



## **Curriculum Two**

### **Self-Tutorial**

# **Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Child Welfare Professionals**

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# Introduction

## Why Should I Take This Course?

The effects of substance use disorders on the welfare of children and families and the roles that families have in treatment and recovery are long-standing concerns of child welfare professionals. Child abuse and neglect is frequently associated with substance-abusing parents who are unable to provide a safe and nurturing environment for their children.

Federal legislation for child welfare and child abuse and neglect has tightened the requirements for families involved in the child welfare system. This has had repercussions for substance abuse treatment: Parents have a relatively short time to demonstrate that they are able to care for their children.

Most substance abuse clients who are parents are not involved with the child welfare system. However, child welfare professionals frequently identify substance abuse as a factor in child abuse or neglect cases.

At this point, child welfare professionals and treatment professionals have shared clients—parents, children, and families—and the child welfare and substance abuse treatment case plans need to be coordinated.

Recognizing that many of the strategies suggested in this curriculum are already used by social workers in the child welfare system, this course emphasizes those that are particularly relevant, and introduces others that may not be widely used. Thus, this course aims to provide supportive strategies and information for child welfare professionals to build and expand partnerships with treatment professionals to optimize outcomes for children and families.

## Purpose of the Course

This curriculum will support child welfare professionals in three major areas:

- Understanding substance use disorders, treatment, and family recovery, and their relationship to parenting
- Building and enhancing partnerships and coordinated case planning and management with substance abuse treatment professionals
- Carrying out responsibilities that arise if the in-home investigation or the screening indicates that alcohol or drug use may be a factor in the abuse or neglect:
  1. Referring parents for alcohol and drug assessments with a qualified substance abuse counselor

2. If alcohol or drug abuse is a factor in the abuse or neglect, addressing the substance abuse needs in the case plan, and coordinating the child welfare and drug treatment plans
3. Referring children for an assessment by a qualified professional to determine the impact of parental substance use and the possibility of the children's use; addressing the children's treatment or counseling needs in the case plan

## What Does This Course Contain?

**Module One, page 13**—provides fundamental information regarding substance use, abuse, and addiction.

**Module Two, page 31**—discusses motivating families to engage in treatment for substance use disorders.

**Module Three, page 46**—describes the substance abuse treatment types, settings, approaches, and key elements of treatment for parents and the unique considerations of women with substance use disorders and issues mothers may face.

**Module Four, page 128**—presents the special considerations for children whose parents have substance use disorders.

**Module Five, page 163**—provides partnership and case management strategies to enhance coordination and collaboration between substance abuse treatment and child welfare professionals.

**Resources, page 191**—contains a wealth of information: (1) child welfare websites, (2) online publications, (3) references and bibliography, and (4) a glossary of terms appropriate to child welfare and substance abuse issues.

## Course Goals

This course is designed to provide information and implementation support to child welfare professionals in the following ways:

- To understand how people develop substance use disorders and how substance abuse affects parenting.
- To know key steps child welfare professionals should take when substance abuse is identified as a factor in a child abuse or neglect case.
- To learn strategies that motivate families to engage in treatment for substance use disorders.
- To understand substance abuse treatment approaches and ways to help parents secure appropriate treatment for the benefit of children and families.
- To recognize unique considerations for women with substance use disorders.

- To recognize special considerations of children whose parents are struggling with substance use disorders.
- To use strategies and resources to assist families in the child welfare system that are grappling with substance use disorders.
- To use strategies and resources that support child welfare professionals' collaboration with treatment counselors so that child welfare professionals may more fully assist families who are affected by substance use disorders.

## How to Use This Course

This course is divided into six modules. We recommend that you begin with Module One and work your way through Module Six because each module builds on the previous one. After completing Module Six, please take the knowledge assessment. After passing the exam, you will be able to print a certificate of completion. This course was approved by the National Association of Social Workers (NASW), Provider #886403746 for four (4) Continuing Education Contact Hours. There is no charge to you to obtain the Continuing Education Credit.

This course is designed to provide comprehensive information regarding substance abuse treatment issues for the child welfare professional. The course is interactive. As you progress through the modules, you will find links to worksheets, pop-up questions, case studies, and information boxes to support your learning experience. You may customize the tutorial by selecting the Learn More links throughout the course, which provide further content on specific topics. The Resources section provides an array of Websites, publications, and other sources on substance abuse, treatment, and recovery issues. We encourage you to find out more about areas of interest and relevance to your client casework through these features.

We recommend that you print out the tools and worksheets and use them once you have completed the course. The exhibits and worksheets are prepared in a format that is viewable and printable using Adobe Acrobat Reader. The Adobe Acrobat Reader can be downloaded free of charge. You may use the icon below to connect. Adobe will guide you through the process of installing it on your computer.



## Benefits of This Course

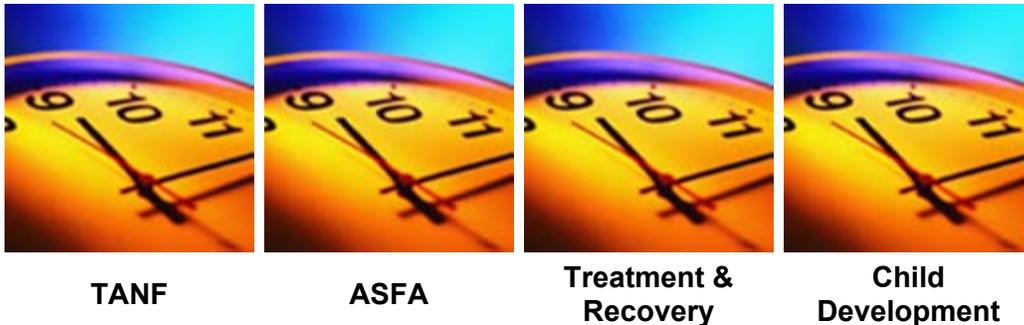
This course is intended to serve as a support for you as you learn information and build and enhance partnerships in service to your clients.

There are benefits to substance-abusing parents and their families when child welfare and substance abuse treatment professionals collaborate. The benefits include:

- **Child welfare and substance abuse professionals can help each other to carry out their professional responsibilities.**
- **By teaming, professionals can reduce the stress on families caused by competing requirements.** By reducing the family stresses caused by competing requirements, the potential for successful treatment and parenting is greatly enhanced.
- **Teaming offers better protection for children.** Parents, child welfare professionals, and treatment professionals can develop joint strategies to ensure that children are better protected while families participate in treatment.

**Child welfare and treatment professionals can reduce costs and time.** By fostering collaboration and communicating effectively, professionals across systems can save time and money that would otherwise be spent on tasks such as locating the correct contacts and tracking down information.

### Four Clocks: Collaboration is Essential



Families involved in the child welfare and treatment systems are often involved with other systems as well. Each system has its own timeline within which parents must accomplish specific goals and meet specific requirements. These systems, and the child's development, can be thought of as ticking clocks.

Families face multiple time constraints that can be at odds with one another. For example, speeding up mandates under the Temporary Assistance for Needy Families (TANF) Program and the Adoption and Safe Families Act (ASFA) has established new "clocks" that measure the time required to achieve desired outcomes in the lives of families affected by substance use disorders and child abuse or neglect.

## Four Clocks: Competing Requirements



TANF

ASFA

Treatment &  
Recovery

Child  
Development

Treatment and recovery timelines constitute an independent “clock” that ticks as parents participate in treatment. The quickly moving child developmental timetable is another “clock.”

These clocks represent the four major timetables associated with each set of requirements, where one requirement can interfere with parents' ability to meet the other requirements. The challenge is to work all of these requirements into a shared strategy that will enable families to remain intact or reunify, or to move toward an alternative placement if those outcomes are not possible.

The next few pages will review four timetables that parents must adhere to:

- Substance abuse treatment timetable
- Child welfare/court timetable
- Welfare reform timetable
- Child’s developmental timetable.

### The Substance Abuse Treatment Timetable



The substance abuse treatment timetable relates to the substance-abusing parent's timetable for treatment and recovery.

Some parents may have timetables that are incompatible with the child welfare and welfare reform deadlines. This includes parents who are not ready for treatment. It includes parents who have co-occurring disorders (e.g., parents with substance use disorders who also have mental health disorders, past traumatic experiences, or a history of domestic violence). It also includes parents who have relapsed but are still working at their recovery.

