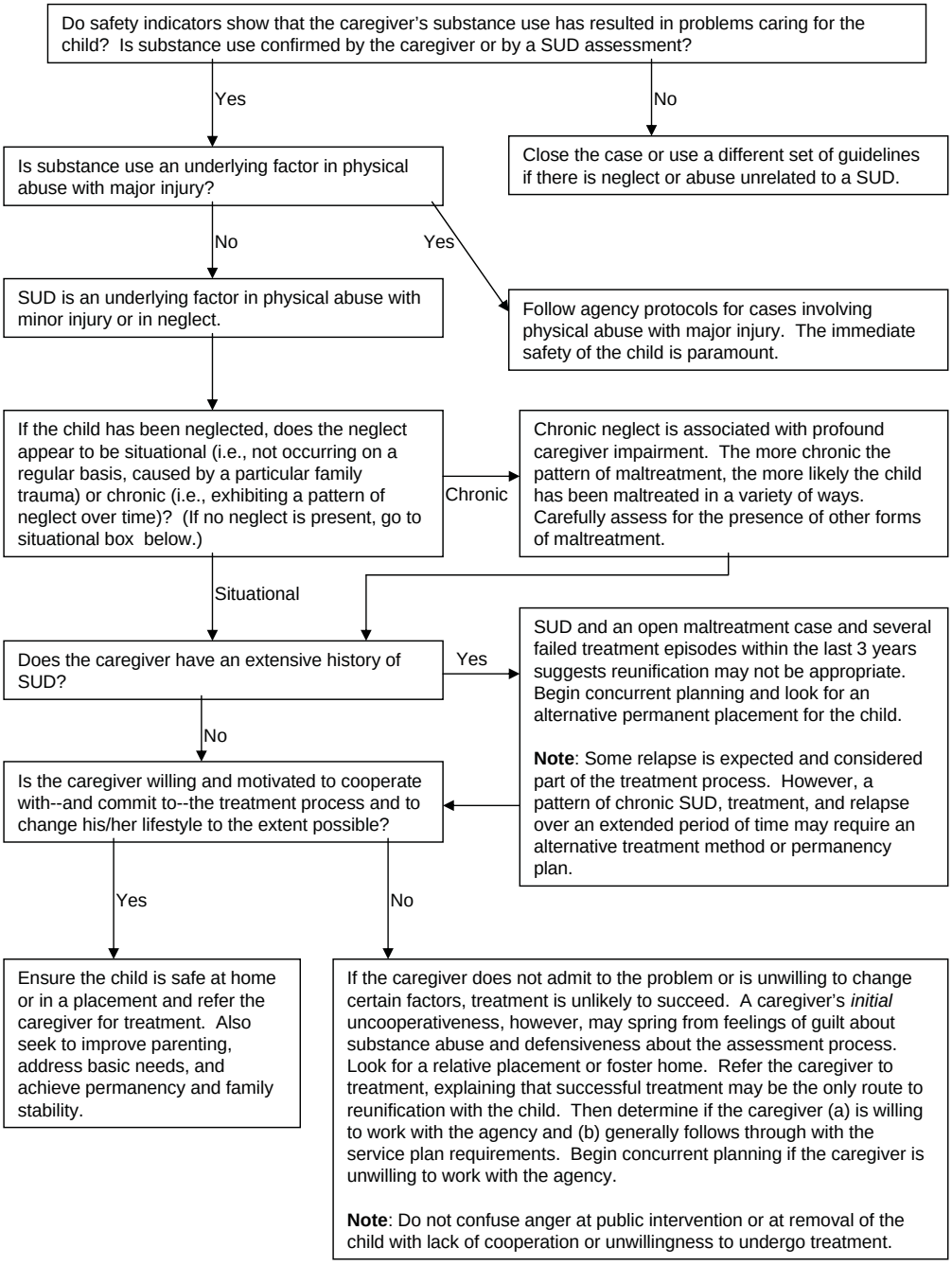
Key Points for Making Referrals and for Using Assessments

The following are key points to remember when making referrals for and conducting SUD assessments within the context of CPS:

- **The quality of the assessment is directly related to the quality of the information provided to the counselor conducting the evaluation**. Frequently, counselors rely on self-reported data in their evaluations. Self-reports often are criticized because there is a perception that individuals with SUDs often lie. This issue can be addressed by comparing the client's view of the problem with information available from other sources, such as a CPS caseworker, other service providers, and family members.
- **A good assessment should address the following family and parenting issues**:
  - How substance use affects the client's ability to be a good parent;
  - The level of care or intervention that would be most appropriate for this individual to address the current level of substance use;
  - What should be required of the parent in order to demonstrate the ability to rear the child safely in light of a problematic use of substances.
- **SUD treatment providers may feel that family-relevant assessments are beyond their professional scope of practice**. If a CPS caseworker encounters a situation in which the only SUD assessment available is conducted by someone with limited experience in addressing family issues, this should be stated explicitly in the caseworker's case notes and in court reports. Additionally, caseworkers should consult with a supervisor if they do not have confidence in the assessment.
- **Communication is critical**. Confidentiality issues surrounding SUD treatment records frequently are cited as a reason why CPS and SUD treatment agencies do not work well together. (Confidentiality is discussed in more detail in Chapter 8, *Putting It Together: Making the Systems Work for Families*.) Clear communication among the various parties is critical for ensuring that case plans and treatment plans are created properly and followed. Additionally, an understanding of each professional culture is crucial to working well together.

See Chapter 8, *Putting It Together: Making the Systems Work for Families*, for more information on how CPS and SUD treatment systems can work together effectively. Additionally, refer to Exhibit 4-2 for more information regarding how SUD issues should be taken into consideration in child maltreatment cases.

Exhibit 4-2
Decision Tree for Child Welfare Cases Involving Caregiver Substance Use Disorders[9]



Adapted from *Tough Problems, Tough Choices: Guidelines for Needs-based ServicePlanning in Child Welfare*, a publication developed by Casey Family Programs, The Annie E. Casey Foundation, and American Humane. It is available at **http://www.americanhumane.org/protecting-children/resources/casey-decision-making-guidelines/products.html**.

For information about how the child welfare system, SUD treatment providers, and the courts can improve screening and assessment policies and protocols, refer to *Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR)* at **http://www.ncsacw.samhsa.gov/files/SAFERR.pdf**.

CHAPTER 5
Treating Substance Use Disorders

In This Chapter

- The goal of treatment
- Treatment considerations
- Common treatment approaches
- Support services
- Gender-sensitive treatment
- Barriers to treatment

Substance use disorders (SUDs), like other chronic diseases, are treatable. Trained SUD treatment providers can determine the best treatment path for individuals to take and can enlist the assistance of other service providers, such as child protective services (CPS) caseworkers, in the treatment process. This chapter discusses the goal of SUD treatment, important treatment considerations, various approaches to treatment, issues related to gender-sensitive treatment, and barriers that may impede individuals from receiving treatment. This chapter is intended to help CPS caseworkers strengthen their understanding of treatment services available to help the families with whom they work. The role of CPS in supporting the treatment process is discussed in more detail in Chapter 6, *The Role of Child Protective Services When Substance Use Disorders Are Identified*.

The Goal of Treatment

An SUD is a medical condition with significant behavioral effects. These behaviors may frustrate, stymie, and anger treatment providers and CPS caseworkers. While individual experiences vary, persons with an SUD often have:

- Little experience or skills with which to cope with their feelings. Their substance use tends to numb discomfort, at least temporarily. Many of these individuals have been turning to drugs and alcohol since their teenage years.
- Difficulty escaping or solving everyday problems without using substances. As a result, they can feel quite helpless when confronted with the day-to-day challenges of life.
- Poor communication skills. They may be ineffective in some areas and over-emote in others.
- Problematic behaviors, such as being manipulative or dishonest. These behaviors may be useful, however, in helping them obtain drugs and alcohol or hiding the use of these substances. Some individuals with SUDs may find it easy to be dishonest because they have buried or avoided their true feelings.

The goal of treatment is to help individuals break the cycle of addiction and dependence so that they may learn better ways of dealing with challenges in their lives. Caseworkers should keep in mind that treatment does not equal recovery. Recovery is a lifelong process, with treatment being one of the first steps. Recovery entails making lifestyle changes to regain control of one's life and accepting responsibility for one's own behavior.[90]

Research has demonstrated that SUD treatment works. A number of national studies over the past decades have shown that SUD treatment can result in abstinence from substance use, significant reduction in the abuse of substances, decreased criminal activity, and increased employment.[91] Recent studies also link SUD treatment for mothers with children in substitute care to improved child welfare outcomes, such as shorter stays in foster care for children and increased likelihood of reunification.[92] Furthermore, treatment has been shown to be cost-effective and to reduce costs in such areas as crime, health care, and unemployment.[93]

Treatment Considerations

SUD treatment is not a "one size fits all" service or one that remains static over time for a particular participant. For example, an individual who drank heavily for 10 years and is mentally ill is likely to have different treatment needs than an individual who recently became addicted to cocaine. When treatment is provided, the following should be considered:

Detoxification

Some individuals require detoxification services before they are able to participate effectively in ongoing treatment and recovery. Detoxification is a process whereby individuals are withdrawn from alcohol and drugs, typically under the care of medical staff; it is designed to treat the acute physiological effects of ceasing the use of substances. It can be a period of physical and psychological readjustment that allows the individuals to participate in ensuing treatment. Medications are available to assist in detoxification. In some cases, particularly for alcohol, barbiturates, and other sedatives, detoxification may be a medical necessity, and untreated withdrawal may be medically dangerous or even fatal.

The immediate goals of detoxification programs are:

- **To provide a safe withdrawal from the substance of dependence and enable individuals to become alcohol- or drug-free**. Numerous risks are associated with withdrawal, ranging from physical discomfort and emotional distress to death. The specific risks are affected by the substance on which the individual is dependent.
- **To provide withdrawal that protects people's dignity**. A concerned and supportive environment, sensitivity to cultural issues, confidentiality, and appropriate detoxification medication, if needed, are important to individuals maintaining their dignity through an often difficult process.
- **To prepare individuals for ongoing alcohol and drug abuse treatment**. While in the detoxification program, individuals may establish therapeutic relationships with staff or other patients that help them to become aware of treatment options and alternatives to their current lifestyle. It can be an opportunity to provide information and motivate them for treatment.

Detoxification is not needed by all individuals and is not intended to address the psychological, social, and behavioral problems associated with addiction. Without subsequent and appropriate treatment, detoxification rarely will have a lasting impact on individuals' substance-abusing behavior. The appropriate level of care following detoxification is a clinical decision based on the individual's needs.[94]

- **Type and setting**. An individual should be placed in the type and setting of treatment that is most appropriate for the specific problems and needs. Just as a doctor may determine that a patient should receive medication instead of surgery to correct a problem, an SUD treatment provider must make decisions about the most appropriate course of treatment for an individual. The type, length, and duration of the treatment vary depending on the type and the duration of the SUD and the individual's support system and personal characteristics. The duration of the treatment may range from weeks or months to years.

- **Reassessment and modification of treatment plan**. An individual's treatment and service plan should be reassessed and continually modified to ensure that the plan meets the person's evolving needs.[95]

- **Involuntary treatment**. An individual does not have to "hit bottom" or "want to change" in order to benefit from treatment. Involuntary or mandated treatment can be just as effective as voluntary treatment. Sanctions or enticements in the family, work, or court setting can significantly increase treatment entry, retention, and success.[96]

- **Attorney involvement**. In instances where the parent has an attorney, the attorney also can play a key role in the early engagement of the client in treatment. CPS caseworkers and SUD treatment providers can facilitate this by reaching out to attorneys to help them understand the treatment process and clients' needs. This helps them represent the clients better and provides a better opportunity for reunification.

- **Timetables**. Because of the potential conflicts between child welfare and treatment timetables, treatment should begin as soon as possible so that there is time for family reunification. Often, however, there are delays in treatment either because it is not available or the need for treatment is not determined right away. CPS caseworkers and SUD treatment providers should work together to engage clients in treatment as early as possible.

Common Treatment Approaches

There are a number of ways to categorize treatment, based on the level of care (i.e., intensity of treatment and services offered) or the theoretical orientation and treatment approach. The following are some common treatment approaches:

- **Cognitive-behavioral approaches** address ways of thinking and behaving. Cognitive-behavioral treatment helps participants recognize situations in which they are most likely to use

Timetables in Child Welfare and Substance Use Disorder Treatment

CPS agencies and SUD treatment providers have their own timetables for establishing family and individual well-being. The Adoption and Safe Families Act (P.L. 105-89) requires CPS agencies to:

- Establish a permanency plan within 12 months of a child entering the child welfare system
- Initiate proceedings to terminate parental rights if a child has been in foster care for 15 of the most recent 22 months.

SUD treatment can range from weeks or months to years. CPS caseworkers and treatment providers, therefore, should communicate frequently to make sure that this time is productive and to serve the children and families most effectively.[97]

drugs, develop strategies for dealing with these situations, and build specific skills to address behaviors and problems that are associated with SUDs. For example, if a woman suggests that she is most likely to use cocaine after she has had a fight with her partner, the therapist would work with her to develop more positive ways of dealing with her anger and frustration following a fight. The treatment provider also may detail possible consequences to the individual, such as breaking parole and being forced to return to prison, as a means of changing behavior.

- **Motivational enhancement treatment** incorporates some elements of cognitive-behavioral treatment, but focuses on increasing and then maintaining participants' motivations for change. Rather than forcing individuals to accept that they have a problem, this approach focuses on the individual's needs and the discrepancies between their goals and their current behaviors. This approach seeks to draw solutions from the treatment participants rather than having the solutions imposed by therapists.

- **Contingency management** includes both motivational enhancement treatment and an additional component of reinforcements and rewards. For example, credits may be offered as a reward for established positive behaviors, such as consistent attendance in group therapy or negative urinalysis testing. These credits then can be exchanged for items (such as baby products).

- **Therapeutic community** is an approach based on both cognitive-behavioral therapy and on the notion that treatment is best provided within the context of a community of individuals who have similar histories. This model was developed to provide treatment to individuals with antisocial character traits in addition to SUDs and tends to be highly confrontational. By having treatment participants confront each others' behaviors and attitudes, they learn a great deal about their own behaviors and also learn from the other participants. Often, therapeutic community models of treatment are found within the correctional system. Given its confrontational nature, a therapeutic community may not be appropriate for some individuals. For example, women who have experienced intimate partner violence likely would not react well to this treatment approach.