### The Child Welfare/Court Timetable



The child welfare/court timetable relates to the time limits parents with children in the foster care system have to develop a safe and nurturing

family environment to which their children can be returned, before losing permanent custody.

Permanency is essential for a child's successful development, and even a year is a long time in a child's life. It can also relate to whether parents can maintain an environment that will prevent child abuse and neglect, thus keeping parents and children together.

This 12-month timetable may move too quickly to give parents sufficient time to complete treatment or to demonstrate sufficient stability to care for their children.



### **The Welfare Reform Timetable**

The welfare reform timetable relates to the requirements about how long a TANF client can receive cash welfare benefits before she must find work, and the total number of years she can receive these benefits in a lifetime.

This timetable may challenge clients time to complete treatment, or it may compel clients to relegate treatment to a lower priority in their lives. In turn, this can affect child welfare outcomes.

### **The Child's Developmental Timetable**



The child's developmental timetable relates to a child's developmental stages. For example, the critical period of brain development occurs prenatally and in infancy, and young children achieve much of their bonding or attachment during the first 18 months of their lives.

By the time children are 3 years of age, they have formed much of their sense of trust and security. By the time children are 9 years of age, the chances for adoption are greatly reduced. It is a challenge to help quickly secure safe and nurturing homes for children while allowing for adequate time for the parents' treatment and recovery. Thus, speedy treatment and recovery can critically affect outcomes for children.

This curriculum will help users understand competing requirements and varying timetables that determine successful outcomes in each arena. It will offer collaboration strategies that can help achieve the required outcomes of both the child welfare and treatment systems.

### **Collaboration: Child Welfare Professional Benefits**

Many parents in the child welfare system have substance use disorders. Parents' involvement with their children and families is an integral part of who they are genetically, emotionally, and socially. Relationships are integral to recovery; therefore, it is beneficial to parents, children, and families when child welfare professionals collaborate with treatment professionals and work together to sustain and strengthen family relationships.

## Collaboration: Families in Treatment Benefits

Families in treatment experience benefits when child welfare professionals understand the context of the parent's substance use disorders and how treatment works. As described on the following pages, collaboration promotes the following benefits for families:

- Improves family engagement
- Enhances family outcomes
- Reduces family stress
- Helps families meet requirements
- Improves information sharing

### Collaboration Benefits: Engagement and Outcomes

Collaboration improves family engagement and enhances family outcomes.

**Improves engagement.** Substance-abusing parents who are not involved in the child welfare system often know their children are in trouble or endangered. They may avoid or leave treatment for fear of losing their children. Treatment can help parents provide for their children's safety and well-being. Explaining this can help engage and retain parents in the treatment process. This support is particularly important for parents of infants and young children who may not have access to other helping adults.

**Improves planning.** Understanding the context of parents with substance use disorders improves working with parents and optimizes family outcomes. Substance-abusing parents are almost always affected by relationships with children, partners, parents, and siblings, and may be dealing with trauma and other co-occurring mental health disorders. Understanding the context of a parent's addiction will help child welfare professionals work with treatment professionals to plan treatment approaches that will enhance positive outcomes for children and families.

### Collaboration Benefits: Stress and Requirements

Collaboration helps to reduce family stress and helps families to comply with requirements.

**Reduces family stress.** Substance-abusing parents are often stressed by parenting responsibilities. This stress can contribute to abuse or neglect. Parents may need help to prevent future abuse or neglect. By doing so, child welfare professionals can help parents retain or regain custody of their children and help prevent future abuse.

**Helps families meet requirements.** Parents' ability to successfully negotiate the child welfare and dependency court requirements can relieve stresses that may lead to

relapse. Child welfare and dependency court requirements may differ from the treatment requirements. This can produce stress for parents who are trying to meet all the requirements, thus prompting relapse. Child welfare professionals should increase the treatment counselors' awareness of these pressure points and help clients meet Federal and State timelines, as well as achieve their goals regarding their children.

## **Collaboration Benefits: Information Sharing**

**Improves information sharing.** Collaboration among professionals can help address the varying needs for information and the need to protect client confidentiality. Treatment professionals are often asked to give child welfare professionals information about their clients' progress in treatment or to testify in court, which raises issues of confidentiality. By collaborating with child welfare colleagues, treatment professionals can identify how to share critical information that will help the client without violating client confidentiality.

### **Learn the Laws and Policies**

Child welfare professionals who work with parents with substance use disorders should develop a good understanding of Federal legislation and the respective State laws that have been implemented to carry out the Federal legislation. For example, child welfare professionals should understand the Federal substance abuse treatment confidentiality regulations and HIPAA privacy laws, which are addressed in Module Five. Similarly, child welfare professionals should understand the Federal Child Abuse Prevention and Treatment Act (CAPTA) requirements regarding reporting prenatal exposure and their State's policies and procedures used to respond to the CAPTA requirements. At the same time, child welfare professionals should seek to carefully understand their agency's policies and procedures and to learn about any interagency agreements and protocols.

## **Concerns of Child Welfare Professionals**

On occasion, this course will suggest that child welfare workers should provide fairly specific guidance to parents who are struggling with early recovery and may need fairly concrete and specific steps. This may make some child welfare professionals uncomfortable because it seems to be in conflict with their social work training.

However, when working with parents who need substance abuse treatment and who are under the ASFA clock to meet statutory deadlines set by the dependency court, specific guidance may be needed. Working with persons affected by substance use disorders may require child welfare workers to recognize potential challenges in cognition during early abstinence and to develop skills to increase the parents' motivation to change. Social workers may need to help parents understand what is being asked of them, the best way to achieve their desired goals, and the consequences of not actively working to achieve these goals.

Remember that addiction treatment and child welfare emerged from different philosophies and approaches. As a result, addiction professionals may reveal their history of recovery to clients while child welfare professionals typically do not discuss their personal backgrounds with clients. When appropriate, child welfare professionals may wish to emphasize their professional skills, training, and experiences as part of their qualifications to carry out their job.

## **Special Issues: Teenagers and Fathers**

**Teenagers in the child welfare system.** Although this course focuses on parents in treatment, children and older youth may also be involved in treatment and with child welfare services. In this course, we primarily address youth who are part of families involved with child welfare and youth involved in independent living programs. Many of these youth may also need support, prevention, or treatment services.

This course does not address the treatment, legal, and court processes for youth in the juvenile justice or criminal justice system. For information regarding these topics, please visit the **Permanency Planning for Children Department Website** of the **National Council of Juvenile and Family Court Judges**, as well as the Office of **Juvenile Justice and Delinquency Prevention Website**.

**Involvement of fathers.** Fostering healthy relationships between fathers and children is integral to recovery from substance abuse and development of parenting skills. Although mothers are most often the individuals in treatment and may be reluctant to involve the fathers, both parents should be involved with child welfare and treatment services. Both parents should also be involved in the lives of their children to the extent that children are safe and protected. Furthermore, the dependency court and child welfare systems are mandated to locate absent fathers.

## **American Indian Children and Families**

Special provisions under the Indian Child Welfare Act (ICWA) are designed to address the unique legal status and rights of American Indian children and families as members of federally recognized Indian tribes. The content of this curriculum, while general in its coverage of treatment systems, contains some preliminary information regarding related child welfare issues for American Indian children and families.

If your client base includes members of American Indian tribes, we encourage you to learn more by visiting the **National Indian Child Welfare Association Website** so that you can best meet the needs and honor the culture and values of American Indian children and families.

## **Cultural Competence**

Understanding and respecting cultural values, attitudes, practices, and other issues is critical to providing effective services. Treatment and child welfare professionals

frequently see clients from different cultural groups and within the context of urban, suburban, and rural/frontier settings. Thus, building cultural competence is an important part of the professional's role. This course does not address the specific issues in depth that may be associated with a particular cultural group or geographic setting. We encourage you to obtain information through your State and local diversity and cultural competence resources, and we offer the following links to Federal resources on the topic:

### **Potential Measures/Indicators of Cultural Competence**

A comprehensive matrix by the Health Resources and Services Administration (HRSA) containing cultural competence measures, indicators, and resources.

### **TAP 10: Rural Issues in Alcohol and Other Drug Abuse Treatment**

Contains descriptions of innovative programs that engage a variety of diverse populations.

## **Personal-Professional Dimensions of Substance Use Disorders**

Many of us know someone who has a substance use disorder. All of us bring to our work our personal perspectives, including views and experiences regarding addiction from our families of origin. Be mindful how your viewpoint may affect the way you view parents with substance use disorders. Remember that each person's experience with substance use disorders is unique and that what worked for you or for your family may be different from what will work for our clients.

Discuss this issue with your supervisor to ensure that your experiences do not interfere with your ability to work objectively with your clients. Recognize that this work is difficult, and it is normal for it to bring out emotions or feelings about past experiences. The important thing is not to stop having feelings, but to identify and discuss them with your supervisor so that they do not interfere with your professional work.

We hope this course will provide useful information in support of your work with families struggling with substance use disorders.

## **Acknowledgments**

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## **Disclaimer**

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Office of Program Analysis and Coordination, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cerry Road, Rockville, MD 20857

# Module One: Primer on Substance Use, Abuse, and Addiction for Child Welfare Professionals

## Participant Objectives of Module One

After reviewing this module, child welfare professionals will be able to:

- Understand why people use substances and how they become addicted
- Describe the continuum of substance use disorders and progression of substance use, abuse, and addiction
- Understand the brain chemistry changes involved in substance use
- Understand how substance use disorders are diagnosed
- Gain the critical context needed to understand parents with substance use disorders, and to effectively manage the challenges faced by the parents and their children

## What This Module Covers

This module provides basic information about substance use, abuse, and addiction. This information will be highlighted and drawn on in the remainder of the course. It provides a basis for child welfare professionals to understand parents with substance use disorders and to effectively manage the challenges faced by the parents and their children. It will answer the following questions:

1. Why do people use alcohol and other drugs?
2. What are the pathways from use to abuse and addiction?
3. How do substances affect brain chemistry?
4. Are there risk factors that affect the likelihood that someone will develop a substance use disorder?
5. How do professionals determine that someone has a substance use disorder?
6. In what ways can substance use disorders have a negative effect on people's lives?
7. How do substance use disorders affect the ability to parent?

Research indicates that substance abuse contributes to 40 to 80 percent of substantiated child maltreatment cases (Curtis & McCullough, 1993; Magura & Laudet, 1996; Murphy, Jellinek, Quinn, Smith, Poitras, & Goshko, 1991).

## **Case Study: The Treatment Process and Collaboration**

Throughout this course the following case study will bring to life several important clinical and procedural issues. This case study is designed to illustrate real life issues that child welfare professionals encounter. It is designed to help you examine important issues, consider processes and procedures, review potential challenges, and explore effective solutions.

### **Lisa's Journey Through Treatment and Recovery**



This case study illustrates the journey made by Lisa, a parent involved in the child welfare and addiction treatment systems. You can follow Lisa through treatment program interviews and subsequent treatment, having to meet deadlines, and her recovery process with typical challenges and a relapse.

Lisa's story illustrates clinical issues, observations and decisions made by child welfare and addiction professionals, confidentiality processes and procedures, and decision points related to her children and competing requirements.

### **Caseworker Molly's Collaboration With Treatment Providers**



This part of the case study highlights the experiences of Molly, a county child welfare professional who is Lisa's caseworker. You can follow Molly collaborating with Sarah, an addiction professional who works at the local substance abuse treatment program, about their shared client and her children. Molly and Sarah learn to work together to help Lisa deal with competing requirements; they observe and evaluate her progress, and influence agency procedures.

## Why Do People Use Alcohol and Other Drugs?

People use alcohol and other drugs for many reasons, which include trying to experience euphoric emotions, attempting to cope with anxious situations, or alleviating emotional or physical pain. Alcohol and other drugs can elicit mood changes by stimulating or depressing natural brain chemicals (Landry, 1994, pp. 8–9).

**Biopsychosocial factors.** The exhibit on the following page illustrates several behavioral, social, and environmental factors that can have an effect on whether a person may develop a substance use disorder. These include risk factors, which increase the likelihood of developing a substance use disorder, and protective factors, which serve to protect against the development of such problems.

This exhibit focuses primarily on child, parenting, and family risk and protective factors. There also exist several biological risk and protective factors. For example, people have differences in relation to brain, sensory, and cognitive functioning. These biological differences can also function as risk and protective factors for substance use disorders (Pandina, 1996). For instance, one person's heightened physiological reaction to a substance of abuse may increase their vulnerability to substance use problems while another person's diminished physiological reaction may decrease their vulnerability.

**Unique combination.** Each individual has specific risk and protective factors. These combine to form a complex interplay of variables that affect the probability of the individual's use and abuse of substances.

**Reminder:** This course includes a glossary of special terms and their definitions. To view the glossary, click on the "Resources" tab above and select "Glossary." □ □

□

**Factors  
Influencing  
Potential for  
Substance**

## Use

Children are exposed to various risk and protective factors which serve to either increase or decrease the likelihood of their experiencing subsequent substance use problems. For instance, various child, parenting, and family factors can heighten the likelihood of developing substance use problems later in life or serve as protective factors against their occurrence.

**Factors  
Influencing  
Potential for  
Substance  
Use** □ □ **Domain**  
□ **Risk Factors**  
□ **Protective  
Factors** □ □ **Child  
Factors** □ **Poor  
conflict  
management  
skills**  
□ **Domain** □ **Risk  
Factors**  
□ **Protective  
Factors** □ □ **Child  
Factors** □ **Poor  
conflict  
management  
skills**  
**Domain** □ **Risk  
Factors**  
□ **Protective  
Factors** □ □ **Child  
Factors** □ **Poor**

conflict  
management  
skills

**Risk Factors**

**Protective**

**Factors**   **Child**

**Factors**  Poor  
conflict  
management  
skills

**Protective**

**Factors**   **Child**

**Factors**  Poor  
conflict  
management  
skills

**Child Factors**

Poor conflict  
management  
skills

**Child Factors**

Poor conflict  
management  
skills

- Poor conflict management skills
- Poor social skills
- Impulsivity
- Favorable attitudes toward substance use
- Early initiation of oppositional behavior
- Low school readiness
- Language delays and learning disabilities
- Attention deficit disorder
- Difficult temperament, easily frustrated, difficulty in

self-soothing

□ Social competence (responsiveness, cultural flexibility, empathy, caring, communication skills, and a sense of humor)

- Social competence (responsiveness, cultural flexibility, empathy, caring, communication skills, and a sense of humor)
- Autonomy (sense of identity, self-efficacy, self-awareness, task-mastery, and adaptive distancing from negative messages and conditions)
- Sense of purpose and belief in a bright future (goal direction, educational aspirations, optimism, faith, and spiritual connectedness)
- Problem-solving (planning, teamwork, and critical

and creative thinking)

**School**

**and Peer Factors**

Ineffective teacher responses

**School and Peer**

**Factors**  Ineffective teacher responses

**School and Peer**

**Factors**  Ineffective teacher responses

- Ineffective teacher responses
- Use of substances among peers
- Classroom aggression
- Peer rejection
- Academic failure beginning in late elementary school
- Truancy
  - Clear classroom management
- Clear classroom management
- Norm of positive behavior among peers
- Positive social opportunities
- Social bonding
- Social skills competency
- Academic achievement
- Regular school attendance

□

### **Parenting Factors**

□ Harsh and

ineffective  
parenting  
skills

- Harsh and ineffective parenting skills
- Favorable parental attitudes towards substance use and own use
- Poor monitoring
- Poor parent and child attachment
- Low cognitive stimulation
  - Consistency in rule enforcement
- Consistency in rule enforcement
- Reinforcement of positive social involvement
- Careful and appropriate parental monitoring
- Strong parental bonding

□ □ Contextu

**al and Family**

**Factors** □ Marital  
discord

□ **Contextual and  
Family Factors**

□ Marital discord  
**Contextual and  
Family Factors**

□ Marital discord

- Marital discord
- Family management problems (e.g., creating and following family rules and rituals)
- Family conflict/abuse
- Parent criminal activity
- Parent substance abuse/history of substance use
- Older children who are using substances
- Life stressors
- Parent mental illness
  - Supportive family bonding
- Supportive family bonding
- Reinforcement for positive social involvement
- Positive family dynamics
- No tobacco and other substance use/abuse in family
- Extended family networks