- **Trauma-informed treatment services** generally follow one or more of the above treatment theories and reflect an understanding of trauma and its impact on SUDs and recovery. This

Model Treatment and Prevention Programs

The following Internet resources provide information about model SUD treatment and prevention interventions and their characteristics:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) has compiled a list of evidenced-based programs that have prevented or reduced SUDs and other related behaviors. SAMHSA's National Registry of Evidence-based Programs and Practices has reviewed these programs rigorously and assessed their effectiveness. To view this list, go to **http://modelprograms.samhsa.gov**.
- SAMHSA's *Guide to Evidence-Based Practices* provides listings for more than 35 websites that contain information and research on specific evidence-based programs and practices for the treatment or prevention of SUDs. Listings can be sorted and browsed by topic areas, target age groups, and settings. To view these listings, visit **http://www.samhsa.gov/ebpWebguide/index.asp**.
- The National Institute on Drug Abuse of the National Institutes of Health offers a list of principles for substance use prevention based on a number of long-term research studies. That list can be viewed at **http://www.nida.nih.gov/Infofacts/lessons.html**.

approach acknowledges that a large percentage of SUD treatment participants have sustained physical, emotional, and sexual trauma in their lives and their disorder may be the result of self-medicating behaviors to deal with post-traumatic stress disorder symptoms.

- **Trauma-specific treatment services** go a step further than trauma-informed treatment services and address the impact of the specific trauma on the lives of participants. This approach works to facilitate trauma healing and recovery as part of the treatment services. Several integrated, trauma-specific, treatment models for women have been developed in recent years.[98]

- **Treatment based upon the relational model of women's development** acknowledges the primacy of relationships in the lives of women and focuses upon the establishment and support of positive relationships. These positive relationships for the treatment participant may be with the therapist or with other significant figures, especially children and spouses.

Support Services

Along with SUD treatment, supplemental services often are provided to give additional support aimed at improving treatment outcomes. The following are important support services for treatment:

- **Case management services** are aimed at eliminating or reducing barriers to participation in treatment and include links to housing, food, medical care, financial assistance, and legal services. Case management also may include problem-solving sessions to assist individuals in establishing priorities among the many demands made upon them by multiple systems.

- **Twelve-step models** that incorporate the 12 steps of Alcoholics Anonymous into treatment. Participants "work the steps" and move through treatment by accomplishing each of the 12 steps with guidance from a sponsor and with emphasis on attendance at meetings. Spirituality or belief in a "higher power" is a central component of 12-step models.

Treatment Example: Methadone Maintenance

Treatment can take many forms and can be multilayered and complex in attempting to address the nature of SUDs. For example, opioid replacement therapy is a treatment that substitutes a noneuphoria inducing and legally obtainable drug (e.g., methadone, buprenorphine) for heroin or another opiate. The treatment also provides counseling and other rehabilitation services. Methadone maintenance treatment is a type of opioid replacement therapy and is very effective. Along with preventing illicit opiate use, methadone has been shown to be effective in reducing criminal activity and increasing employment. Additionally, this treatment method reduces the risk of HIV-associated behaviors (e.g., needle use and sharing) and infection.[99]

Individuals engaged in methadone maintenance treatment can face heavy discrimination within the child welfare system from judges, attorneys, and caseworkers who believe the ultimate goal of treatment should be a completely drug-free individual. Stopping the methadone treatment, however, leaves the individual at a very high risk for relapse to illicit opiate use and its associated high-risk factors, including unsafe injection practices and illegal behavior in order to support a habit. All of these can significantly increase the risk of abuse or neglect to children in the custody of these parents. Hence, the decision to require a detoxification from methadone must be considered carefully and based upon sound clinical principles rather than upon the stigma associated with methadone treatment.

TANF and Substance Use Disorder Treatment

In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) fostered a new vision for public assistance. PRWORA established the Temporary Assistance for Needy Families (TANF) block grant, which treats welfare as short-term, time-limited assistance designed to help families move to work and self-sufficiency. Its work requirements and time limits allow little room for work exemption and, therefore, created an incentive for agencies to examine the needs of those recipients overcoming serious and more difficult challenges, such as SUDs.[100] National estimates of the welfare population who have substance abuse issues range from 16 to 37 percent.[101] The 2007 National Survey on Drug Use and Health (NSDUH) reports a rate of 8.0 percent for illicit drug use in the general population.[102]

Both TANF and substance abuse treatment program administrators recognize that treatment in the absence of work does not fully meet the needs of TANF clients with substance abuse issues.[103] Instead, TANF clients should receive treatment while concurrently pursuing work and work-related activities related to self-sufficiency.[104]

- **Recovery mentor or advocate programs** pair a person in recovery with individuals in need of treatment to support their engagement and retention in the process. Recovery mentors or advocates offer the unique perspective of having been through a similar experience and can offer the client insight to matters that CPS caseworkers and SUD treatment providers cannot.
- **Abstinence monitoring** includes urinalysis testing, breath testing for alcohol, and the use of the sweat patch and other technologies. This can be an important component of treatment as it provides opportunities for feedback to individuals who are working to change addictive behavior. Negative drug test results can be used for reinforcement of changed behavior, while positive test results can be a cue to the treatment participant and therapist that the treatment plan may need adjusting.

There also are numerous other support services (e.g., mental health counseling, medical care, employment services, child care) that may be provided to assist families.

Gender-sensitive Treatment

Historically, SUD treatment has been focused on men, and fewer women had access to treatment services. In recent years, however, additional emphasis and funding have begun to address women's specific needs.[105]

Women

The ability to access and to remain in treatment can be difficult for anyone. Motivation, transportation, insurance coverage, and waiting lists all can impede an individual's attempts at recovery. Women, however, often face additional challenges when seeking treatment.

Both men and woman can have significant others who have SUDs. However, women with partners with SUDs are more likely to abuse substances themselves.[106] For instance, some women have partners with SUDs and face the loss of these relationships when they make the decision to seek help. These partners may discourage women's efforts to obtain treatment. Violence in these relationships

is not uncommon. Not only do these women face the loss of a relationship, but many also face the loss of economic support. This has particular importance when the women are also mothers with young, dependent children.

Even if mothers do not have to contend with unsupportive partners, seeking treatment still can be difficult. Many women do not want to enter treatment because they fear their children will be taken away if it is discovered that they have an SUD. Women also may fear the social stigma of being considered a "bad mother" if others find out about their drug use. When women decide to enter treatment, child care frequently is a critical hurdle to overcome. Few residential programs allow children to remain with their mothers while in treatment, and few outpatient programs provide child care, leaving it up to the mothers to identify a safe, reliable place for their children or to pay for licensed child care services.

The profile of women who have SUDs differs from their male counterparts. Compared to men, a greater number of women who enter treatment have a history of physical or sexual abuse.[107] Additionally, among persons with AIDS, a greater percentage of females than males were exposed through injection drug use and may participate in risky sexual behavior or trade sex for drugs.[108] Additionally, women are more likely than men to have co-occurring mental health problems.[109]

Women receive the most benefit from treatment when the treatment program provides comprehensive services that meet their basic needs, such as transportation, job counseling and training, legal assistance, parenting training, and family therapy, as well as food, clothing, and shelter. Additionally, research shows that women benefit from a continuing relationship with the SUD treatment provider throughout treatment and that women, during times of lapse or relapse, often need the support of the community and the encouragement of close friends and family.[110] For more information on components of women-centered SUD treatment, visit **http://www.nida.nih.gov/WHGD/WHGDPub.html**.

Men

Men face many of the same treatment hurdles as women, but while treatment historically has focused on men, there is still relatively little literature that discusses men's roles within the family, particularly how their substance use affects their roles as fathers and partners. Most often, mothers are the focus of CPS cases and are involved in treatment. While some of these women may be reluctant to involve fathers in the treatment process, both parents should be involved whenever possible, provided it does not

Involving Fathers in Case Planning

The importance of involving nonresidential fathers is particularly relevant when the mother is the perpetrator of child maltreatment, and the child has to be removed from the home. Fathers can be a source of support to the mother of their child, both financially and emotionally; are an irreplaceable figure in the lives of their children; and can be a supportive presence as the family deals with the problems that contributed to the maltreatment, especially when the mother is going through SUD treatment. If it is determined that the family is not a safe place for the child, the nonresidential father is a placement option that should be considered.

Of course, there may be times when involving the nonresidential father in the case planning process is impossible or ill-advised, including when the father is involved in illegal activities. More often than not, however, the nonresidential father can play a useful role, although bringing him into the process may require skilled negotiating on the part of the caseworker.

increase safety risks. In addition, CPS caseworkers usually are required by the court to seek and to involve absent parents. In some cases, it is the fathers of the children in the child welfare system who become the focus of intervention due to the presence of mothers in treatment. In these cases, men's roles as fathers and primary caregivers for their children warrant significant attention as they struggle to provide appropriate, nurturing, and consistent parenting.

Barriers to Treatment

Most people who have SUDs do not receive treatment. According to NSDUH, approximately 23.2 million people in 2007 needed SUD treatment. Of these, 2.4 million (10.4 percent) received treatment at a specialty facility (including hospitals, drug or alcohol rehabilitation facilities, and mental health centers), and the remaining 20.8 million did not. Of the individuals who were classified as needing but not receiving treatment, only an estimated 1.3 million reported that they perceived a need for treatment for their problem, and 380,000 reported that they had made an effort to receive treatment.[111] Among women of childrearing age (18 to 49 years) who needed treatment in the past year, only 10.4 percent received it, and only 5.5 percent felt they needed it.[112]

There are multiple and complex barriers to treatment. According to NSDUH, of those individuals who did not receive treatment even after making efforts to obtain it, the most commonly reported reason was because they were unable to afford it or lacked health coverage.[113] Other reasons that individuals may not be able to receive, or want to receive, SUD treatment include:

- Lack of available treatment spaces
- Not knowing where to go for treatment
- An ambivalence or fear about changing behavior
- A belief that they can handle the problem without treatment
- Concerns about negative opinions among neighbors, community members, or co-workers regarding treatment
- Relationships with partners and with family members who still may be using substances and who do not support the individual's efforts to change
- A perception of "giving in" when treatment is mandated by an outside source, such as the court or social services department
- Co-occurring mental health disorders exacerbated by the individual's attempts at abstinence
- A lack of transportation to and from treatment
- Economic difficulties in which the need to work takes priority over the participation in treatment
- A lack of available child care during treatment times.

CPS caseworkers can help clients who have SUDs identify barriers to participation in treatment and support the development of strategies to overcome these barriers.

CHAPTER 6

The Role of Child Protective Services When Substance Use Disorders Are Identified

In This Chapter

- Family assessment and case planning
- Supporting parents in treatment and recovery
- Supporting children of parents with SUDs

Once substance use disorders (SUDs) are identified as an issue to be addressed in a family's case plan, the child protective services (CPS) caseworker needs to have a discussion with the family to understand their perceptions of the role and the impact substance abuse or dependence has in their lives. This discussion should include what can be done about the issue and how the family can be motivated to change. Since a discussion about SUDs may be met with denial and even anger toward the caseworker, a focus on the needs of the children generally will align caseworkers and parents in determining the best way to improve the situation. This chapter discusses family assessments and how they can be used in case planning, how to support parents who are in treatment and recovery, and how to assist children whose parents have SUDs.

Family Assessment and Case Planning

During the initial family assessment or investigation, the CPS caseworker identifies the behaviors and conditions of the child, parent, and family that contribute to the risk of maltreatment, which may include a family member's SUD. During the family assessment, the caseworker engages the family in a process designed to gain a greater understanding of family strengths, needs, and resources so that children are safe and the risk of maltreatment is reduced.[114] In particular, the caseworkers work with the family to:

- Identify family strengths that can provide a foundation for change (e.g., support systems)
- Reduce the risk of maltreatment by identifying and by addressing the factors that place children at risk
- Help the children cope with the effects of maltreatment, parental SUDs, and other co-occurring problems.

A family-focused response to address family functioning issues is essential to an effective case plan. Families are involved with CPS because of serious breakdowns in functioning that can be influenced profoundly by a family member's SUD, as well as by the same family member's transition to recovery. Not only must the parents' substance use be addressed, but the behavioral problems and issues that have developed for children over the span of their parents' substance use also must be resolved. To cease substance abuse and to make positive changes in their lives, it is vital for parents to move toward full acceptance of their substance abuse or addiction and its consequences. When parents address their SUDs and other issues, positive changes in family functioning can be achieved while the families also receive services through CPS.

North Carolina Family Assessment Scale

One recognized family assessment tool that addresses alcohol and drug issues is the North Carolina Family Assessment Scale (NCFAS). The following is a list of domains (i.e., areas of influence) that are measured by the NCFAS and could be used in any family assessment. The domain descriptions highlight ways in which alcohol and drug issues can be included in a CPS family assessment.

- **Environment**. This domain refers to the neighborhood and social environment in which the family lives and works. Risk factors in this domain may include the presence or use of drugs in the household or community.
- **Parental capabilities**. This domain refers to the parent or caregiver's capacity to function in the role of the parent. This includes overall parenting skills, the supervision of children, disciplinary practices, the provision of developmental opportunities for children, and the parent's mental and physical health. The caseworker should assess whether, how, and to what extent the client uses alcohol and drugs and how this may affect the ability to parent the children.
- **Family interactions**. This domain addresses interactions among family members as well as the roles played by family members with respect to one another. Many family interactions can be affected by the use of alcohol and drugs. Items in this domain that may point to the possibility of an SUD include a parent's nonresponsiveness to the children or children serving as the primary caretakers of younger siblings.
- **Family safety**. This domain includes any previous or current reports or suspicions regarding physical, emotional, or sexual abuse of children, as well as neglect.
- **Child well-being**. This domain refers to the physical, emotional, educational, and relational functioning of the children in the family. Parental SUDs can negatively affect various areas of child well-being, such as mental and physical health, academic performance, behavior, and social skills. Caseworkers also should assess if the children are using drugs or alcohol.[115]

For more information about the NCFAS, visit **http://www.nfpn.org/images/stories/files/ncfas_scale_defs.pdf** or **http://www.friendsnrc.org/download/outcomeresources/toolkit/annot/ncfas.pdf**.

Despite the positive nature of these changes, however, both children and parents may find change difficult. For example, a parent newly in recovery can find coping with a child's needs very taxing. The problems in family functioning that have developed over time can be overwhelming as the parent notices them for the first time. Similarly, children experiencing a parent's recovery may have trouble accepting the parent's attempt to function in a role that he previously was unable to perform due to an SUD (e.g., disciplining the child). Caseworkers and SUD treatment providers should encourage progress, reward success, and support the newly sober parents in their efforts to make changes in all areas of family functioning and in being substance free.

Supporting Parents in Treatment and Recovery

While SUD treatment should be provided only by trained professionals, CPS caseworkers can maintain an integral role in the process for both the parents and the children.

Providing Support During the Stages of Change

A common theory in the field of SUD treatment is that individuals transition through different stages of thought and behavior during the treatment process. Exhibit 6-1 describes the stages and how CPS caseworkers can assist their clients during each stage.