**Community Factors**  Low neighborhood attachment and community disorganization

**Community Factors**  Low neighborhood attachment and community disorganization

**Community Factors**  Low neighborhood attachment and community disorganization

- Low neighborhood attachment and community disorganization
- Community norms (favorable toward drug use)
- Transitional communities (e.g., frequent changes in neighborhood members resulting in low cohesion)
- Availability of drugs
- Extreme economic deprivation
- Poverty  Community connection and supports

- Community connection and supports
- Healthy beliefs and clear standards
- Community-supported substance abuse prevention efforts and programs
- Availability of constructive recreation
- Careful and appropriate monitoring of youth's activities□□

□Adapted from the **Partners for Substance Abuse Prevention Website.** □□

Adapted from the **Partners for Substance Abuse Prevention Website.** □□

## Case Study: Lisa's Initial Interview at the Treatment Agency



Lisa is a 42-year-old woman who was referred to treatment by Child Welfare Services (CWS). Her two adult daughters previously attempted an intervention because they felt that she was neglecting their two younger brothers, Ian age 6, and Ricky, age 5. Lisa refused substance abuse treatment evaluation when pressured by her daughters, who then called CWS for help. At present, Lisa's two younger children are remaining at home but the CWS worker has made a referral to substance abuse treatment as part of Lisa's service plan.

During her initial treatment interview, Sarah, the treatment counselor, conducts a biopsychosocial assessment and takes a substance use history from Lisa to gather information regarding the risk factors that influenced Lisa's substance use. Sarah learns that Lisa married at 17 years old to "get away from" an alcoholic father. Lisa's mother married Lisa's father when she was 16 years old. While drinking, which was most evenings, Lisa's father would become physically abusive with Lisa's mother and verbally abusive to Lisa and her older brother.

In an attempt to remove herself from her home life, Lisa had several male relationships prior to her marriage at age 17. Her first husband was the father of her two older girls, who were born when Lisa was 18 and 20. Her husband was physically and emotionally violent toward Lisa and the girls, and the marriage ended in divorce when Lisa was 24. Following the divorce Lisa began smoking marijuana occasionally and drinking 3 or 4 beers a day to "feel better." Lisa admits she uses methamphetamine but does not believe it is a big problem in her life and doesn't think it affects her younger children.

At age 33 Lisa began a relationship with Dan, and while they never married, he is the father of her two younger boys. Dan is a methamphetamine user and was convicted for drug manufacturing and sales. He has just been released from prison. Before his arrest, Dan introduced Lisa to methamphetamine, which she began using to stay awake while working her job on the night shift at an all-night coffee shop.

### Questions to Ask Yourself:

What roles do Lisa's father and Dan play in her current substance use?

Who are Lisa's supportive relationships?

What are Lisa's strengths?

How urgent is the safety risk to Ian and Ricky with Lisa's current substance use pattern?

## **What are the Pathways From Use to Abuse and Addiction?**

Various theories examine the way people develop substance use disorders. Scientists are investigating how pathways leading from use to a substance use disorder, such as abuse or addiction, are affected by biological, psychological, social, cultural, and environmental factors. Research notes that men and women often experience different progressions from substance use to abuse and addiction.

**Patterns of use.** Alcohol and other drug use exists on a continuum. Not everyone who uses substances becomes addicted. The patterns are generally identified as: substance use, abuse, and dependence. Any level of substance use by a parent can present risks for children. Thus, child welfare workers must always determine whether substance use is a factor in the reported abuse or neglect. If it is, assessments must be conducted to determine the nature and severity of the substance use, as identified on the continuum. In such cases, child protective services uses substance abuse interventions as a means of reducing risk and maintaining the parent-child relationship. While legal bonds can be permanently severed by legal action, emotional bonds remain. Substance abuse intervention is an essential element in protecting the long-term well-being of the child.

The exhibit on the following page describes the primary categories of substance use problems, the implications for child welfare, and examples of risks to children.

<b>Alcohol and Drug Use Continuum and Implications for Child Welfare</b>	
<b>Alcohol and Drug Use Continuum</b>	<b>Implications for Child Welfare and Examples of Risks to Children</b>
<p>Substance use—the use of alcohol or other drugs to socialize and feel their effects. Use may not appear abusive and may not lead to dependence; however, the circumstances under which a parent uses can put children at risk of harm.</p>	<ul style="list-style-type: none"> <li>• Driving with children in the car while under the influence</li> <li>• Use during pregnancy can harm the fetus</li> </ul>
<p>Substance abuse—includes at least one of these factors in the last 12 months:</p> <ul style="list-style-type: none"> <li>• Effects have seriously interfered with health, work, or social functioning</li> <li>• Person has engaged in hazardous activity on a recurring basis, such as driving or operating machinery under the influence</li> <li>• Person has experienced use-related legal problems</li> <li>• Person has continued use despite ongoing or recurring problems caused or exacerbated by use—this includes a maladaptive pattern of use, such as binge drinking</li> </ul>	<ul style="list-style-type: none"> <li>• Children may be left in unsafe care—with an inappropriate caretaker or unattended—while parent is using alcohol or other drugs</li> <li>• A parent may neglect or sporadically address the children’s needs for regular meals, clothing, and cleanliness</li> <li>• Even when the parent is in the home, the parent’s use may leave children unsupervised</li> <li>• Behavior toward children may be inconsistent, such as a pattern of screaming insults then expressing remorse</li> </ul>
<p>Addiction (or substance dependence)—a pattern of use that results in three or more of the following symptoms in a 12-month period:</p> <ul style="list-style-type: none"> <li>• Tolerance—needing more of the drug or alcohol to get “high”</li> <li>• Withdrawal—physical symptoms when alcohol or drugs are not used, such as tremors, nausea, sweating, and shakiness</li> <li>• Unable to control use—a strong craving or compulsion to use and an inability to limit use</li> <li>• The alcohol or drug increasingly becomes the focus of the person’s life at the expense of all other areas, including family, work, social, and recreational</li> <li>• Continued use despite ongoing or recurring physical or psychological problems caused or exacerbated by the alcohol and drug use</li> </ul>	<ul style="list-style-type: none"> <li>• Despite a clear danger to children, the parent may engage in addiction-related behaviors, such as leaving children unattended while seeking drugs</li> <li>• Funds are used to buy alcohol or drugs, while necessities, such as buying food, are neglected</li> <li>• A parent may not be able to think logically or make rational decisions regarding children’s needs or care</li> </ul>
<p>American Psychiatric Association, 2000; SAMHSA, 2005.</p>	

## Alcoholism and Alcohol Abuse

In many States, the number of people treated for alcohol problems equals the number treated for all drugs combined. The amount of alcohol consumed and symptoms of dependence are discussed below and need to be considered in child safety and risk assessments. Importantly, even when alcohol use does not reach the criteria for abuse or dependence, the child welfare worker should assess parental alcohol use or abuse as an indicator of risk to children.

**Key questions.** Key questions to ask include: “How is the drinking affecting the parent’s ability to make sound judgments regarding the welfare of the child?” and “What behaviors are resulting or have resulted from the parent’s alcohol use that may put the child at risk?”

**How much is too much?** The National Institute on Alcohol Abuse and Alcoholism (NIAAA) suggests that health care professionals should be concerned about alcohol addiction if a woman drinks more than 7 drinks per week or 3 drinks at a time. For men, the level is 14 drinks per week, or 4 per occasion (NIAAA, 2004). Further, NAAA identifies the following four symptoms of alcohol dependence or alcoholism:

- **Craving**—strong need or compulsion to drink
- **Loss of control**—The inability to limit one’s drinking
- **Physical dependence**—Withdrawal symptoms, such as nausea, sweating, shakiness, and tremors occur during periods of non-use
- **Tolerance**—The need to drink more to get “high”

**Learn More:** Review the NIAAA document *Alcoholism: Getting the Facts*

**Learn More:** Review the *NIAAA Alcohol Alert* on diagnostic criteria

## Substances Affect Brain Chemistry and Functioning

Click on the brain scan for more information.