Exhibit 6-1 Stages of Change and the CPS Caseworker's Tasks [116]		
Parent's Stage	**Stage Description**	**Tasks**
Precontemplation	No perception of having a problem or needing to change	Increase parent's understanding of risks and problems with current behavior; raise parent's doubts about behavior
Contemplation	Initial recognition that behavior may be a problem and uncertain about change	Discuss reasons to change and the risks of not changing (e.g., removal of child)
Decision to change	Conscious decision to change; some motivation for change identified	Help parent identify best actions to take for change; support motivation for change
Action	Takes steps to change	Help parent implement change strategy and take steps
Maintenance	Actively works on sustaining change strategies and maintaining long-term change	Help parent to identify triggers of SUD and use strategies to prevent relapse
Relapse	Slips (lapses) from change strategy or returns to previous problem behavior patterns (relapse)	Help parent re-engage in the contemplation, decision, and action stages

A Family-centered Response to Methamphetamine Use

The North Carolina Division of Family Services and the Family and Children's Resource Program recently compiled a list of practice guidelines for establishing a safe, family-centered response to methamphetamine use. The following suggestions may be useful to CPS caseworkers in assisting families who are affected by methamphetamine use:

- **Family engagement**. Working with clients who use methamphetamine can be frustrating, but the caseworker should avoid prejudging or demonizing them. Assess each family individually and help build upon their strengths.
- **Case decisions**. Parental SUDs do not necessarily constitute child maltreatment. Each case needs to be assessed individually.
- **Collaboration**. Collaborate with other professionals, such as substance abuse treatment providers, law enforcement, medical personnel, and mental health experts.
- **Placement**. Placement in foster care never should be automatic, even in the case of finding a child in a methamphetamine lab. The caseworker should assess each situation thoroughly and explore the possibility of placement with kin. However, the caseworker should keep in mind that methamphetamine use is sometimes a problem for extended families.
- **Permanence**. It can be a challenge to achieve family reunification within the time frames set forth in the Adoption and Safe Families Act. This is often because of the time required to recover from methamphetamine use and the fact that some users may be involved in the criminal justice system.
- **Education**. Ensure that foster parents and others involved in the case are knowledgeable about methamphetamine use.[117]

Once the parent is in treatment, the CPS caseworker can coordinate with the SUD treatment provider to monitor progress, to develop ongoing supports, and to intervene in times of crisis. Ongoing communication allows both systems to obtain a more complete picture of the family, which will allow for the development and modification of appropriate service plans.

When working with parents who are in treatment or who are in the process of recovery, CPS caseworkers should be mindful of the process that the parent is going through and address the relevant issues or needs. In early recovery, the client still may be detoxifying from drugs or alcohol and experiencing mood swings. The issues the client may need to address (or may need help in addressing) in order to stay sober typically include employment, housing, transportation, and a connection with an affirmative support system. Further along in recovery, the client may demonstrate several positive life changes that the caseworker can acknowledge, build upon, and encourage.

Throughout the recovery process, the caseworker, as well as the client, should have a clear understanding of the possibility of relapse and have a plan to address the situation if it occurs. Some frequently identified factors that contribute to lapse and to relapse include:

- Feeling complacent in recovery
- Feeling overwhelmed, confused, stuck, or stressed
- Having strong feelings of boredom, loneliness, anger, fear, anxiety, or guilt
- Engaging in compulsive behaviors such as gambling or sexual excess
- Experiencing relationship difficulties
- Failing to follow a treatment plan, quitting therapy, or skipping doctor appointments
- Being in the presence of drugs or alcohol.

Using Motivational Interviewing

Motivation can be defined as a willingness or a desire to change behavior.[118] Parents in the CPS system who have SUDs may be ambivalent about addressing their issues. They may be comfortable with their substance-related behaviors and believe that they serve a useful function in their lives.[119] Caseworkers and SUD treatment providers often find that motivating these parents to make behavioral changes is one of the most challenging aspects of their jobs.

Motivational interviewing is one approach CPS caseworkers can use to increase individuals' willingness to change. This type of interviewing accepts that ambivalence toward change is normal and seeks to engage and to mobilize the treatment participant on this basis.[120]

The four general principles of motivational interviewing are:

- Ambivalence about substance use is normal and is an obstacle in recovery.
- Ambivalence can be overcome by working with the client's motivations and values.

More information on how to support and to facilitate treatment and recovery is available in *Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers*, a publication prepared by the National Center for Substance Abuse and Child Welfare under contract for the Substance Abuse and Mental Health Services Administration and the Administration for Children and Families within the U.S. Department of Health and Human Services. The publication is available at **http://www.ncsacw.samhsa.gov/files/UnderstandingSAGuide.pdf**.

- The relationship between the caseworker or treatment provider and the client should be collaborative with each participant bringing his own expertise.
- Argument and aggressive confrontation should be avoided.[121]

The connections, realizations, new understandings, and solutions should come from the client rather than from the CPS caseworker.

For more information on motivational interviewing, go to **http://www.motivationalinterview.org** or **www.americanhumane.org/rmqic**.

Supporting Children of Parents with Substance Use Disorders

Caseworkers also have a key role in supporting children as their parents seek treatment for SUDs. As discussed earlier, children in the child welfare system whose parents have SUDs are at risk for a number of developmental and emotional problems. One of the difficulties in providing services to these children is that their problems, which are affected or compounded by their parents' SUDs, might not emerge until later in their lives. In addition, these children also are more likely than children of parents who do not have SUDs to remain in foster care for longer periods of time.[122] Because of their greater risks and longer stays in out-of-home care, it is particularly important for CPS caseworkers to assess thoroughly the needs (e.g., developmental, emotional, behavioral, educational) of these children and to link them with appropriate services in a timely manner. Both the assessments and service provision should be matched to the children's developmental levels and abilities. Children from families affected by SUDs do not always move through the developmental continuum in the normal sequential phases.

Children often have misperceptions about their role in their parents' problems. One approach to helping children deal with issues associated with a parent's SUD is to talk through lessons, such as the three Cs:

- You did not *cause* it (the parent's SUD).
- You cannot *control* it.
- You cannot *cure* it (which addresses the issue of the child taking on the role of the parent in the parent-child relationship).

Similarly, caseworkers can discuss a number of other important issues with children whose parents have an SUD, including:

- **Addiction is a disease**. Their parents are not bad people; they have a disease and may show inappropriate behavior when using substances.
- **The child is not the reason that the parent has an SUD**. Children do not cause the disease and cannot make their parents stop.
- **There are many children in situations like theirs**. There are millions of children whose parents have an SUD. They are not alone.
- **They can talk about the problem**. Children do not have to be scared or be ashamed to talk about their problems. There are many individuals and groups they can talk to and receive assistance.[123]

Services for children, such as those offered through the Strengthening Families Program, include problem-solving models that emphasize how to prevent the child from developing an addictive disorder later in life (with an emphasis on abstinence).

Title IV-E Waiver Projects Targeting Families Affected by Substance Abuse

Since 1996, several States have implemented waiver demonstration projects that allow Title IV-E foster care funds to be used to pay for services for families in the child welfare system with substance abuse problems. The following describes some of these projects:

- Illinois began its demonstration project in 2000, and with a recent 5-year extension, it is scheduled to continue through 2011. Through this project, recovery coaches engage substance-affected families during the treatment process, work to remove treatment barriers, and provide ongoing support. The project emphasized treatment retention for caregivers who already had been referred to substance abuse treatment and whose children already had received out-of-home placements.

  An evaluation of the first phase of the Illinois demonstration project found that compared to parents who received standard services, the parents who worked with recovery coaches:

  - Accessed treatment more quickly
  - Experienced lower rates of subsequent maltreatment
  - Achieved family reunification faster.[124]

  The evaluation also identified barriers to reunification, including domestic violence, mental health issues, and inadequate housing. The extension addresses these co-occurring problems and broadens the geographic scope of the demonstration.

- From 1999 to 2005, New Hampshire's Project First Step placed licensed alcohol and drug abuse counselors in two district CPS offices. The counselors conducted substance abuse assessments concurrently with CPS maltreatment investigations, facilitated access to treatment and other services, assisted with case planning, and provided intensive case management services. The evaluation findings were modest, yet they showed some promising trends.[125]
- From 1996 to 2002, substance abuse specialists in Delaware were co-located in local CPS offices. The specialists accompanied CPS workers on home visits, consulted on case planning, and provided referrals to treatment and support services. Division of Family Services officials found that the addition of specialists on site was helpful to caseworkers in recognizing the signs of substance abuse, exploring addiction-associated issues with family members, and making appropriate referrals.

For additional information on the substance abuse waivers, visit **http://www.acf.hhs.gov/programs/cb/programs_fund/cwwaiver/substanceabuse/index.htm**.

CHAPTER 7
Child Protective Services and Substance Use Disorder Treatment Providers: Similarities and Differences

In This Chapter

- Areas of similarity
- Areas of difference

Just as there often is an overlap between the clients who child protective services (CPS) and substance use disorder (SUD) treatment agencies serve, there also is common ground in the structures and the principles that guide these two systems. CPS caseworkers and SUD treatment providers should understand the similarities and the differences between the two systems so that they can offer the most comprehensive services possible to children and families. This chapter traces the areas of similarity and difference between the CPS and SUD treatment systems.

Areas of Similarity

There are many areas in which CPS and SUD treatment agencies overlap, including programmatic goals, the characteristics of the families served, management challenges, and new demands regarding outcomes.

Shared Goals

Though their primary emphases may differ, both CPS and SUD treatment agencies want family members to stop abusing substances and want children to be safe. In addition, they serve many families in common, even though they may be working with different family members. Professionals in each field should recognize that involving and providing appropriate services to the entire family is the most effective way of addressing the family's issues.

Since both systems have common goals, they also should share the responsibility for achieving them. CPS caseworkers need to know whether parents are sufficiently recovered from SUDs before recommending that their children live at home, but CPS caseworkers cannot treat SUDs. SUD treatment providers know that children provide an important incentive for parents to enter and remain in treatment, but SUD treatment providers cannot make decisions regarding where children will live. When each agency only emphasizes its own particular objective, it is unlikely that either will succeed. When both focus on the broader goals of helping the entire family, despite pressures and forces that make that focus difficult, the odds are better that the agencies and the families will succeed.

Shared Characteristics of Families Served

As discussed earlier, individuals with SUDs and parents who maltreat their children often have many other problems (e.g., mental illness, health issues, histories of domestic violence, poverty). They require services that are beyond the scope of either CPS or SUD treatment agencies. Many of these problems overlap, so both CPS and SUD treatment agencies find themselves trying to address problems, such as a serious mental disorder, criminal records, HIV/AIDS, and limited job skills. Too often, each agency tries to tackle these varied problems on its own, overlooking opportunities to share this enormous responsibility with others.

Shared Management and Operational Challenges

CPS and SUD treatment program administrators and staff often face similar challenges in managing their agencies and operating their programs. These challenges may be external, such as locating services that families need, coordinating with agencies that provide those services, navigating complex bureaucracies, and responding to political opinions or media coverage that portray families as unworthy of support. Other challenges are internal, such as difficulties in hiring and training staff, high staff turnover and burnout, low pay, and outdated computer record-keeping systems.

To the extent that administrators and staff can design strategies that build on their common management challenges, they may ease some of these burdens. For example, both CPS and SUD treatment managers spend time locating and coordinating services, such as housing or mental health counseling, frequently for the same families. Time could be saved, and possibly outcomes improved, if managers collaborated in securing these services. In addition, managers could design joint training programs for staff from both agencies and seek continuing education units for staff who participate.

Shared Pressures to Attain Measurable Outcomes

Federal legislation requires both CPS and SUD treatment agencies to achieve measurable results, such as employment for adults and permanency decisions for children. Therefore, managers from both systems are required to design and to monitor their programs to attain those results. This means that managers in both systems have to:

- Establish clear goals for staff
- Create internal monitoring and progress review systems
- Identify problems early and resolve them quickly.

CPS and SUD treatment program managers can share ideas for establishing processes that lead to measurable results. They also can collaborate in designing monitoring and tracking systems in a way that provides useful information between their agencies as well as within them.

Areas of Difference

Notwithstanding these similarities, CPS and SUD treatment agencies may become confused or frustrated when trying to work together, even when they share overarching goals. The two systems differ in some fundamental ways, including how families enter programs, the choices available to families while they are participating, and the consequences for families if they cannot meet the standards required for completion. These different contexts lead to different experiences for families involved with each system. Likewise, staff in each system face disparate experiences and challenges.

Parents can be angry or frightened when CPS caseworkers come to their homes and question their children and neighbors, especially when caseworkers

determine that their children have to be removed. When families come to the attention of CPS agencies, they often become involved with the courts, SUD treatment agencies, and other service providers. If they refuse to comply with the requirements established by these agencies, or if they cannot make adequate progress, they know they risk losing their children permanently.

In contrast, people generally enter SUD treatment voluntarily when they decide they are ready, and they leave when they want, even if they still are using substances. At times, however, courts order treatment as a condition of probation or parole. Coercive treatment has increased over the past several years, in part due to the increase in the use of drug courts, which are special courts designed for arrestees who have SUDs.

CPS and SUD treatment agencies also differ in the following ways:

- The primary focus of CPS is on the safety and well-being of children, and the primary focus of SUD treatment is on adult recovery. Staff of the two systems may see themselves as serving different clients, even if the clients are from the same family.
- The two systems operate under different laws and regulations.
- Funding for the two systems comes from different sources and with different conditions, even while often serving the same family.
- CPS caseworkers and SUD treatment providers may have different training, professional backgrounds and credentials, and disciplines. They also commonly use different terms and have different definitions of certain terms. For example, CPS caseworkers usually do not differentiate between substance use, abuse, or addiction. Caseworkers generally only want to know if the substance use affects an individual's ability to parent.
- Data collection requirements, computer systems, and management reporting requirements are often inconsistent or incompatible between the two systems.

Both systems operate within strict confidentiality guidelines and staff can be uncomfortable sharing information with each other, which can cause frustration. (See Chapter 8, *Putting It Together: Making the Systems Work for Families*, for a more detailed discussion of confidentiality issues.)

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CHAPTER 8

Putting It Together: Making the Systems Work for Families

In This Chapter

- Principles to guide collaboration
- Collaboration at all levels
- Techniques for promoting collaboration
- Confidentiality and information sharing

While many child protective services (CPS) and substance use disorder (SUD) treatment agencies find collaboration challenging, it is crucial to achieving positive outcomes for families involved with both systems. This chapter presents principles to guide CPS agencies in forming collaborative relationships with SUD treatment and other agencies. It proposes techniques to improve collaboration at both the policy and the frontline levels. This chapter also discusses confidentiality issues, which often determine what types of information can be shared during the collaborative process.

Setting the Stage: Principles to Guide Collaboration

As discussed earlier, CPS and SUD treatment agencies often have different structures, funding streams, and definitions of success. These differences affect collaboration at the Federal level as well as at the administrative and frontline levels in States and counties.

Families whose members have SUDs and who are involved with the child welfare system have multiple and complex needs as well as strengths. Their needs often span many social service disciplines. No single person, agency, or profession has the capacity to address all of their circumstances. Collaboration builds on the individual strengths of each agency and family member, forging shared approaches that are more effective than an individual response.

Collaboration is grounded in interdependent relationships and is more important when the problems are complex, the needs are varied, and the systems are different. In order to be effective, collaborative relationships should include the following:

- **Trust** that enables individuals to share information, to speak honestly with each other, and to respect other points of view
- **Shared values** that are honored by all participants
- **A focus on common goals** in spite of the fact that participants come from agencies that have different missions, philosophies, or perceptions
- **A common language** that all participants can understand and that is not unnecessarily technical or filled with acronyms

- **Respect** for the knowledge and experience that each participant and each profession brings to the relationship, which includes recognizing the strengths, needs, and limitations of all participants
- **A collective commitment** to working through conflict that encourages participation by all group members
- **A desire to share decision-making, risk taking, and accountability** that supports group members in participating in important decisions and assuming responsibility for the outcome of group decisions.[126]

One of the biggest challenges facing both CPS caseworkers and SUD treatment providers is securing services from other social service agencies with whom relationships may not exist. For example, families involved with either CPS or SUD treatment agencies most likely will need some combination of the following services: mental health, domestic violence, income support, housing, transportation, health care, child care, and early childhood education. While collaboration with all these service providers is important, the need for mental health, domestic violence, and income support services among families receiving child welfare services and affected by substance abuse is especially critical and warrants special attention.

CPS, SUDs, and Court Involvement

The court system is a key partner of both the child welfare and the SUD treatment systems. The courts ultimately decide if a child should be removed from or returned to a home. Therefore, judges and other court staff should have a general knowledge of SUDs and child welfare issues and how those issues are relevant to each case. This requires cross-training as well as ongoing communication and collaboration among the three systems. Along with making decisions to remove from or to return a child to the home, courts also may be involved with these same families through the criminal justice system or the drug courts.

If families also are involved in the criminal justice system, caseworkers may want their case plans to require the completion of all conditions of probation or parole in order for the parents to care for their children. However, the criminal justice system and the juvenile court system may have very different goals with respect to parental SUDs, with one focusing on the prevention of further criminal behavior (an emphasis on public safety) and the other focusing on the welfare of the children in the family.

Many States and communities are utilizing drug courts, which serve as an alternative to a strictly punitive, non-treatment oriented approach. Drug courts integrate public health and public safety and make treatment a priority.[127] They use ongoing, active involvement by judges to provide structure and support, and they hold both families and agencies, such as CPS, accountable for the commitments they make. Drug courts steer individuals with SUDs who commit nonviolent crimes, such as larceny or drug dealing, to treatment instead of jail; follow sentencing guidelines that set standards to ensure equity for jail time based on the crime; and utilize community partnership programs that encourage police, probation and parole officers, treatment providers, and citizens to work together to create healthy and safe environments that benefit everyone. Additionally, drug courts:

- Assess the substance user's needs
- Create an effective, mandated treatment plan
- Provide the necessary follow-up to assist with the treatment process.

Accountability for the participant attending treatment rests with the drug court. In one study, more than two-thirds of participants mandated by drug courts to attend treatment completed it, which is a completion rate six times greater than most previous efforts.[128]

Drug courts are becoming an increasingly popular alternative for responding to methamphetamine use. The ability to respond quickly and consistently to violations of the treatment plan, coupled with the accountability measures and the ever-present threat of going to jail due to a violation, make drug courts one of the most effective mechanisms for dealing with methamphetamine use.[129] For additional information on drug courts and methamphetamine use, visit **http://www.ojp.usdoj.gov/BJA/pdf/MethDrugCourts.pdf**.

Family Treatment Drug Courts (FTDCs) are specialized drug courts designed to work with parents with SUDs who are involved in the child welfare system. A national evaluation found that FTDCs were more successful than traditional child welfare case processing in helping substance-abusing parents enter and complete treatment and reunite with their children.[130]

For more information on drug courts in general, refer to the National Drug Court Institute/National Association of Drug Court Professionals website at **http://www.ndci.org** and the Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project publication, *Juvenile and Family Drug Courts: An Overview*, available at **http://www.ncjrs.org/html/bja/jfdcoview/welcome.html**.

For more information on the courts and CPS, refer to the *User Manual Series* publication, *Working with the Courts in Child Protection*, at **http://www.childwelfare.gov/pubs/usermanuals/courts/**.

In many States, CPS and social welfare are housed within one umbrella social services agency. While this configuration does not guarantee that collaboration will occur, it eliminates some of the structural problems often encountered when agencies do not share a common organizational context.

Collaboration at All Levels

Collaboration among agency officials at the highest levels is a necessary, but not always sufficient, condition for collaboration on the frontline. Suggestions for fostering collaboration are discussed below.

Collaboration at the State Level

There are several steps that State CPS and other officials can take to promote collaboration among their agencies:

- **Establish ongoing interagency task forces and authorize members to make decisions**. The task forces should be charged with addressing issues that make it difficult for staff to coordinate services. Topics might include designing integrated screening or assessment instruments, developing mechanisms to track participants across different agencies, or proposing methods for staff to share information under the rules of confidentiality.
- **Create joint mission statements** with SUD treatment and other agencies and promote the mission statement through notices, memos, or policy directives that are signed by officials from each agency.
- **Prepare integrated funding requests** to support integrated programming activities. Develop and execute shared advocacy strategies for securing those funds.

- **Require cross-training of staff** and schedule staff from other systems to deliver that training. Hold these training sessions at other agencies.
- **Co-locate staff** in each other's agency.
- **Create interagency agreements** such as Memorandums of Understanding (MOUs). For more information about MOUs, see Appendix H, *Memorandums of Understanding*.

Collaboration on the Frontline

There are several steps that frontline staff and supervisors can take to promote collaboration among their agencies:

- **Visit each other's programs**, talk to program participants, and meet each other's staff. CPS caseworkers should visit SUD treatment programs, observe activities, and hear from families who are in recovery. Similarly, SUD treatment professionals should visit CPS offices and accompany caseworkers on some home or field visits.
- **Convene multidisciplinary case staffings**, some of which should include family members. During these meetings, caseworkers and families should develop shared plans for services, allocate tasks, and discuss ways they can share responsibility for activities and outcomes.
- **Discuss differences** in a way that helps everyone understand each other's point of view, the rules, each one's limitations, and the scope of authority.

Techniques for Promoting Collaboration

Collaboration is not likely to occur unless staff from participating agencies have opportunities to understand their partners and to work together to solve shared problems. SUDs and child maltreatment are complicated issues; staff who work in one field generally know little about the other field. In addition, both SUDs and maltreatment are clouded by sensational media stories, shame, and stigma, making it especially important that frontline practitioners have access to accurate information. Information sharing, professional development and training, and co-location are examples of techniques that can promote collaboration.

Information Sharing

The easiest way for CPS caseworkers and SUD treatment providers to collaborate is to share information. Information sharing between colleagues can range from general information about each system (e.g., agency protocols) to case-specific information (e.g., a permanency plan or strategy for handling a parent's possible relapse). CPS caseworkers should be knowledgeable, however, of any confidentiality laws that restrict what information they are allowed to share. Confidentiality issues are discussed later in this chapter.

Professional Development and Cross-training

Professional development provides structured learning experiences that go beyond teaching about new rules or forms. Professional development allows caseworkers to understand their discipline better, to advance their careers, and to feel part of an important human services system. Cross-training means teaching workers from one field, such as CPS, about the fundamental concepts and practices of another field, such as SUD treatment.

CPS agencies can design professional development and cross-training programs in ways that mirror the interagency relationships they want to develop—relationships in which individuals are encouraged to explore and to discuss values, ideas, and policies.

Co-location

Some CPS agencies have SUD treatment providers on site. Co-location demonstrates that agency officials consider cooperation and collaboration to be agency.

Online Tutorials for Knowledge-building and Cross-systems Work

The National Center on Substance Abuse and Child Welfare, an initiative of the Administration for Children and Families and the Substance Abuse and Mental Health Services Administration, has developed four free online self-tutorials to build knowledge about SUDs and child welfare and to support and facilitate cross-systems work. The tutorials are each intended for a specific audience: child welfare professionals, substance abuse treatment professionals, judicial officers and attorneys in the dependency system, and legislators. A certificate for claiming Continuing Education Units is available upon successful completion of each tutorial. The tutorials are available at **http://www.ncsacw.samhsa.gov/tutorials/index.asp**.

For more information on training resources, visit **http://www.childwelfare.gov/systemwide/training/**.

priorities and integral elements of agency culture. If senior officials decide to co-locate staff, they are more likely to realize that collaboration is an expected method of conducting business, not merely an agency buzzword.

Co-location can be highly effective in helping CPS caseworkers and SUD treatment providers develop relationships that are essential to delivering comprehensive and well-organized services. It can change what are often a series of sequential referrals into concurrent discussions (case staffings) that bring greater expertise to case planning. Caseworker stress and burnout can be reduced if several people participate in making difficult and sensitive decisions regarding child placement. Co-location also may make it easier for family members to participate in designing their service plan, to comply with requirements that come from both treatment and CPS agencies, and to understand the roles that different caseworkers perform in helping them succeed.

Co-location, however, is not a perfect solution. It does not automatically create relationships or guarantee collaboration. Co-location can introduce management challenges related to supervision, space, pay differences, performance requirements, or work expectations. Furthermore, it can be administratively complex and, at times, programmatically inappropriate when too many people are involved with one family. When this happens, families may feel overburdened, they may worry that their confidences have been violated, or they may think that decisions are being made without their involvement.

Confidentiality and Information Sharing

As CPS and SUD treatment agencies work more closely, they are faced with deciding how and when to share information about families. Both agencies recognize the importance of allowing families to have privacy to discuss and to address such difficult, sensitive problems as SUDs and child maltreatment. Both also must adhere to a variety of laws and regulations that govern disclosure of information and protect family privacy.

At times, staff within each agency may feel that laws regarding confidentiality make it difficult to share or to receive information, and confidentiality rules may be put forth as a reason for their inability to communicate. For example, a CPS caseworker may become frustrated if an SUD treatment provider cannot share information regarding a parent's progress in treatment; the caseworker may feel that this information might inform child custody decisions. On the other hand, an SUD treatment provider may become frustrated when decisions regarding a child's placement are made without a CPS caseworker discussing how it may affect the parent's progress in treatment. However, a study of seven innovative

CPS agencies and SUD treatment programs noted that while Federal and some State laws are obstacles to information exchange, these laws did not create insurmountable barriers to collaboration.[131] This section discusses confidentiality laws and ways to share information appropriately.

Confidentiality Laws

Laws addressing various aspects of confidentiality involving professional relationships, communications, and situations vary. These laws may focus on:

- SUD treatment privacy requirements
- Mandated reporting of child abuse and neglect
- Privacy of CPS records
- Client-therapist confidentiality statutes
- Research programs and data collection on human subjects.[132]

SUD treatment confidentiality laws are based on the view that individuals with SUDs are more likely to seek treatment if they know that information about them will not be disclosed unnecessarily to others. Without the assurance of privacy, the fear of public disclosure of their problem possibly could prevent some individuals from obtaining needed treatment.

At times, however, there are important reasons for agencies to share information when working with the same families. Federal SUD treatment regulations specify circumstances under which it is appropriate that information be shared, including if the information relates to reports of child abuse or neglect. See Appendix I, *Confidentiality and the Release of Substance Use Disorder Treatment Information*, for a list of circumstances in which patient record information can be released. Additionally, the Child Abuse Prevention and Treatment Act of 1974 (P.L. 93–247) requires that States allow for the public disclosure of information regarding a death, or near death, of a child when it is the result of maltreatment.

SUD treatment providers are subject to mandatory child abuse reporting laws in their States, requiring treatment staff to report incidents of suspected child abuse and neglect. However, this exemption from standard confidentiality requirements applies only to initial reports of child abuse or neglect. It does not apply to requests or even subpoenas for additional information or records, even if the records are sought for use in civil or criminal investigations. Thus, patient files and patient-identifying information protected by the Federal confidentiality law still must be withheld from CPS agencies and the court unless there is some other authorization such as patient consent, an appropriate court order, or in some cases, a Qualified Service Organization Agreement (QSOA). Consent forms and QSOAs are discussed later in this chapter.

Key considerations related to the types of information that can be shared between CPS caseworkers and SUD treatment providers include:

- **CPS case information**. Factors surrounding the case, any previous case history, the family environment, and other factors that are informative to the SUD treatment provider in conducting the assessment and in developing the treatment plan. CPS caseworkers must obtain appropriate consent to share this information.

Subpoenas

A subpoena to testify in court is not sufficient to require the release of confidential information, as specified under Federal regulations related to confidentiality, nor is a police search warrant. If subpoenaed to court to testify, an SUD treatment provider should first refuse, citing Federal regulations related to confidentiality. Only with a judge's subsequent court order that finds a just cause to ignore this law in this particular case may a counselor testify without a client's written consent.

- **SUD screening information**. Federal law and regulations allow CPS caseworkers to share with SUD treatment personnel information gathered during a screening for the purpose of referring an individual for an assessment.

- **SUD diagnosis and treatment information**. An SUD treatment agency may not disclose this information without written consent or court order. This is true even if the CPS agency referred the family member to the treatment program and mandated the assessment. For an example of a consent form, see Appendix J, *Sample Qualified Service Organization Agreement and Consent Form*.

- **Attendance in treatment programs**. SUD treatment programs may report a family member's attendance at treatment, or their failure to attend, as long as the patient has signed a written consent that has not expired or been revoked. Attendance is often a key component of the family's case plan.

- **A treatment participant's relapse**. SUD treatment programs may report information about relapse to CPS caseworkers if that information is covered by a valid written consent signed by the patient. However, for many CPS agencies, the key information may be whether the family member is making satisfactory progress in treatment, even if relapse has occurred.

- **Combined case plan**. Most of the discussion between SUD treatment providers and CPS caseworkers will be permissible as long as the information discussed is covered by a valid written consent form. It is advisable to tell family members that their case will be discussed at periodic meetings or telephone calls and specifically who will participate in the discussions.

If CPS caseworkers release the results of a substance abuse evaluation or any information regarding a client's treatment, they violate Federal regulations related to confidentiality. Everyone, not just SUD treatment providers, is bound by Federal confidentiality statutes, and CPS caseworkers can be prosecuted for violating these laws. Caseworkers should clarify with their supervisor or their agency's attorney any questions they may have about this statute and should document any legal advice given that pertains to this statute.

Ways to Share Information Appropriately

In order for the CPS caseworker and SUD treatment provider to communicate, it is important to obtain the client's consent early, preferably at the time of the referral to treatment. Clients involved with CPS agencies may consent voluntarily to information disclosures in order to aid investigations of child maltreatment because their refusal to cooperate may result in losing custody of their children. However, information that has been disclosed through consent may not be used in criminal investigations or to prosecute the person. A consent form is only valid until the date, event, or condition on which it expires, or at any time when the treatment participant or client revokes consent. Therefore, it is a good idea to set the expiration date far enough into the future to ensure that needed information can be retrieved by the other agency. It is permissible to have the consent form contain an end date that fits circumstances.[133] (See Appendix I, *Confidentiality and the Release of Substance Use Disorder Treatment Information*, for details about what should be included in a voluntary consent form.)