Substances of abuse cause significant changes in brain chemistry. As a result, scientists consider substance use disorders to be brain-based diseases. The following is a brief overview:

- Substance-induced brain chemical imbalances disrupt normal communication between neurons. This can strongly affect the way that people feel, think, behave, and perceive. This helps to explain why substances of abuse can make people feel depressed, think poorly, behave in ways not normal to them, or misperceive what others say or do.
- As the person continues to use the substance, the reward pathway—a part of the brain responsible for experiencing pleasure—is affected.
- Addiction means that the person engages in a compulsive behavior, even when faced with negative consequences. The behavior is reinforcing or rewarding.
- The person's loss of control in limiting his or her intake of the addictive substance is a major hallmark of addiction.

Substance-induced changes to the brain are complex, serious, and may be permanent. It is important that a parent receive a medical evaluation, and that assessments of future risk and permanency planning for the child realistically address parental capacity.

Blackouts, which begin in the early stage of alcoholism, are not the same as passing out. A blackout is a type of amnesia or memory loss in which the person cannot remember what they did or said. Some people cannot remember how they got home or where they parked their car. A parent may say he or she does not remember an episode of abuse or neglect of the child. The abuse may have occurred during a blackout (Breshears, 2004).

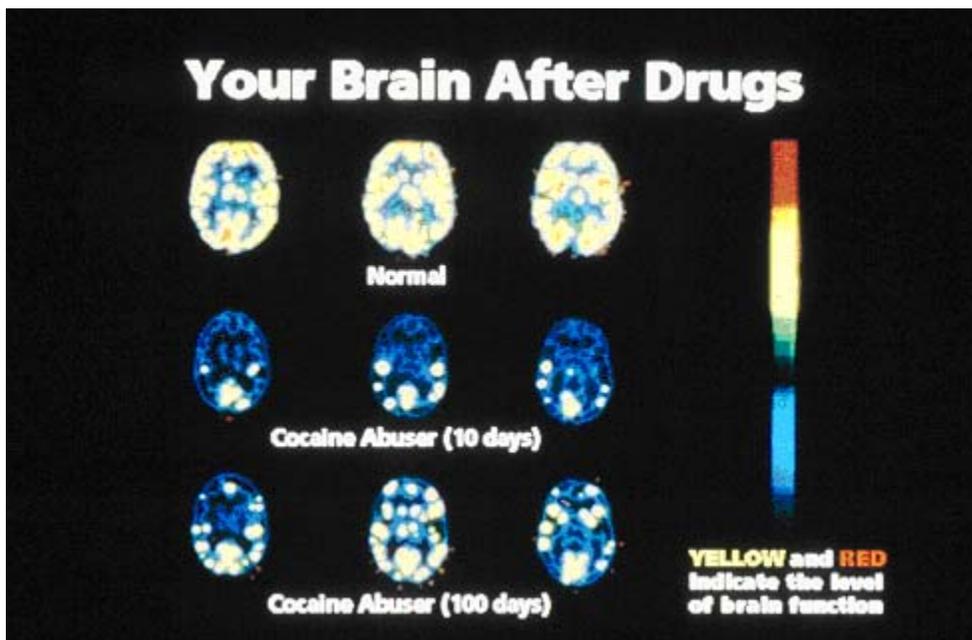
**Learn More:** Review the **NIAAA publications Website**

## Long-Term Effects on the Brain

The brain can be physically injured and changed by drug use, and this injury can last for a long time. The brain scan below illustrates that once an individual is addicted to a drug such as cocaine, the brain can be harmed for a long time. In the brain scan below, the level of brain function activity is indicated in yellow and red.

The top row shows a normal-functioning brain without drugs. In this brain, there are a lot of bright yellow and red areas. This indicates a lot of brain activity. In other words, the neurotransmitters are very active.

The middle row shows the brain of a cocaine addict after 10 days of not using any cocaine. As can be seen, there is much less brain activity than the brain scan from the drug-free individual, even though the cocaine addict has not used cocaine for 10 days. The third row shows the brain of the same cocaine addict after 100 days without any cocaine. As can be seen, there is some improvement. However, the individual's brain is still not back to a normal level of functioning more than 3 months later.



**Learn More:** Review **The Brain: Understanding Neurobiology Through the Study of Addiction**

## Assessing Substance Use Disorders

*How do professionals determine whether a person has a substance use disorder?*

Substance abuse professionals use various tools to assess whether a person has a substance use disorder. This course will address screening and assessment in Module Two.

Generally speaking, substance-related assessment tools draw from the American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) criteria, which are routinely used to diagnose substance use disorders (APA, 2000). The APA DSM-IV criteria addresses substance abuse and substance dependence, also known as addiction. The next two pages will describe:

- Criteria for substance abuse
- Criteria for substance dependence

## Criteria for Substance Abuse

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

- 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)
- 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)
- Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
- 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 a spouse about the consequences of intoxication, physical fights)

**Please note:** Substance abuse can lead to substance dependence. Also, for substance abuse to be diagnosed, a person's symptoms must not meet the criteria for substance dependence.

## Criteria for Substance Dependence

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

- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of the substance to achieve intoxication or desired effect
  - Markedly diminished effect with continued use of the same amount of the substance
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for the substance
  - The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
- The substance is often taken in larger amounts or over a longer period than was intended
- There is a persistent desire or unsuccessful efforts to cut down or control substance use
- 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., frequenting bars), or recover from its effects
- Important social, occupational, or recreational activities are given up or reduced because of substance use
- The substance use is continued despite the 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)

**Learn More:** Review **Criteria for Substance Dependence Diagnosis**

## Adverse Effects of Substance Use Disorders

The lives of people with substance use disorders are out of balance. The person's substance abuse and the negative effects that result from it can have an enormous impact on his or her family and friends. The exhibit below illustrates how substance use disorders can have a negative effect on a person's biological, psychological, social, and spiritual lives.

Adverse Effects of Substance Use Disorders	
Domain	Adverse Effect
Physical	Substance abuse can cause general feelings of malaise, and is associated with an increase in illness and death.
Cognitive	Impairments in thinking and judgment may lead to additional detrimental effects.
Psychological	Suspiciousness of others, depression, and anxiety can result from substance abuse.
Emotional	Instability and lack of emotional bonds and supports.
Social	Tendency to be surrounded by others who are abusing leads to social isolation and existence in an unhealthy social sphere.
Spiritual	The relationship with inner self and "higher power" is confused and often lost during the addictive phase.
Parenting	The relationship with children is compromised by substance abuse.
Family Abuse	The relationship with partner/spouse and others is strained by substance abuse.
Financial	Spending to support the substance use disorder can lead to financial ruin.
Legal	Criminal activity related to substance abuse can lead to incarceration or other legal consequences (e.g., removal of child or termination of parental rights).

Several Native American tribes have teachings that health and well-being is dependent on the balance between mind, body, spirit, and context. This model, known as the relational worldview (Cross, 1997), suggests that life is a complex interplay between all of these factors. Substance abuse affects each of these factors in unique ways, often causing life to spin out of balance. Families often experience escalating problems, along with the progression of the disease. However one understands it, substance use disorders have pervasive effects on the user and on people related to the user.

**Learn More:** Review [Understanding the Relational Worldview in Indian Families](#)

## Case Study: Lisa's Current Situation



When Lisa arrives for her initial interview at the day treatment program, the substance abuse counselor Sarah notes that she appears frail, underweight and unkempt, her skin is pale, her teeth are in poor condition and a front tooth appears to be chipped. Lisa chain-smokes throughout the entire interview. The probing questions of the seasoned counselor (a certified addiction counselor in recovery) help to uncover information about Lisa's situation.

Sarah learns that Lisa's housing situation is currently stable. However, Lisa feels that her night job interferes with her relationship with her boys and is an unsafe environment for anyone trying to not use drugs. She has not seen a doctor since Ricky was born. She says that her night job is her only employment option and means of paying her rent. Lisa states that her only friends are the other waitresses at the coffee shop. They also use methamphetamine to stay awake on the job, and after work they have a few drinks before heading home. Sarah believes that Lisa is minimizing the amount of drugs she is using and that she does not clearly understand the adverse consequences of her drug use on her own health or on her children.

Lisa admits that Ian and Ricky have been absent from school 28 days this year, but she claims they haven't been absent for the last 2 weeks. While she admits to using methamphetamine to get through her shifts and having "a couple drinks to wind down," she feels her current substance use has no effect on her household. She states, "It is just hard for me, working evenings, and making sure the boys stay on track."

When asked about her intentions in regard to her relationship with Dan (Ian and Ricky's father) now that he has been released from prison, Lisa admits she doesn't know what the relationship will be like now but that she is still in love with him. She also says that having another person around making money would help out a lot since now she's barely making ends meet—barely being able to pay for food for the kids by the end of the month.

### Questions to Ask Yourself:

Does Lisa meet criteria for substance abuse or dependence?

Which areas of life functioning are most urgent for Lisa to address?

What role does Lisa's substance use play in Ian and Ricky school absences?

## **Conclusion to Module One**

Each individual has specific risk and protective factors. These combine to form a complex interplay of variables that affect the probability of the individual's use and abuse of substances. When parents have Substance Use Disorders, there are additional considerations for Child Welfare. By taking these factors into consideration, in addition to the brain function changes involved in substance abuse, Child Welfare Workers can gain the critical context needed to understand parents with Substance Use Disorders, and to effectively manage the challenges faced by the parents and their children.

# Module Two: Engaging Families in Substance Abuse Treatment

## Participant Objectives of Module Two

After reviewing this module, child welfare professionals will be able to:

- Recognize the important role of child welfare professionals in helping parents to enter and sustain treatment for substance use disorders
- Identify the needs and experiences of parents that bring them into treatment
- Understand the special provisions for Native American children under the Indian Child Welfare Act
- Identify specific strategies for engaging parents at different stages in the treatment and recovery process

## What This Module Covers

This module provides information and strategies that child welfare professionals can use to help parents who have substance use disorders engage in and maintain substance abuse treatment. It answers the following questions:

- What is the role of the child welfare professional in screening substance use disorders?
- What do child welfare professionals need to know about parents' needs and experiences that bring them into treatment?
- How can child welfare professionals motivate and assist parents to seek and engage in appropriate treatment?
- How can child welfare professionals continue to motivate and engage parents during treatment and recovery?
- What resources can child welfare professionals use to complete assessments of parents?
- How can child welfare professionals interpret and use assessment information from treatment providers?

## Engaging Families in Treatment

*Why is it important to engage parents and families in substance abuse treatment?*

Engaging parents and families in substance abuse treatment is a continuous process for child welfare workers. It involves screening parents for potential substance use disorders, motivating parents to engage in and remain in treatment, and helping parents to sustain recovery.

**Whose role?** A child welfare worker may mistakenly believe that substance abuse treatment occurs first, before other interventions can occur; and that it happens someplace else, under someone else's watch. Some workers believe that their key decision is to send the parents to treatment and have the parents return for the next step in the child welfare process when they are "cured."

**Remain engaged.** However, child welfare workers must remain involved throughout the treatment and recovery process. Child welfare workers, along with treatment counselors and the dependency court, have important roles and responsibilities, and make important decisions during each stage of this process.

When child welfare workers understand what brings parents into treatment and the ongoing process of engaging parents in treatment, they are better able to help parents meet dependency court timetables and ensure ongoing child safety and well-being.

## Case Study: Molly Calls Sarah the Addiction Counselor



Molly is a child welfare worker with the county department of human services. It is a typical day and she is frustrated. It seems that most of her cases involve parents who are abusing substances. While each of the situations are different, they share a common thread: it is difficult for Molly to know if the parents' treatment is working, if they will be able to continue caring for their children, and if they will meet the court deadlines for making such a determination.

The child welfare agency and the treatment centers have signed agreements regarding the disclosure of information, which Molly feels is a step in the right direction. But the information she receives from the treatment facilities is generally focused on the addicted parent. It does not provide a clear picture about the parents' abilities to provide for their children's safety and well-being.

Knowing that for one family - Lisa and her two children - an important review hearing is coming up, Molly picks up the phone. At the other end of the phone is Sarah, a substance abuse treatment counselor at the local day treatment facility where Lisa has been for the past month.

Molly: "Sarah, it's Molly, the caseworker for Lisa's children. I'm checking in to see how her treatment is progressing and I need a report for court." Sarah: "Molly, glad you called. I've been so swamped with all these clients and paper work ... Yes, I know Lisa's hearing is coming up, and I've been gradually trying to help her get ready. She's really committed to treatment once and for all ... but it's a hard road, recovery. You know what they say, "One day at a time, for the rest of your life!"

### Questions to Ask Yourself:

With Molly's concerns about Ian and Ricky's safety, how do you think Molly feels when Sarah responds, "One day at a time?"

What information would you want from Sarah to justify Sarah's statement that Lisa is committed to treatment?

## Screening: The Role of Child Welfare Professionals

*What is the role of child welfare professionals in screening for substance use disorders?*

**Screening.** When there has been a report of child abuse or neglect that is to be investigated, emergency response workers or investigators are generally the first to see parents. These child welfare professionals may have the first opportunity and primary responsibility to conduct the initial screening of parents for potential substance use disorders. Overt signs and symptoms may be observed as part of the initial screening and assessment for child abuse and neglect. Screening can also be performed by other agencies that may be working with parents such as mental health agencies, maternal and child health agencies, or the criminal justice system. Treatment programs do not usually perform screening.

**Referral.** When the child welfare or other professional notes that the screening indicates potential substance abuse, the child welfare professional should refer the parent to a substance abuse treatment provider for further assessment. At that time the substance abuse treatment provider may provide further referral, as necessary, to the most appropriate treatment program.

Tip: Check your agency handbook or manual regarding the specific protocols and procedures used in your agency.

## Who Needs to be Screened?

Substance abuse screenings tend to be viewed in two main ways. In one approach, child welfare professionals try to determine which parents might have a problem with substance abuse, and conduct the screening for those parents they have identified to determine if their hunch is true. Alternatively, child welfare professionals can assume that everyone involved with child maltreatment may be at high risk for substance-related problems and therefore screen everyone, and then rule out individuals who do not appear to be at risk for substance-related problems.

**Screen everyone.** Evidence demonstrates that the second approach should be followed. Child welfare professionals are recommended to screen everyone, identify those who may be at risk, and rule out those who appear not to be at risk. Although caseworkers should follow agency protocol to the extent possible, all individuals should be screened for substance-related problems.

## Case Study: Lisa's Safety Assessment Home Visit



Lisa's referral to the day treatment program resulted from initial observational screens conducted by CWS staff. Following Lisa's daughters' phone call to CWS, an investigator went out to Lisa's home to conduct an in-home safety assessment. This was to determine if a case should be opened and whether or not the children were in immediate danger.

The investigator noticed that the family was living in complete disarray. The living room was cluttered with empty pizza boxes, soda and beer cans, and dirty dishes were piled high in the sink and on the stove in the kitchen. There was no milk, dairy products, fruit, vegetables, or meat in the refrigerator. Clothes were strewn throughout the home's two small bedrooms.

The caseworker noted that the two boys were dressed in clothes that they had outgrown and that were filthy and worn out. Both boys appeared to have upper respiratory infections, and they stated they had not eaten that day. During the visit, Lisa appeared anxious and jittery although there were no overt signs of drug use in the home such as drug paraphernalia. The CWS investigator asked Lisa direct questions about her substance use pattern and adverse consequences that resulted from her alcohol and drug use.

These observations and Lisa's answers about feeling that she was using drugs more than she intended and was having problems stopping led the caseworker to believe that the children were being neglected and that Lisa might have a substance-related problem. The caseworker felt that a case needed to be opened and that Lisa should be referred to a local treatment program for a substance-related assessment. As part of her intake with CWS, Lisa signed release of information forms that allowed the caseworker to share the observations made at the in-home visit with the treatment counselor who would be conducting Lisa's substance-related assessment.

At this point, the investigator determined that Lisa's children were at a moderate level of risk and that immediate removal was not necessary. However, she opened a case, petitioned the court to require Lisa to participate in family maintenance services and referred Lisa's family to Molly who would provide on-going in-home services to the family.

### Questions to Ask Yourself:

Do you agree with the assessment that Ian and Ricky are at a moderate level of risk?

What questions should investigators ask about substance use?

## Purpose of Screening

Screening is a combination of observation, interviews, and the use of a standardized set of questions, such as those that are included in many effective screening tools.

**Determine need for assessment.** The purpose of a substance-related screening is to determine the risk or probability that a parent has a substance use disorder, and whether more in-depth assessment by treatment professionals is needed. Many effective screening tools are available for use by child welfare professionals, and your agency may already have one they use.