Another way that information can be shared between systems is through a QSOA. SUD treatment providers may disclose information under a QSOA without the patient's consent. A QSOA is an agreement between two service organizations to share information about and to protect the confidentiality of individuals they serve. A QSOA should not be confused with an MOU, which usually is an agreement between two or more organizations to provide services to a common set of clients.

A qualified service organization is one that provides services to the SUD treatment program. CPS agencies meet this definition if they provide services

that help the SUD treatment agency serve the client. The heads of both the SUD treatment agency and the CPS agency must sign this agreement. Once signed, QSOAs permit disclosure of information to enable the organization to provide a service to the alcohol and drug abuse treatment program. QSOAs cannot be used for other purposes, such as obtaining reimbursement. Information obtained as part of a QSOA may not be re-disclosed to any other agency without permission.[134] See Appendix J, *Sample Qualified Service Organization Agreement and Consent Form*, for a sample QSOA form.

Confidentiality is an important part of communication. The parameters and limitations of communication have to be established locally. Furthermore, administrative procedures need to be put in place to encourage communication among staff. When approached with care, confidentiality rules do not automatically limit communication. Rather, they set the context within which staff can share important information, and families can be assured that sensitive aspects of their lives will be protected.

It is important to note, however, that regardless of privacy rules and confidentiality of information under Federal laws, mandatory reporters of child abuse and neglect are required to report suspected cases of child maltreatment, according to an Information Memorandum issued by the U.S. Department of Health and Human Services in September 2005. The memorandum "to affirm the obligation of mandatory reporters to report child abuse and neglect under State and Federal laws" refers specifically to exceptions to the confidentiality and privacy rules in the Health Insurance Portability and Accountability Act (HIPAA), the Public Health Service Act Title X family planning program, and the confidentiality rules relating to patient records in federally funded alcohol and drug abuse treatment services.[135]

Federal Guidelines Regarding Confidentiality

The following are examples of Federal guidelines for patient confidentiality in cases involving SUDs or child maltreatment:

- **The Code of Federal Regulation, Alcohol and Drug Abuse Treatment Confidentiality**, **42 C.F.R., Part II**, provides guidelines for maintaining patient confidentiality, including rules for information sharing, for SUD treatment agencies. They can be viewed at **http://www.access.gpo.gov/nara/cfr/waisidx_03/42cfr2_03.html**.
- **The Child Abuse and Neglect Prevention and Treatment Act (CAPTA), 45 C.F.R. 1340.14**, requires States to have guidelines for maintaining confidentiality of child abuse and neglect reports. It can be viewed at **http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfr1340_03.html**.
- **HIPAA of 1996 (P.L. 104–191)** provides standards for health plans, health care providers, and health care clearinghouses to ensure the security and privacy of health information, including access to records. HIPAA also upholds mandatory child abuse reporting laws. For more information on HIPAA and its relationship to SUD treatment, visit the Substance Abuse and Mental Health Services Administration website at **http://www.hipaa.samhsa.gov/hipaa.html**.

For more information on child maltreatment legal issues and laws, visit **http://www.childwelfare.gov/systemwide/laws_policies/**.

Conclusion

For staff in any agency, it is easy to lose sight of the other systems and agencies that share a common client base. Families that experience SUDs and child maltreatment have needs, problems, and strengths that are diverse and complex. As a result, they often require the services of multiple agencies. It is critical that CPS caseworkers and SUD treatment providers have an understanding of the other system as well as the skills and desire to work toward a common goal. It is equally important that families are consulted in order to make certain that the collaborative structure helps them to address their SUDs and to ensure the safety and well-being of their children. With all of the parties committed to working jointly toward the same goals and being open to innovative approaches, successful outcomes can be achieved.

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APPENDIX A
Glossary of Terms

Addiction – the overpowering physical or psychological urge to continue alcohol or drug use in spite of adverse consequences. Often, there is an increase in tolerance for the drug and withdrawal symptoms sometimes occur if the drug is discontinued.

Adjudicatory Hearings – held by the juvenile and family court to determine whether a child has been maltreated or whether another legal basis exists for the State to intervene to protect the child.

Adoption and Safe Families Act – signed into law November 1997 and designed to improve the safety of children, to promote adoption and other permanent homes for children who need them, and to support families. The law requires child protective services (CPS) agencies to provide more timely and focused assessment and intervention services to the children and families who are served within the CPS system.

Alcoholism – a dependency on alcohol characterized by craving and loss of control over its consumption, physical dependence and withdrawal symptoms, and tolerance.

AOD – alcohol and other drugs.

Assessment – evaluation or appraisal of a candidate's suitability for substance use disorder (SUD) treatment and placement in a specific treatment modality or setting. This evaluation includes information regarding current and past SUDs; justice system involvement; medical, familial, social, education, military, employment, and treatment histories; and risk for infectious diseases (e.g., sexually transmitted diseases, tuberculosis, HIV/AIDS, and hepatitis).

CASA – court-appointed special advocates (usually volunteers) who serve to ensure that the needs and interests of a child in judicial proceedings are fully protected.

Case Closure – the process of ending the relationship between the CPS worker and the family that often involves a mutual assessment of progress. Optimally, cases are closed when families have achieved their goals and the risk of maltreatment has been reduced or eliminated.

Case Plan – the casework document that outlines the outcomes, goals, and tasks necessary to be achieved in order to reduce the risk of maltreatment.

Caseworker Competency – demonstrated professional behaviors based on the knowledge, skills, personal qualities, and values a person holds.

Central Registry – a centralized database containing information on all substantiated/founded reports of child maltreatment in a selected area (typically a State).

Child Abuse Prevention and Treatment Act (CAPTA) – see Keeping Children and Families Safe Act.

Child Protective Services (CPS) – the designated social services agency (in most States) to receive reports, investigate, and provide intervention and treatment services to children and families in which child maltreatment has occurred. Frequently, this agency is located within larger public agencies, such as departments of social services.

Cognitive Behavioral Therapy – a school of psychotherapy that originated in the United States and subscribes to a behavioral emphasis on stimulus-response relationships and psychological learning theory.

Concurrent Planning – identifies alternative forms of permanency by addressing simultaneously both reunification and legal permanency with a new parent or caregiver, should reunification efforts fail.

Craving – a powerful, often uncontrollable, desire for drugs, alcohol, or other substances.

Cultural Competence – a set of attitudes, behaviors, and policies that integrates knowledge about groups of people into practices and standards to enhance the quality of services to all cultural groups served.

Denial – a psychological defense mechanism disavowing the significance of events. Denial also can include a range of psychological maneuvers designed to reduce awareness of the fact that using a substance (or engaging in a behavior) is the cause of an individual's problems rather than a solution to those problems. Denial can be a major obstacle to recovery.

Detoxification – process in a structured medical or social milieu in which the individual is monitored for withdrawal from the acute physical and psychological effects of drug or alcohol addiction.

Differential Response – an area of CPS reform that offers greater flexibility in responding to allegations of abuse and neglect. Also referred to as "dual track" or "multi-track" response, it permits CPS agencies to respond differentially to children's needs for safety, the degree of risk present, and the family's needs for services and support. See "dual track."

Disclosure – a communication of client- or patient-identifying information or the communication of information from the record of a client or patient who has been identified.

Dispositional Hearings – held by the juvenile and family court to determine the disposition of children after cases have been adjudicated, such as whether placement of the child in out-of-home care is necessary and the services the children and family will need to reduce the risk of maltreatment and to address its effects.

Drug – a substance that, by its chemical nature, affects the structure or function of a living organism.

Dual Diagnosis (also Dual Disorder) – a term used to describe a condition in which a single person has more than one major clinical psychological or psychiatric diagnosis. Often, this phrase is used to describe people who have a severe mental illness as well as a co-existing SUD.

Dual Track – term reflecting new CPS response systems that typically combine a nonadversarial service-based assessment track for cases in which children are not at immediate risk with a traditional CPS investigative track for cases where children are unsafe or at greater risk for maltreatment. See "differential response."

Evaluation of Family Progress – the stage of the CPS case process during which the CPS caseworker measures changes in family behaviors and conditions (risk factors), monitors risk elimination or reduction, assesses strengths, and determines case closure.

Family Assessment – the stage of the child protection process during which the CPS caseworker, community treatment provider, and the family reach a mutual understanding regarding the behaviors and conditions that must change to reduce or eliminate the risk of maltreatment, the most critical treatment

needs that must be addressed, and the strengths on which to build.

Family Group Conferencing – a family meeting model used by CPS agencies to optimize family strengths in the planning process. This model brings the family, extended family, and others important in the family's life (e.g., friends, clergy, neighbors) together to make decisions regarding how best to ensure the safety of the family members.

Family Unity Model – a family meeting model used by CPS agencies to optimize family strengths in the planning process. This model is similar to the Family Group Conferencing model.

Full Disclosure – CPS information to the family regarding the steps in the intervention process, the requirements of CPS, the expectations for the family, the consequences if the family does not fulfill the expectations, and the rights of the parents to ensure that the family completely understands the process.

Guardian ad Litem – a lawyer or lay person who represents a child in juvenile or family court. Usually this person considers the best interest of the child and may perform a variety of roles, including those of independent investigator, advocate, advisor, and guardian for the child. A lay person who serves in this role is sometimes known as a court-appointed special advocate or CASA.

Habituation – the result of repeated consumption of a drug that produces psychological, but not physical, dependence. The psychological dependence produces a desire (not a compulsion) to continue taking drugs for the sense of improved well-being.

Home Visitation Programs – prevention programs that offer a variety of family-focused services to pregnant women and families with new babies. Activities frequently encompass structured visits to the family's home and may address positive parenting practices, nonviolent discipline techniques, child development, maternal and child health, available services, and advocacy.

Immunity – established in all child abuse laws to protect reporters from civil law suits and criminal prosecution resulting from filing a report of child abuse and neglect.

Initial Assessment or Investigation – the stage of the CPS case process during which the CPS caseworker determines the validity of the child maltreatment report, assesses the risk of maltreatment, determines if the child is safe, develops a safety plan if needed to ensure the child's protection, and determines services needed.

Intake – the stage of the CPS case process in which the CPS caseworker screens and accepts reports of child maltreatment.

Interview Protocol – a structured format to ensure that all family members are seen in a planned strategy, that community providers collaborate, and that information gathering is thorough.

Involuntary Commitment – process by which patients who have not committed any crime are brought to SUD treatment against their wishes by relatives, police, or through a court proceeding. Also known as "protective custody" or "emergency commitment."

Juvenile and Family Courts – established in most States to resolve conflict and to otherwise intervene in the lives of families in a manner that promotes the best interest of children. These courts specialize in areas such as child maltreatment, domestic violence, juvenile delinquency, divorce, child custody, and child support.

Keeping Children and Families Safe Act – The Keeping Children and Families Safe Act of 2003 (P.L. 108-36) included the reauthorization of CAPTA in its Title I, Sec. 111. CAPTA provides minimum standards for defining child physical abuse and neglect and sexual abuse that States must incorporate into their statutory definitions in order to receive Federal funds. CAPTA defines child abuse and neglect as "at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death,

serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm."

Kinship Care – formal child placement by the juvenile court and child welfare agency in the home of a child's relative.

Liaison – a person within an organization who has responsibility for facilitating communication, collaboration, and coordination between agencies involved in the child protection system.

Mandated Reporter – individuals required by State statutes to report suspected child abuse and neglect to the proper authorities (usually CPS or law enforcement agencies). Mandated reporters typically include professionals, such as educators and other school personnel, health care and mental health professionals, social workers, child care providers, and law enforcement officers.-Some States identify all citizens as mandated reporters.

Memorandum of Understanding – an agreement between two or more organizations to define a given relationship and each party's responsibilities within the agreement.

Multidisciplinary Team – established between agencies and professionals within the child protection system to discuss cases of child abuse and neglect and to aid in decisions at various stages of the CPS case process. These teams also may be designated by different names, including child protection teams, interdisciplinary teams, or case consultation teams.

Neglect – the failure to provide for a child's basic needs. Neglect can be physical, educational, or emotional. *Physical neglect* can include not providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection (heat or coats). *Educational neglect* includes failure to provide appropriate schooling, failure to address special educational needs, or allowing excessive truancies. *Psychological neglect* includes the lack of any emotional support and love, chronic inattention to the child, or exposure to spouse, drug, or alcohol abuse.

Neurotransmitters – a group of chemicals in the brain that transmit nerve impulses from one neuron to another across a space called a synapse. Drugs act on the brain at the neurotransmitter level. The presence of a drug in the brain changes how many neurotransmitters are available to send nerve impulses from one neuron to the next. The level or amount of a drug in the brain affects how well different kinds of chemical signals are transmitted, changing how an individual thinks and feels.

Out-of-home Care – child care, foster care, or residential care provided by persons, organizations, and institutions to children who are placed outside their families, usually under the jurisdiction of juvenile or family court.

***Parens Patriae* Doctrine** – originating in feudal England, a doctrine that vests in the State a right of guardianship of minors. This concept gradually has evolved into the principle that the community, in addition to the parent, has a strong interest in the care and nurturing of children. Schools, juvenile courts, and social service agencies all derive their authority from the State's power to ensure the protection and rights of children as a unique class.

Parent or Caretaker – person responsible for the care of the child.

Patient Placement Criteria – standards of, or guidelines for, SUD treatment that describe specific conditions under which patients should be admitted to a particular level of care, under which they should continue to remain in that level of care, and under which they should be discharged or transferred to another level. They generally describe the settings, staff, and services appropriate to each level of care and establish guidelines based on diagnosis and other specific areas of patient assessment.

Physical Abuse – the inflicting of a nonaccidental physical injury. This may include burning, hitting, punching, shaking, kicking, beating, or otherwise harming a child. It may, however, have been the

result of over-discipline or physical punishment that is inappropriate to the child's age.

Prevention – the theory and means for reducing the harmful effects of drug use in specific populations. Prevention objectives are to protect individuals before signs or symptoms of substance use problems appear, to identify persons in the early stages of substance abuse and intervene, and to end compulsive use of psychoactive substances through treatment.

Primary Prevention – activities geared to a sample of the general population to prevent child abuse and neglect from occurring. Also referred to as "universal prevention."

Protective Factors – strengths and resources that appear to mediate or serve as a buffer against risk factors that contribute to vulnerability to maltreatment or against the negative effects of maltreatment experiences.

Protocol – an interagency agreement that delineates joint roles and responsibilities by establishing criteria and procedures for working together on cases of child abuse and neglect.

Psychological Maltreatment – a pattern of caregiver behavior or extreme incidents that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value to meeting another's needs. This can include parents or caretakers using extreme or bizarre forms of punishment or threatening or terrorizing a child. Psychological maltreatment also is known as emotional abuse or neglect, verbal abuse, or mental abuse.

Recovery – achieving and sustaining a state of health in which the individual no longer engages in problematic behavior or psychoactive substance use and is able to establish and accomplish goals.

Relapse – the return to the pattern of substance abuse or addiction, as well as the process during which indicators appear before the client's resumption of substance use.

Response Time – a determination made by CPS and law enforcement regarding the immediacy of the response needed to a report of child abuse or neglect.

Review Hearings – held by the juvenile and family court to review dispositions (usually every 6 months) and to determine the need to maintain placement in out-of-home care or court jurisdiction of a child.

Risk – the likelihood that a child will be maltreated in the future.

Risk Assessment – the measurement of the likelihood that a child will be maltreated in the future; frequently carried out through the use of checklists, matrices, scales, and other methods.

Risk Factors – behaviors and conditions present in the child, parent, or family that likely will contribute to child maltreatment occurring in the future.

Safety – absence of an imminent or immediate threat of moderate to serious harm to the child.

Safety Assessment – a part of the CPS case process in which available information is analyzed to identify whether a child is in immediate danger of moderate or serious harm.

Safety Plan – a casework document developed when it is determined that the child is in imminent or potential risk of serious harm. In the safety plan, the caseworker targets the factors that are causing or contributing to the risk of imminent serious harm to the child, and identifies, along with the family, the interventions that will control them and ensure the child's protection.

Secondary Prevention – activities targeted to prevent breakdowns and dysfunctions among families who have been identified as being at risk for abuse and neglect.

Service Agreement – the casework document developed between the CPS caseworker and the family, which outlines the tasks necessary to achieve risk reduction goals and outcomes.

Service Provision – the stage of the CPS casework process during which CPS and other service providers offer specific services to reduce the risk of maltreatment.

Sexual Abuse – inappropriate adolescent or adult sexual behavior with a child. It includes fondling a child's genitals, making the child fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism, sexual exploitation, or exposure to pornography. To be considered child abuse, these acts have to be committed by a person responsible for the care of a child (for example a babysitter, a parent, or a day care provider) or related to the child. If a stranger commits these acts, it would be considered sexual assault and handled solely by the police and criminal courts.

Substance Abuse – a pattern of substance use resulting in clinically significant physical, mental, emotional, or social impairment or distress, such as failure to fulfill major role responsibilities, or use in spite of physical hazards, legal problems, or interpersonal and social problems.

Substance Dependence – see "addiction."

Substance Use – consumption of low or infrequent doses of alcohol and other drugs, sometimes called experimental, casual, or social use, such that damaging consequences may be rare or minor.

Substance Use Disorder (SUD) – a medical condition that includes the abuse of or addiction to (or dependence on) alcohol or drugs.

Substantiated – an investigation disposition concluding that the allegation of maltreatment or risk of maltreatment was supported or founded by State law or State policy. A CPS determination means that credible evidence exists that child abuse or neglect has occurred.

System of Care – a comprehensive continuum of child welfare, SUD, and other support services coordinated to meet the multiple, evolving needs of clients.

Tertiary Prevention – treatment efforts geared to address situations in which child maltreatment already has occurred, with the goals of preventing child maltreatment from occurring in the future and of avoiding the harmful effects of child maltreatment.

Tolerance – a state in which the body's tissue cells adjust to the presence of a drug in given amounts and eventually fail to respond to ordinarily effective dosages. Consequently, increasingly larger doses are necessary to produce desired effects.

Treatment – the stage of the child protection case process during which specific services are delivered by CPS and other providers to reduce the risk of maltreatment, support families in meeting case goals, and address the effects of maltreatment.

Universal Prevention – activities and services directed toward the general public with the goal of stopping maltreatment before it starts. Also referred to as "primary prevention."

Unsubstantiated (also Not Substantiated) – an investigation disposition that determines that there is not sufficient evidence under State law or policy to conclude that the child has been maltreated or is at risk of maltreatment. A CPS determination means that credible evidence does not exist that child abuse or neglect has occurred.

Withdrawal – symptoms that appear during the process of stopping the use of a drug that has been taken regularly.

APPENDIX B
Resource Listings of Selected National Organizations Concerned with Child Maltreatment and/or Substance Use Disorders

The following are several representatives of the many national organizations and groups dealing with various aspects of child maltreatment and substance use disorders. Visit **http://www.childwelfare.gov** to view a more comprehensive list of resources and visit **http://www.childwelfare.gov/organizations/index.cfm** to search an organization database. Inclusion on this list is for information purposes only and does not constitute an endorsement by the Office on Child Abuse and Neglect or the Children's Bureau.

National And Federal Substance Use Disorder Organizations

Addiction Technology Transfer Centers

address: National Office
University of Missouri–Kansas City
5100 Rockhill Road
Kansas City, MO 64110-2499

phone: (816) 235-6888

fax: (816) 235-6580

email: no@nattc.org

website: http://www.nattc.org

A nationwide, multidisciplinary resource that draws upon the knowledge, experience, and latest work of recognized experts in the field of addictions.

Community Anti-Drug Coalitions of America

address: 625 Slaters Lane, Suite 300
Alexandria, VA 22314

phone: (800) 54-CADCA

fax: (703) 706-0565

email: info@cadca.org

website: http://cadca.org

Builds and strengthens the capacity of community coalitions to create safe, healthy, and drug-free communities. Supports its members with technical assistance and training, public policy, media strategies and marketing programs, conferences, and special events.

Join Together Online

address: 715 Albany Street, 580-3rd Floor
Boston, MA 02118

phone: (617) 437-1500

fax: (617) 437-9394

email: info@jointogether.org

website: http://www.jointogether.org

Supports community-based efforts across the country to reduce, prevent, and treat substance use disorders. Focuses attention on strengthening community capacity to expand the demand for and supply of high-quality substance use disorder treatment.

National Alliance for Drug Endangered Children (DEC)/National DEC Resource Center

address: 1942 Broadway, Suite 314
Boulder, CO 80302

phone: (303) 413-3064

fax: (303) 938-6850

website: http://www.nationaldec.org/

Promotes the DEC team concept and public awareness for the problems faced by DEC through multidisciplinary training for communities. It supports a nationwide network of professionals serving DEC by providing referrals to experts, updated research, and best practice information.

National Health Information Center

address: P.O. Box 1133
Washington, DC 20013-1133

phone: (301) 565-4167

(800) 336-4797

fax: (301) 984-4256

email: info@nhic.org

website: http://www.health.gov/nhic

A health information referral service that links consumers and health professionals to organizations best able to answer their questions.

National Institutes of Health

address: 9000 Rockville Pike
Bethesda, MD 20892

phone: (301) 496-4000

email: nihinfo@od.nih.gov

website: http://www.nih.gov

Seeks to acquire knowledge to help prevent, detect, diagnose, and treat disease and disability, from the rarest genetic disorder to the common cold. Relevant institutes include the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism.

National Organization on Fetal Alcohol Syndrome

address: 900 17th Street, NW, Suite 910
Washington, DC 20006

phone: (202) 785-4585

(800) 66-NOFAS

fax: (202) 466-6456

email: information@nofas.org

website: http://www.nofas.org

Dedicated to eliminating birth defects caused by alcohol consumption during pregnancy and improving the quality of life for those individuals and families affected by fetal alcohol syndrome.

Office of National Drug Control Policy

address: Drug Policy Information Clearinghouse
P.O. Box 6000
Rockville, MD 20849–6000

phone: (800) 666–3332

fax: (301) 519–5212

website: http://www.whitehousedrugpolicy.gov

Establishes policies, priorities, and objectives for the Nation's drug control program to reduce illicit drug use, manufacturing, and trafficking; drug-related crime and violence; and drug-related health consequences. Produces the National Drug Control Strategy, which directs the Nation's anti-drug efforts and establishes a program, a budget, and guidelines for cooperation among Federal, State, and local entities.

Substance Abuse and Mental Health Services Administration

address: 1 Choke Cherry Road
Rockville, MD 20857

phone: (240) 276-2000

fax: (240) 276-2010

website: http://www.samhsa.gov

Seeks to improve the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance use disorders and mental illnesses.

Child Welfare Organizations

American Humane Association Children's Division

address: 63 Inverness Drive, East
Englewood, CO 80112-5117

phone: (303) 792-9900

fax: (303) 792-5333

website: www.americanhumane.org

Conducts research, analysis, and training to help public and private agencies respond to child maltreatment.

American Professional Society on the Abuse of Children

address: 350 Poplar Avenue
Elmhurst, IL 60126

phone: (630) 941-1235
(877) 402-7722

fax: (630) 359-4274

email: apsac@apsac.org

website: www.apsac.org

Provides professional education, promotes research to inform effective practice, and addresses public policy issues. Professional membership organization.

American Public Human Services Association

address: 810 First Street, NE, Suite 500
Washington, DC 20002-4267

phone: (202) 682-0100

fax: (202) 289-6555

website: www.aphsa.org

Addresses program and policy issues related to the administration and delivery of publicly funded human services. Professional membership organization.

AVANCE Family Support and Education Program

address: 118 N. Medina
San Antonio, TX 78207

phone: (210) 270-4630

fax: (210) 270-4612

website: www.avance.org

Operates a national training center to share and disseminate information, materials, and curricula to service providers and policymakers interested in supporting high-risk Hispanic families.

Child Welfare League of America

address: 2345 Crystal Drive, Suite 250
Arlington, VA 22202

phone: (703) 412-2400

fax: (703) 412-2401

website: www.cwla.org

Provides training, consultation, and technical assistance to child welfare professionals and agencies, while educating the public about emerging issues affecting children.

National Black Child Development Institute

address: 1313 L Street, NW
Suite 110
Washington, DC 20005-4110

phone: (202) 833-2220

fax: (202) 833-8222

email: moreinfo@nbcdi.org

website: www.nbcdi.org

Operates programs and sponsors a national training conference through Howard University to improve and protect the well-being of African-American children.

National Children's Advocacy Center

address: 210 Pratt Avenue
Huntsville, AL 35801

phone: (256) 533-KIDS

fax: (256) 534-6883

website: http://www.nationalcac.org

Provides prevention, intervention, and treatment services to physically and sexually abused children and their families within a child-focused team approach.

National Indian Child Welfare Association

address: 5100 SW Macadam Avenue, Suite 300
Portland, OR 97239

phone: (503) 222-4044

fax: (503) 222-4007

website: www.nicwa.org

Disseminates information and provides technical assistance on Indian child welfare issues. Supports community development and advocacy efforts to facilitate Tribal responses to the needs of families and children.

National Resource Center for Child Protective Services

address: 925 #4 Sixth Street, NW
Albuquerque, NM 87102

phone: (505) 345-2444

fax: (505) 345-2626

website: http://www.nrccps.org

Focuses on building State, local, and Tribal capacity through training and technical assistance in child protective services, including meeting Federal requirements, strengthening programs, eligibility for the Child Abuse Prevention and Treatment Act grant, support to State Liaison Officers, and collaboration with other national resource centers.

Child Abuse Prevention Organizations

National Alliance of Children's Trust and Prevention Funds

address: 5712 30th Avenue, NE
Seattle, WA 98105

phone: (206) 526-1221

fax: (206) 526-0220

email: alliance@psy.msu.edu

website: www.ctfalliance.org

Assists State children's trust and prevention funds in strengthening families and protecting children from harm.

Prevent Child Abuse America

address: 500 N. Michigan Avenue, Suite 200
Chicago, IL 60611

phone: (312) 663-3520

fax: (312) 939-8962

email: mailbox@preventchildabuse.org

website: www.preventchildabuse.org

Conducts prevention activities such as public awareness campaigns, advocacy, networking, research, and publishing. Also provides information and statistics on child abuse.

For the General Public

Childhelp

address: 15757 North 78th Street
Scottsdale, AZ 85260

phone: (800) 4-A-CHILD (child abuse hotline)
(800) 2-A-CHILD (TDD child abuse hotline)
(480) 922-8212

fax: (480) 922-7061

website: http://www.childhelp.org/

Provides crisis counseling to adult survivors and child victims of child abuse, offenders, and parents, and operates a national hotline.

National Center for Missing and Exploited Children

address: Charles B. Wang International Children's Building
699 Prince Street
Alexandria, VA 22314-3175

phone: (800) 843-5678 (24-hour hotline)
(703) 274-3900

fax: (703) 274-2220

website: www.missingkids.com

Provides assistance to parents, children, law enforcement, schools, and the community in recovering missing children and raising public awareness about ways to help prevent child abduction, molestation, and sexual exploitation.

Parents Anonymous

address: 675 West Foothill Blvd., Suite 220
Claremont, CA 91711

phone: (909) 621-6184

fax: (909) 625-6304

email: Parentsanonymous@parentsanonymous.org

website: www.parentsanonymous.org

Leads mutual support groups to help parents provide nurturing environments for their families.

For More Information

Child Welfare Information Gateway

address: 1250 Maryland Avenue, SW
Eighth Floor
Washington, DC 20024

phone: (800) 394-3366

(703) 385-7565

fax: (703) 385-3206

email: info@childwelfare.gov

website: http://www.childwelfare.gov/

Collects, stores, catalogs, and disseminates information on all aspects of child maltreatment and child welfare to help build the capacity of professionals in the field. A service of the Children's Bureau.

National Center for Substance Abuse and Child Welfare

address: 4940 Irvine Blvd., Suite 202
Irvine, CA 92620

phone: (714) 505-3525

fax: (714) 505-3626

email: ncsacw@cffutures.org

website: www.ncsacw.samhsa.gov

Disseminates information, provides technical assistance, and develops knowledge that promotes effective practice, organizational, and system changes related to substance use disorder and child welfare issues at the local, State, and national levels.

National Clearinghouse for Alcohol and Drug Information

address: P.O. Box 2345
Rockville, MD 20847

phone: (240) 221-4019

(800) 729-6686

(877) 767-8432 (En Español)
(800) 487-4889 (TDD)

fax: (240) 221-4292

email: info@health.org

website: http://ncadi.samhsa.gov

Serves as the world's largest resource for current information and materials concerning substance use disorder prevention and addiction treatment. A service of the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention.

APPENDIX C

State Telephone Numbers for Reporting Child Maltreatment

Each State designates specific agencies to receive and investigate reports of suspected child abuse and neglect. Typically, this responsibility is carried out by child protective services (CPS) within a Department of Social Services, Department of Human Resources, or Division of Family and Children Services. In some States, police departments also may receive reports of child abuse or neglect.

Many States have local or toll-free telephone numbers for reporting suspected maltreatment. **The reporting party must be calling from the same State where the child is allegedly being maltreated for most of the following numbers to be valid.**

For States not listed, or when the reporting party resides in a different State from the child, please call **Childhelp, 800-4-A-Child** (800-422-4453), or your local CPS agency. States may occasionally change the telephone numbers listed below. To view the most current contact information, including State Web Addresses, visit **http://www.childwelfare.gov/pubs/reslist/rl_dsp.cfm?rs_id=5&rate_chno=11-11172**.