## Characteristics of Effective Screening Tools

In general, an effective screening tool has the following characteristics:

- **It is easy to administer**—for example, it can be memorized and administered orally without reference to a written form; it can be administered separately or worked into other screening checklists or tools, as appropriate; and it contains no more than four to six questions.
- **It is capable of detecting a problem**—because it contains the types of key questions that are best known to indicate the presence of a substance use disorder, such as the following:
  - Questions that address unintended use and/or desire to restrict use (control of use/abuse): "Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?" "Can you stop drinking without a struggle after one or two drinks?"
  - Questions about some form of consequences of use or concerns about such consequences (consequences of use/abuse): "Have people annoyed you by criticizing your drinking or drug use?" "Have you ever felt bad or guilty about your drinking?" "Have you ever lost a job because of drinking or drug use?"
- **It is inexpensive and does not require much time to administer**—or much paperwork to record.
- **It is fast and simple**—and can be completed quickly without need of explanations and directions to respond.
- **It is designed for use with a broad range of individuals**—including those with all types of substance use disorders, and diverse populations. (Many screening tools focus only on alcohol and may not be appropriate for screening for other substance use disorders.)

### **Example of Screening Questions: The UNCOPE**

**U** – Have you continued to **use** alcohol or drugs longer than you intended?

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

**C** – Have you ever wanted to **cut down** or stop using alcohol or drugs but couldn't?

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

**P** – Have you ever found yourself **preoccupied** with wanting to use alcohol or drugs?

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

**Scoring:** Two or more positive responses indicate possible abuse or dependence and need for further assessment

## Screening and Assessment for Child Abuse and Neglect

Child welfare workers routinely carry out screening and assessment for child maltreatment that involves interviews, observations, and document reviews. As part of their assessment for child maltreatment, child welfare workers can add a screening tool for substance use disorders.

**Determine contribution.** This allows them to combine the results of the screening tool with other observations and interviews about substance use or abuse to determine the extent to which the substance use disorder contributes to endangering children. In general, the child welfare worker is assessing the extent to which:

- The children are in a life-threatening living situation that may be caused by parents who abuse substances and leave their children unattended or uncared for.
- The child is viewed very negatively by the parent, particularly when the child's emotional or physical needs interfere with the parent's search for or use of substances.
- The family cannot meet the basic needs of the child because financial resources are being used to purchase substances.
- The parent or someone living in the home exhibits harmful behavior toward a child, particularly when they are under the influence of substances.

### Screenings Versus Assessments.

Substance abuse screenings are brief, rapidly administered tools while assessments are comprehensive processes designed to identify critical areas to be addressed in the client's treatment plan. Child welfare professionals frequently conduct screenings, while assessments should be conducted by addiction professionals.

## **In-Home Indicators of Potential Substance Abuse**

Child welfare professionals should check for the following indicators as part of onsite investigations (Young & Gardner, 2002):

- A report of substance use was included in the child protective services call or report
- Paraphernalia is found in the home (syringe kit, pipes, charred spoon, foils, large number of liquor or beer bottles, etc.)
- The home or the parent may smell of alcohol, marijuana, or drugs
- A child reports use by parent(s) or other adults in the home
- A parent exhibits physical behavior of being under the influence of alcohol or drugs (slurred speech, inability to mentally focus, physical balance affected, extremely lethargic or hyperactive, etc.)
- A parent shows signs of addiction (needle tracks, skin abscesses, burns on inside of lips, etc.)
- A parent admits to substance use
- A parent shows or reports experiencing physical effects of addiction or being under the influence, including withdrawal (nausea, euphoria, slowed thinking, hallucinations, or other symptoms)

As with all cases of child abuse and neglect, workers must observe persons who frequent the home. The behaviors of parents' friends or associates can be an indication of behaviors practiced or of potential dangers to the child.

## Determining ICWA Protection

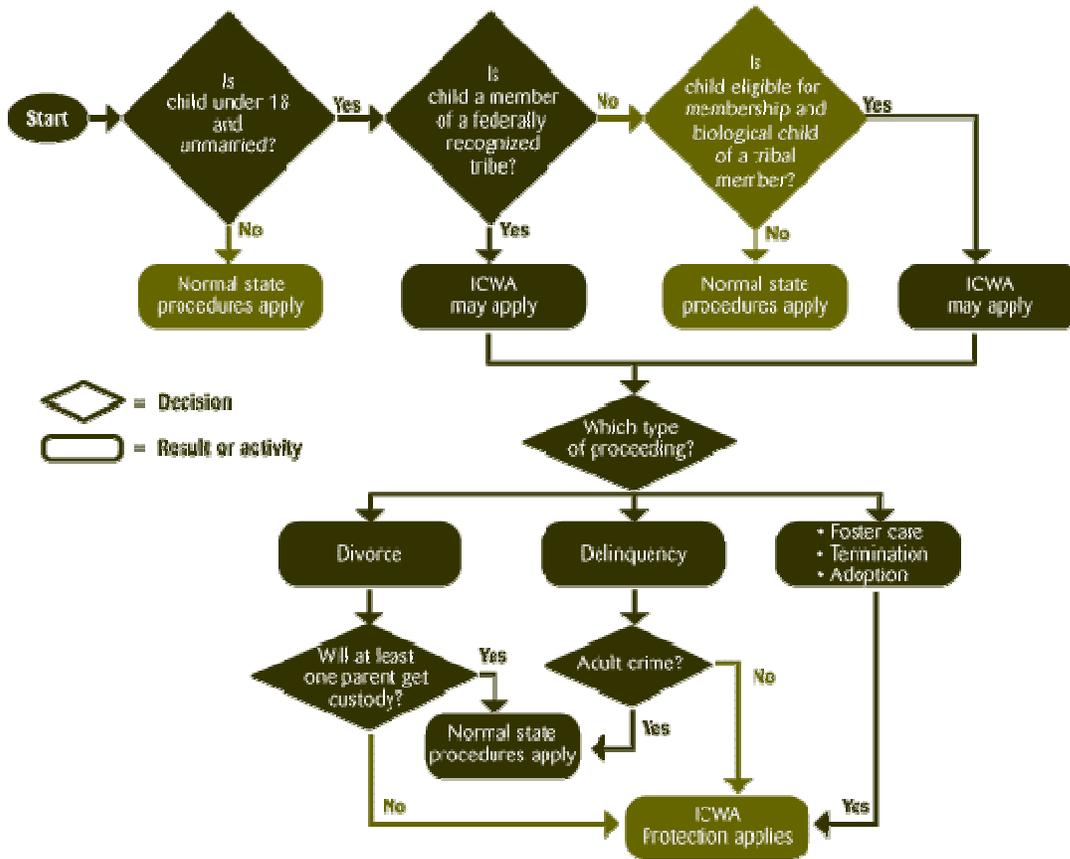
As part of the screening and assessment process in child welfare services, workers need to determine if the Indian Child Welfare Act (ICWA) applies to the family. ICWA provides safeguards to protect the interests of Indian families and addresses the removal of Indian children from their families and the considerations that must take place in doing so. The ICWA applies to unmarried Indian children and youth under 18 years of age who are: (1) a member of a federally recognized Indian tribe, or (2) the biological child of a member of an Indian tribe and eligible for membership in a tribe. The ICWA applies to unmarried Indian children and youth under 18 years of age who are:

- A member of a federally recognized Indian tribe, or
- The biological child of a member of an Indian tribe and eligible for membership in a tribe.

The two most common violations of ICWA are: (1) the failure to identify Indian children and (2) the failure to inform the tribe once children are identified. To carry out the intent of ICWA, the State child welfare agency and other service providers must fully participate in these provisions and make active efforts to contact the appropriate tribes, involve the tribes in decisions about the family, and allow the tribe to take over the responsibility if it wishes to do so.

Learn More: [Will ICWA Apply?](#)

# Will ICWA Apply?



## **Substance Use Reporting and Child Welfare Data Collection**

State data systems vary greatly regarding what information is collected about child welfare families and how it is collected. To ensure that States allocate sufficient resources to treat substance use disorders among child welfare families, it is critical that each child welfare worker identify the data collection points in their case systems where this information can be collected. Typically, this information is underreported because it is not adequately addressed in the mandated child welfare information system, or it is an optional field.