Alabama (AL)
334-242-9500

Alaska (AK)
800-478-4444

Arizona (AZ)
888-SOS-CHILD
(888-767-2445)

Arkansas (AR)
800-482-5964

Colorado (CO)
303-866-5932

Connecticut (CT)
800-842-2288
800-624-5518 (TDD)

Delaware (DE)
800-292-9582

District of Columbia (DC)
202-671-SAFE (7233)

Florida (FL)
800-96-ABUSE
(800-962-2873)

Hawaii (HI)
808-832-5300

Idaho (ID)
800-926-2588

Illinois (IL)
800-252-2873
217-524-2606

Indiana (IN)
800-800-5556

Iowa (IA)
800-362-2178

Kansas (KS)
800-922-5330

Kentucky (KY)
800-752-6200

Maine (ME)
800-452-1999
800-963-9490 (TTY)

Massachusetts (MA)
800-792-5200

Mississippi (MS)
800-222-8000
601-359-4991

Missouri (MO)
800-392-3738
573-751-3448

Montana (MT)
866-820-KIDS (5437)

Nebraska (NE)
800-652-1999

Nevada (NV)
800-992-5757

New Hampshire (NH)
800-894-5533
603-271-6556

New Jersey (NJ)
877-652-2873
800-835-5510 (TDD/TTY)

New Mexico (NM)
800-797-3260
505-841-6100

New York (NY)
800-342-3720
518-474-8740
800-369-2437 (TDD)

Oklahoma (OK)
800-522-3511

Pennsylvania (PA)
800-932-0313

Puerto Rico (PR)
800-981-8333
787-749-1333

Rhode Island (RI)
800-RI-CHILD
(800-742-4453)

South Carolina (SC)
803-898-7318

Tennessee (TN)
877-237-0004

Texas (TX)
800-252-5400

Utah (UT)
800-678-9399

Vermont (VT)
800-649-5285 (after hours)

Virginia (VA)
800-552-7096
804-786-8536

Washington (WA)
866-END-HARM
(866-363-4276)
800-562-5624 (after hours)
800-624-6186 (TTY)

West Virginia (WV)
800-352-6513

APPENDIX D

Diagnostic and Statistical Manual of Mental Disorders Criteria[1]

Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    b. Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria sets for withdrawal from the specific substances).
    b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance often is taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

[1] American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (4th ed.) Text Revision (DSM-IV-TR).* Washington, DC: Author.

Specify if:

a. With physiological dependence—evidence of tolerance or withdrawal (i.e., either Item 1 or 2 is present).

b. Without physiological dependence—no evidence of tolerance or withdrawal (i.e., neither Item 1 nor 2 is present).

Criteria for Substance Abuse

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).

2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).

3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).

4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

The symptoms never have met the criteria for substance dependence for this class of substance.

APPENDIX E

Commonly Abused Substances

This appendix presents information about some of the most commonly abused types of substances and the drugs affiliated with those types. A table provides additional information on commonly abused substances, including street names and methods of use.

Types of Commonly Abused Substances

Cannabinoids (e.g., marijuana, hashish) can produce feelings of euphoria, anxiety, or depression as well as distort perception and slow reaction time. Marijuana, the most commonly used illicit drug, has been associated with automobile and industrial accidents as well as physical ailments, most notably cancer.[1] It is usually smoked, making its health risks similar to those of tobacco in terms of pulmonary and cardiac effects.

Club Drugs (e.g., GHB, ketamine, MDMA, flunitrazepan, yaba) include a variety of drugs from other drug categories (e.g., hallucinogens, depressants). The name is derived from the fact these substances often are used by younger people at nightclubs and parties. Some club drugs, gamma hydroxyl butyrate (GHB) and Rohypnol in particular, have gained notoriety for use in drug-assisted sexual assault cases and, therefore, are referred to as "predatory drugs." Certain club drugs, such as ketamine, have medical or veterinary uses, but are used in a significantly different quantity or by a population other than for whom they are intended. Yaba, which means "crazy medicine" in Thai, is a combination of methamphetamine and caffeine and is becoming increasingly available at rave parties. Like methamphetamine, use of yaba can result in a rapid heart rate and damage to the small blood vessels in the brain, which can lead to stroke. Its use also can lead to violent behavior, paranoia, confusion, or insomnia.

Depressants (e.g., barbiturates) include some drugs that are prescribed to reduce anxiety or act as a sedative or anticonvulsant. Depressants are used illicitly to produce feelings of well-being and to lower inhibitions. Signs of use include fatigue, confusion, and impaired coordination and memory. Alcohol, the most commonly abused substance, is categorized as a depressant.

Hallucinogens (e.g., acid, mescaline, psilocybin, phencyclidine) have no known medical use and are illegal. These substances produce altered states of perception and feeling. Users often are disoriented or inattentive. The effects of hallucinogens are unpredictable and depend on several factors, including the user's personality, the surroundings in which they are used, the quantity taken, and the drug's purity.

[1] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2003). *Marijuana: Facts for teens* [On-line]. Available: http://www.nida.nih.gov/MarijBroch/Marijteens.html.

Users may experience a "bad trip" that can include terrifying thoughts and feelings, fear of insanity or death, and deep despair. An observable, long-term effect for some users is persistent perception disorder, which is commonly referred to as flashbacks.

Inhalants (e.g., aerosol sprays, nitrous oxide, butyl nitrate) usually are legal and readily available household and commercial products whose chemical vapors are inhaled to produce mind-altering effects. Observable effects of use include runny nose, watery eyes, and headaches. Users can ingest the substances by inhaling directly from product containers, sniffing a cloth saturated with the substance, or sniffing the substance from a plastic bag that is placed over the nose and mouth. Deeply inhaling vapors or using large amounts over a short time may result in disorientation, violent behavior, unconsciousness, or even death. High concentrations of inhalants can cause suffocation by displacing oxygen in the lungs. One of the significant factors in the use of inhalants is their accessibility, particularly for children. National surveys indicate inhaling dangerous products is becoming a widespread problem.[2]

Opioids and Narcotic Pain Relievers (e.g., heroin, morphine, oxycodone, hydrocodone) are used illegally for their euphoric effects. Many opioids and narcotic pain relievers originally were developed to relieve pain, and doctors still prescribe some for that purpose. The pain of withdrawal from heroin and other opioids is made worse by the fact that these drugs medicate pain. Therefore, individuals in withdrawal may experience pain they did not feel while using opiates and may not be able to deal with pain as they normally would. Signs of use include needle marks as well as decreased pulse and respiration rates.

Stimulants (e.g., cocaine, amphetamines, methamphetamine) can produce effects such as increased alertness, over-activity, depression, and insomnia. Cocaine is a powerful stimulant that primarily affects the dopamine system—the part of the brain that regulates feelings of pleasure and excitement. Cocaine use can cause violent or hypersexual behavior, paranoid thinking, and agitation or anxiety. Prenatal exposure to cocaine can cause premature labor, low birth weight, and fetal death. Studies also indicate that exposure to cocaine leads to problems in school-aged children in such areas as problem solving, inhibition, impulse control, and abstract reasoning.[3] The effects of methamphetamine and amphetamines, which are other types of stimulants, are similar, although methamphetamine often has a greater impact on the central nervous system. Methamphetamine is generally less expensive than cocaine, and because the body metabolizes it more slowly, its effects may last as much as 10 times longer

Commonly Abused Commercial Products

Adhesives: Model airplane glue, household glue, rubber cement.

Aerosols: Spray paint, hair spray, air freshener, fabric protector.

Anesthetics: Nitrous oxide, ether, chloroform.

Cleaning agents: Dry cleaning fluid, spot remover, degreaser.

Gases: Nitrous oxide, butane, propane, helium.

Solvents: Nail polish remover, paint thinner, lighter fluid, gasoline.

[2] UNational Inhalant Prevention Coalition. (2004). *About inhalants* [On-line]. Available: http://www.inhalants.org/about.htm.

[3] Lester, B. M., LaGasse, L. L., & Siefer, R. (1998). Cocaine exposure and children: The meaning of subtle effects. *Science*, *282*(5389), 633–634.

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than a high from cocaine.[4] Individuals who use methamphetamine may experience serious health and psychiatric conditions, including memory loss, aggression, violence, psychotic behavior, and potential coronary and neurological damage.[5]

The types of substances used by adolescents and adults change faster than current literature can document, and families may mention drugs that are unknown to child protective services caseworkers. Three valuable Federal Internet resources for current information on a variety of substances are:

- The National Clearinghouse for Alcohol and Drug Information (**http://ncadi.samhsa.gov/**)
- The National Institute on Drug Abuse (**www.drugabuse.gov**)
- The Office of National Drug Control Policy (**www.whitehousedrugpolicy.gov**).

Drug Group	Drug	Street Names	Method of Use
Cannabinoids	Hashish	Hash	Smoked in hand-rolled cigarettes, pipes, or water pipes (i.e., "bongs").
	Marijuana	Grass, pot, weed	
Club Drugs	Gamma hydroxy butyrate	GHB, "G"	Mixed into drinks or injected.
	Ketamine	Special K, "K," Kit Kat, vitamin K	Mixed into drinks, injected, added to smokable materials, snorted, or consumed in pill form.
	MDMA (3,4-methylenedioxy methamphetamine)	Ecstasy, X, XTC, E	Consumed in pill form, mixed into drinks, or injected.
	Flunitrazepan	Rohypnol (commercial name), roofies	Mixed into drinks or injected.
	Yaba	Crazy medicine, Nazi speed	Consumed in pill form, inhaled (by melting tablets and inhaling vapors), snorted, or injected.
Depressants	Alcohol	Booze, juice, hooch	Swallowed in liquid form.
	Barbiturates, methaqualone, benzodiazepines	Downers, ludes	Consumed in capsules, tablet, or pill form; mixed into drinks; or injected.

[4] American Council for Drug Education. (1999). *Basic facts about drugs: Methamphetamine* [On-line]. Available: http://www.acde.org/common/Meth.htm.

[5] Otero, C., Boles, S., Young, N. K., & Dennis, K. (2004). *Methamphetamine: Addiction, treatment, outcomes and implications*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Drug Group	Drug	Street Names	Method of Use
Hallucinogens	Lysergic acid diethylamide	Acid, LSD	Swallowed in tablet or capsule form, or placed into thin squares of gelatin, paper, sugar cubes, gum, candy, or crackers.
	Mescaline	Peyote, cactus, mesc	Chewed, swallowed in capsule or pill form, or ground and infused in hot water and consumed as tea.
	Psilocybin/Psilocyn	Mushrooms, shrooms	Chewed, smoked, or ground and infused in hot water and consumed as tea.
	Phencyclidine	Angel dust, crystal, PCP	Snorted, injected, applied to leafy material and smoked, or swallowed in liquid, capsule, tablet, or pill form.
Inhalants	Airplane glue, aerosol sprays, gasoline, paint thinner	Air blast, highball	Inhaled or sniffed, sometimes using a paper bag, rag, gauze, or ampoule.
	Cyclohexyl, amyl nitrate, or butyl nitrate	Poppers, snappers	
	Nitrous oxide (N_20)	Whippets	
Opioids and narcotic pain relievers	Heroin	Smack, junk	Injected, snorted, or smoked.
	Morphine	M, monkey, white stuff	Injected, snorted, or smoked.
	Opium	Black stuff, block, gum, hop	Swallowed or smoked.
	Oxycodone	Oxycontin (commercial name), O.C.	Swallowed, injected, or snorted.
	Hydrocodone	Vicodin (commercial name)	Swallowed.
Stimulants	Amphetamines	Speed, uppers	Swallowed in capsule, tablet, or pill form; injected; smoked; or snorted.
	Cocaine	Coke, blow, Connie	Snorted or injected.
	Crack cocaine	Crack, rock	Smoked.
	Methamphetamine	Meth, crystal, crystal meth, Tina, T, crank, speed	Snorted, injected, smoked, or swallowed.
Other compounds	Anabolic steroids	Anadrol (commercial name), Oxandrin (commercial name), roids, juice	Injected, swallowed, applied to skin
	Dextromethorphan (DXM)	Robotripping, robo, triple C (Note: DXM is found in some cough and cold medications)	Swallowed

For more information on commonly used drugs and their effects and health consequences, visit **http://www.nida.nih.gov/drugpages/drugsofabuse.html**.

APPENDIX F

Commonly Used Screening Instruments

The substance use disorder treatment field has developed and tested several screening instruments. The following table provides a short description of the more commonly used instruments that have been found valid when used in appropriate settings. It is essential to review the materials accompanying the instruments before using them. These materials provide practical guidance, such as how many positive responses indicate that alcohol or drug use may be a problem, and they may suggest alternative wording of questions that might work better in child welfare settings.

Many of these screening instruments are available from Federal websites, especially the National Institute on Alcohol Abuse and Alcoholism (**http://www.niaaa.nih.gov**) and the National Institute on Drug Abuse (**http://www.nida.nih.gov**). Some are available in Spanish. For screening instruments in other languages, it may be necessary to work with a translator who is not a friend or a relative of the family.

Selected Substance Use Disorder Screening Instruments

Instrument	Purpose	Summary	For More Information
Adult Substance Use Survey (ASUS) *(For use with the Self-Appraisal Survey)*	Screens for an individual's perceived alcohol and drug use and abuse, mental health concerns, motivation for treatment, anti-social attitudes and behaviors, and level of defensiveness.	• Sixty-four questions that can be self-administered or asked by another person. Available in Spanish. • Takes 8–10 minutes to administer. Training is required and available. A user's guide is available. • Free for use in Colorado but permission is required.	Kenneth Wanberg, Ph.D. Center for Addiction Research and Evaluation, Inc. 5460 Ward Road, Suite 140 Arvada, CO 80002 (303) 421-1261

Selected Substance Use Disorder Screening Instruments			
Instrument	**Purpose**	**Summary**	**For More Information**
Alcohol Use Disorders Identification Test (AUDIT)[1]	Designed to identify individuals whose alcohol use has become a danger to their health. Includes three subscales that assess amount and frequency of drinking, alcohol dependence, and problems caused by alcohol.	• Ten questions that can be self-administered or asked by another person. • Takes about 1 minute to complete. • Targeted at adults. • Free except for training materials.	Thomas Babor Alcohol Research Center University of Connecticut 263 Farmington Avenue Farmington, CT 06030-2103
CAGE Questionnaire[2]	Related to drinking behavior.	• Four questions that can be self-administered or asked by another person. • Targeted at individuals 16 years of age or older. • Questions can be incorporated into other questionnaires. • Free.	Available through numerous publications, websites, and treatment and prevention programs, including: http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/InstrumentPDFs/16_CAGE.pdf
CAGE-AID[3]	Similar to the CAGE Questionnaire, but this expanded version includes questions about the use of illicit drugs as well as alcohol.	• Nine questions that can be self-administered or asked by another person. • Targeted at individuals 16 years of age or older. • Questions can be incorporated into other questionnaires. • Free.	Available through numerous publications, websites, and treatment and prevention programs.
Drug Abuse Screening Test (DAST)[4]	Designed to screen for the use of illegal drugs.	• Twenty questions (short version has 10) whose cumulative score indicates whether there is a drug problem, whether the person should be monitored, or whether the person should be assessed further.	The Addiction Research Foundation Center for Addiction and Mental Health 33 Russell Street Toronto, M5S2S1 Ontario, Canada (415) 595-6111 (800) 463-6273

[1] Babor, T., de la Puente, J. R., Saunders, J., & Grant, M. (1992). *AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for use in primary health care.* Geneva, Switzerland: World Health Organization.

[2] Mayfield, D., McLeod, G., & Hall, P. (1974). The CAGE questionnaire: Validation of a new alcoholism instrument. *American Journal of Psychiatry, 131*(10), 1121–1123.

[3] Brown, R. L., & Rounds, L. A. (1998). Conjoint screening questionnaires for alcohol and other drug abuse: Criterion validity in primary care practice. *Wisconsin Medical Journal, 94*(3), 135–140.

[4] Skinner, H. A. (1982). The Drug Abuse Screening Test (DAST). *Addictive Behavior*, *7*(4), 363–371.

Selected Substance Use Disorder Screening Instruments			
Instrument	**Purpose**	**Summary**	**For More Information**
Michigan Alcoholism Screening Test (MAST)[5]	Designed to screen for lifetime alcoholism-related problems.	• Twenty-five questions that can be self-administered or asked by another person. Shorter version also available. • Takes 5 minutes to administer. • Targeted at adults. • Minor cost for original, then can be copied.	Melvin L. Selzer, M.D. 6967 Paseo Laredo La Jolla, CA 92037 (619) 459-1035
Self-Appraisal Survey (SAS) (*For use with the Adult Substance Use Survey)*	Designed to screen for alcohol and chemical dependency and to determine both the extent of use and the effects of use on aspects of life.	• Twenty-four questions that can be self-administered by participants and 12 items for caseworkers to complete using observations and other information. • Takes about 15 minutes. • Free in Colorado, but permission is required.	Kenneth Wanberg, Ph.D. Center for Addiction Research and Evaluation, Inc. 5460 Ward Road, Suite 140 Arvada, CO 80002 (303) 421-1261
Substance Abuse Subtle Screening Inventory (SASSI)[6]	Designed to screen for chemical dependency and efforts to fake or conceal problems. It has eight subscales that can assess defensiveness and other dependency characteristics.	• Eighty-eight questions. • Takes 10–15 minutes. • Requires training to administer, but can be self-administered. • Requires training to interpret and score. • Must be purchased.	The SASSI Institute 201 Camelot Lane Springville, IN 47462 (800) 726-0526 http://www.sassi.com

[4] Selzer, M. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *American Journal of Psychiatry, 127*(12), 1653–1658.

6 Miller, G. (1985). *The Substance Abuse Subtle Screening Inventory (SASSI) manual*. Bloomington, IN: Spencer Evening World.

Triage Assessment for Addictive Disorders (TAAD)	Designed for both drug and alcohol use in face-to-face interviews where time commitment is minimal.	• Thirty questions. • Takes 12–13 minutes to administer and score. • Can be administered by anyone with good interviewing skills. • Requires expertise to score. • Must be purchased.	Norman G. Hoffmann, Ph.D. Evince Clinical Assessments P.O. Box 17305 Smithfield, RI 02917 (800) 755-6299 http://www.evinceassessment.com
TWEAK Alcohol Screen	Developed and validated for women. Recommended by the California Institute of Mental Health.	• Five questions that can be self-administered or asked by another person. • Takes 5 minutes to administer and score. • No training is required. • Free	Marcia Russell, Ph.D. Research Institute on Addictions 1021 Main Street Buffalo, NY 14203 (716) 887-2507 http://www.ria.buffalo.edu
UNCOPE	Designed to detect alcohol or drug problems.	• Six questions found in existing instruments and research reports. • Can be self-administered or asked by another person. • No training is required. • Free.	Norman G. Hoffmann, Ph.D. Evince Clinical Assessments P.O. Box 17305 Smithfield, RI 02917 (800) 755-6299 http://www.evinceassessment.com/research.html

Although screening tools are a great resource, they are not meant to be the sole source of decision-making. Rather, child protective services caseworkers must rely on multiple sources of information as well as their professional training and experience to help them decide whether substance use is a problem for a specific family.

APPENDIX G

State of Connecticut Department of Children and Families Substance Abuse Screening and Information Form

Date: _____/_____/_____

DCF Worker: _____ Phone: _____

DCF Supervisor: _____ Phone: _____

Client Name: _____ SAFE #: _____

Date client referred to SAFE, if applicable: _____

This form shall be completed by the social worker upon return to the office. Please check **every** box either "yes" or "no," as appropriate. If there is any "yes" box checked for questions 1-13, a referral for an evaluation shall be made to Project Safe.

1. Yes ☐ No ☐ Client appeared to be under the influence of drugs and/or alcohol.

2. Yes ☐ No ☐ Client showed physical symptoms of trembling, sweating, stomach cramps, or nervousness.

3. Yes ☐ No ☐ Drug paraphernalia was present in the home, i.e., pipes, charred spoons, foils, blunts, etc.

4. Yes ☐ No ☐ Evidence of alcohol abuse was present in the home, i.e., excessive number of visible bottles/cans whether empty or not.

5. Yes ☐ No ☐ There was a report of a positive drug screen at birth for mother and child.

List drugs detected: _____

6. Yes ☐ No ☐ There was an allegation of substance abuse in the CPS report.

7. Yes ☐ No ☐ The child(ren) reports substance abuse in the home. When?_____

_____

8. Yes ☐ No ☐ The client has been in substance abuse treatment. When? _____

_____

9. Yes ☐ No ☐ The client has used the following in the last 12 months:

Marijuana/Hashish ☐ Heroin/Opiates ☐ Cocaine/Crack ☐

Other drugs: _____

_____

10. Yes ☐ No ☐ Client shared that he/she has experienced negative consequences from the misuse of alcohol.

DWI/DUI ☐ Domestic Fights ☐ Job Loss ☐ Arrests ☐

Other: _____

_____

11. Yes ☐ No ☐ Client shared he/she has experienced trouble with the law due to the use of alcohol or other drugs.

DWI/DUI ☐ Domestic Violence ☐ Drug Possession Charge ☐

Other: _____

_____

12. Yes ☐ No ☐ There are adults who may be using drugs and/or misusing alcohol who have regular contact with the client's children.

13. Yes ☐ No ☐ The client acknowledged medical complications due to the use of substances.

_____

14. Other Comments:

_____

_____

_____

Adapted from Young, N. K., & Gardner, S. L. (2002). *Navigating the pathways: Lessons and promising practices in linking alcohol and drug services with child welfare, Technical Assistance Publication (TAP) Series 27*, p. 131–132. (SAMHSA Publication No. SMA-02-3639). Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

APPENDIX H

Memorandums of Understanding[1]

What is a Memorandum of Understanding (MOU)?

An MOU is a written agreement that serves to clarify relationships and responsibilities between two or more organizations that share services, clients, and resources.

Why is it important to have an MOU?

MOUs help strengthen community partnerships by delineating clear roles between individuals, agencies, and other groups. Communities with MOUs report that the strengthened partnerships resulted in enhanced services for children and families.

What is actually included in an MOU?

Generally, MOUs can address a variety of issues and topics. Content areas to consider including in an MOU are:

- Clarification of agency roles;
- Referrals across agencies;
- Assessment protocols;
- Parameters of confidentiality;
- Case management intervention;
- Interagency training of staff;
- Agency liaison and coordination;
- Process for resolving interagency conflicts;
- Periodic review of the MOU.

[1] Bragg, H. L. (2003). *Child protection in families experiencing domestic violence* [On-line]. Available: http://www.childwelfare.gov/pubs/usermanuals/domesticviolence/.

How do we know our community is ready to develop an MOU?

Communities that are concerned about reducing the incidence of child maltreatment are excellent candidates for creating an MOU. In communities that are experiencing strained relationships between potential partners, the process of writing an MOU provides a unique opportunity to address misperceptions and differences and to work jointly to resolve gaps in service delivery.

What strategies should we undertake as we begin the MOU process?

Depending on existing relationships within communities, one strategy may include inviting key supporters to meetings to explore the feasibility of MOU development. Communities have reported that once they had the commitment and investment from the various agencies, the MOU process quickly crystallized and resulted in a written MOU. An additional strategy may include inviting an outside consultant to facilitate a partnership that leads to the development of an MOU.

What are the problems that might arise during the MOU process?

Problems may arise concerning misperceptions about each other's goals, missions, and philosophy. Professionals from child welfare agencies report that the MOU meetings helped them understand each other's language and history and provided a context in which to view other philosophies and missions. Additional problematic issues may include confidentiality policies, assessment decisions, levels of intervention, and out-of-home placement for children. The MOU provides an opportunity to address these critical issues to meet the needs of the community.

How does the MOU actually help families and children?

Families affected by child maltreatment report that they are reluctant to request assistance, are required to participate in services that do not address the underlying issues, and frequently feel misunderstood by professionals. Communities with existing MOUs have reported that children who are maltreated were less likely to be placed in out-of-home settings and that families were more motivated to work with professionals to reduce the risk of future child abuse and neglect. Families in communities where MOUs have been established reported a higher level of satisfaction in working with professionals.

APPENDIX I

Confidentiality and the Release of Substance Use Disorder Treatment Information

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act (1970) and the Drug Abuse Office and Treatment Act (1972) regulate the disclosure of confidential information by substance use disorder treatment programs that receive Federal assistance. Generally, a provider cannot release any information that identifies an individual in the program and cannot acknowledge the presence of an individual in the treatment program. The following are exceptions under which client information can be released:

- It will be used in internal communications between or among those with a legitimate interest who need the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of substance use disorders if the communications are within the program or between a program and an entity that has direct administrative control over the program.
- It relates to a medical emergency requiring assistance.
- It relates to research or an audit of the program or service.
- It relates to a crime on the premises involving drug use or a mental condition.
- It relates to reports of suspected child abuse and neglect.

  A court order has been obtained.
- It will be used by qualified organizations providing services to the program.
- Proper consent, by way of a criminal justice consent form, has been obtained from the individual in the program (in the case of a minor, the consent must be obtained from the patient, the parents, or both). This consent must be in writing and must contain each of the following items:
  - The name and general description of the program(s) making the disclosure;
  - The name of the individual or organization that will receive the disclosure;
  - The name of the patient who is the subject of the disclosure;
  - The purpose or need for the disclosure;
  - How much and what kind of information will be disclosed;

- A statement regarding revocation of consent;
- The date, event, or condition upon which the consent will expire;
- The signature of the patient;
- The date on which the consent is signed.[1]

Adapted from U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. (2000). Legal issues. *Juvenile Accountability Incentive Block Grants Program Bulletin* [On-line]. Available: http://www.ncjrs.org/html/ojjdp/jiabg_blltn_03_1_00/6.html.

APPENDIX J

Sample Qualified Service Organization Agreement and Consent Form

XYZ Service Center ("the Center") and

_____

(Name of the alcohol/drug program)

(the "Program") hereby enter into an agreement whereby the Center agrees to provide:

_____

(Nature of services to be provided to the program)

Furthermore, the Center:

(1) Acknowledges that in receiving, transmitting, transporting, storing, processing, or otherwise dealing with any information received from the Program identifying or otherwise relating to the patients in the Program ("protected information"), it is fully bound by the provisions of the Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2; and the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR, Parts 142, 160, 162, and 164, and may not use or disclose the information except as permitted or required by this Agreement or by law;

(2) Agrees to resist any efforts in judicial proceedings to obtain access to the protected information except as expressly provided for in the regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2.

(3) Agrees to use appropriate safeguards (*can define with more specificity*) to prevent the unauthorized use or disclosure of the protected information;

(4) Agrees to report to the Program any use or disclosure of the protected information not provided for by this Agreement of which it becomes aware (*insert negotiated time and manner terms*);

(5) Agrees to ensure that any agent, including a subcontractor, to whom the Center provides the protected information received from the Program, or created or received by the Center on behalf of the Program, agrees to the same restrictions and conditions that apply through this agreement to the Center with respect to such information;*

(6) Agrees to provide access to the protected information at the request of the Program, or to an individual as directed by the Program, in order to meet the requirements of 45 CFR § 164.524, which provides patients with the right to access and copy their own protected information (*insert negotiated time and manner terms*);

(7) Agrees to make any amendments to the protected information as directed or agreed to by the Program pursuant to 45 CFR § 164.526 (*insert negotiated time and manner terms*);

(8) Agrees to make available its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of protected information received from the Program, or created or received by the Center on behalf of the Program, to the Program or to the Secretary of the Department of Health and Human Services for purposes of the Secretary determining the Program's compliance with HIPAA (*insert negotiated time and manner terms*);

(9) Agrees to document disclosures of protected information, and information related to such disclosures, as would be required for the Program to respond to a request by an individual for an accounting of disclosures in accordance with 45 CFR § 164.528 (*insert negotiated time and manner terms*);*

(10) Agrees to provide the Program or an individual information in accordance with paragraph (9) of this agreement to permit the Program to respond to a request by an individual for an accounting of disclosures in accordance with 45 CFR § 164.528 (*insert negotiated time and manner terms*);

Termination

(1) The program may terminate this agreement if it determines that the Center has violated any material term;

(2) Upon termination of this agreement for any reason, the Center shall return or destroy all protected information received from the Program, or created or received by the Center on behalf of the Program. This provision shall apply to protected information that is in the possession of subcontractors or agents of the Center. The Center shall retain no copies of the protected information.

(3) In the event that the Center determines that returning or destroying the protected information is infeasible, the Center shall notify the Program of the conditions that make return or destruction infeasible (*insert negotiated time and manner terms*).

Upon notification that the return or destruction of the protected information is infeasible, the Center shall extend the protections of this Agreement to such protected information and limit further uses and disclosures of the information to those purposes that make the return or destruction infeasible, as long as the Center maintains the information.

Executed this _____ day of _____, 20 ___.

_____	_____
President	Program Director
XYZ Service Center	[Name of the Program]
[address]	[address]

*Although HIPAA requires these paragraphs to be included in Business Associate agreements, 42 C.F.R. § 2.11 requires qualified service organizations to abide by the Federal drug and alcohol regulations, which prohibit such organizations from redisclosing any patient-identifying information even to an agent or subcontractor. Legal Action Center has asked the U.S. Department of Health and Human Services for an opinion on this issue.

Obtained from Legal Action Center. (n.d.). *Sample qualified service organization/business associate agreement* [Online]. Available: http://www.lac.org/doc_library/lac/publications/QSO-BA%20Agreement%20Form.pdf.

Sample Consent Form

Consent for the Release of Confidential Information

I, _____, authorize _____
(Name of patient) (Name or general designation of program making disclosure)

to disclose to _____
(Name of person or organization to which disclosure is to be made)

the following information:_____
(Nature and amount of information to be disclosed; as limited as possible)

The purpose of the disclosure authorized in this is to:

_____
(Purpose of disclosure, as specific as possible)

_____

I understand that my substance use disorder treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

_____

I understand that generally (*insert name of program*) may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____ _____
Date Signature of Patient

_____
Signature of parent, guardian, or uthorized representative where required.

_____

Adapted from Legal Action Center. (n.d.). *Sample consent - basic* [On-line]. Available: http://www.lac.org/doc_library/lac/publications/Consent-Basic.pdf.

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