**SACWIS.** The Statewide Automated Child Welfare Information System (SACWIS) is a comprehensive, automated case management tool that supports the social workers' foster care and adoptions assistance case management practice. SACWIS is operational in some States and under development in other States. It can be a critical tool to more accurately report parental substance use disorders in child welfare caseloads.

**Learn More:** Child welfare workers can find out the status of SACWIS in their States by going to the **States' SACWIS Status** Website. Ask your State agency responsible for SACWIS where in your State system case file reporting can you note that substance use disorders are a critical factor in the lives of specific clients.

## **Assessment for Substance-Related Disorders**

Once a screening indicates there may be a substance use problem, and in concert with other child welfare assessments, the child welfare worker should refer parents to a substance abuse treatment professional for a complete assessment.

**Based on diagnostic criteria.** The substance-related assessment process generally includes interview questions that address criteria for substance-related disorders, as defined by the DSM-IV. In addition, the treatment professional will conduct assessments for co-occurring disorders, if applicable, and treatment planning and placement.

**Ongoing process.** Comprehensive assessments are designed to determine current treatment needs and level of care. Patients' treatment and level of care are based on their treatment needs, which drive the treatment process. Since treatment needs change over time, assessment and treatment planning is an ongoing process. It is discussed in more detail in Module Three.

**Learn More:** Review the NIAAA report, *Alcohol Problems in Intimate Relationships: Identification and Intervention—A Guide for Marriage and Family Therapists*

## Case Study: Lisa Receives a Substance-Related Assessment



The release of information forms were signed at the first appointment with Lisa. This permits the information from the home visit to be shared with the treatment counselor Sarah, along with other information from the CWS case. This information includes: (1) the children have not been removed from the home but will be under court-ordered family maintenance; (2) the family will be receiving in-home services, Lisa will be required to complete parenting classes and weekly random drug tests; (3) there was no previous CWS involvement; and (4) Lisa has no criminal history, but the father of the two boys has recently been released from prison on drug-related charges.

With this information, Sarah is better prepared to conduct an in-depth assessment with Lisa. The immediate goal is for Sarah to be able to obtain as much information as possible, from Lisa and from other persons with knowledge about the family. This includes child welfare, other service providers and family members if appropriate. By gathering information from multiple sources, Sarah can get an accurate picture of Lisa's needs and use this information to help increase Lisa's motivation to actively engage in treatment.

During the assessment interview, Sarah uses her program's standard assessment tool. It includes questions based on DSM-IV diagnostic criteria. After weighing the information that she has gathered regarding Lisa and her family, Sarah determines that Lisa has substance dependence and Lisa agrees to enter treatment. Sarah recommends to Lisa's child welfare worker, Molly, that Lisa enter the intensive outpatient program for a minimum of 90 days with a planned transition to longer-term outpatient treatment. She will be attending 3 days per week for 5 hours, be required to randomly drug test each week and attend a minimum of 3 self-help groups each week.

Molly is pleased that Sarah has been able to conduct an informed assessment and supports her recommendation. However, she expresses concern about Lisa's level of motivation and about child care arrangements for Ian and Ricky while Lisa is attending meetings and is at the treatment program. Molly will find after school child care options for the 3 days that Lisa is at the treatment program. Sarah and Molly agree to remain in close contact regarding Lisa's progress in treatment and agree that their separate drug tests requirements will be coordinated so that Lisa does not have two drug testing requirements. Lisa enrolls in the program and is assigned a counselor and a family advocate. The advocate graduated from the program, was trained in motivational interviewing, and provides support services to Lisa and other women in the program.

### Questions to Ask Yourself:

Do you agree with the substance abuse treatment plan?

What roles would you like to see the family advocate play in Lisa's recovery?

## Understanding Parents with Substance Use Disorders

*What do child welfare professionals need to know about the needs and experiences (clinical issues) of parents with substance use disorders?*

**Coexisting problems.** It is critical for child welfare professionals to understand the issues that may have encouraged or supported substance use disorders among parents. Many parents in the child welfare system have experienced significant trauma or violence in their lives, or have undiagnosed mental health disorders, such as depression.

**Reasons for use.** Although addiction is characterized as a primary disorder (not simply a symptom of a different, underlying problem), parents may use substances to cope with life problems. For example, they may use substances to:

- Self-medicate the pain of loss and destruction in their lives (e.g., experiences of domestic violence)
- Express anger and discouragement about their inability to make "normal" progress with their lives
- Manage untreated anxiety or depression
- Medicate the pain or discomfort of untreated health problems
- Punish themselves for failure

## **Characteristics of Parents with Substance Use Disorders**

Many parents are likely to have a combination of the following characteristics that may contribute to substance abuse and consequently have a negative effect on the safety of their children:

- Limited educational, vocational, and fiscal resources may affect their ability to earn a living and provide for their children.
- Mental and physical illnesses, such as PTSD, other anxiety disorders, depression, and bipolar disorder can affect their daily behavior toward their children and their ability to focus on children's needs.
- Physical illnesses can affect their stamina and their ability to sustain nurturing care over a continuous period of time.
- Difficult and traumatic life experiences, including childhood experiences of abuse or neglect, domestic violence, or homelessness, may have interrupted their development as children. These may have deprived them of normal parental role models and life experiences.

## **The Effects of Substance Abuse on Parenting**

Parents and caregivers are expected to perform basic functions and tasks for their dependent children to support the children's physical, social, emotional, intellectual, and spiritual development. When a parent has a substance use disorder, it reduces their ability to perform many parenting functions and fully meet their children's needs. Frequently, life becomes topsy-turvy and chaotic for the children.

**Prenatal exposure effects.** Parenting may become particularly difficult when children have been prenatally exposed to substances, and may exhibit the neurological and behavioral effects of this exposure. This may include continuous fretting and crying among infants, emotional and developmental issues among toddlers and young children such as failure to attach, or hyperactivity and behavioral management problems among older children and adolescents. Without mental health and medical treatment, these behavioral needs will further exacerbate the difficulties of parenting.

In addition, long-term effects of prenatal exposure to alcohol and other drugs can include lower IQ; reasoning problems, including difficulties in higher executive functioning, fine motor, or visual-perceptual-motor deficits; and communication/language problems (Young, 1997).

## The Effects of Specific Substances on Parenting

The following are illustrations of the ways that specific substances of abuse may affect parenting. Keep in mind that this list is illustrative, and substances of abuse can have a wide range of effects on parenting.

The Effects of Substances of Abuse on Behavior and Parenting		
Substance	General Effects	Parenting Effects
<b>ALCOHOL</b>		
Alcohol	<ul style="list-style-type: none"> <li>• Lowers inhibitions, often leading to inappropriate or risky behaviors</li> <li>• Impairs judgment</li> <li>• Diminishes motor coordination</li> </ul>	<ul style="list-style-type: none"> <li>• A parent may forget or neglect to attend to parenting responsibilities.</li> <li>• A parent may stay out all night and leave children alone due to intoxication.</li> <li>• A parent may have rages and depressive episodes, creating an unstable environment for children.</li> </ul>
<b>ILLEGAL DRUGS</b>		
Cocaine	<ul style="list-style-type: none"> <li>• In addition to an influx of energy, cocaine also heightens the senses. Colors appear brighter, smells seem stronger, and noises sound louder.</li> <li>• After prolonged use, cocaine also increases irritability and aggression in the user.</li> <li>• Cocaine can result in psychotic distortions of thought such that the user imagines and acts on projections to others of his or her own aggression.</li> </ul>	<ul style="list-style-type: none"> <li>• A child's crying, which may be only a mild annoyance to a non-using parent, is magnified in its intensity to the parent on cocaine.</li> <li>• A parent may become angry or impatient with a child for any reason because of thought distortion and misperception of the child's intent.</li> </ul>
Crack/Crack Cocaine	<ul style="list-style-type: none"> <li>• In the smokeable form known as crack, cocaine cycles rapidly through the body so that a physical and psychological "high" vanishes quickly, within 5 to 15 minutes, leaving in its wake anxiety, depression, and paranoia, as well as an intense craving for a return to the euphoric state.</li> <li>• Crack heightens feelings of power and control over one's life, feelings that may be sorely lacking in those belonging to oppressed social groups.</li> </ul>	<ul style="list-style-type: none"> <li>• A parent addicted to crack can leave an infant or toddler alone for hours or sometimes days at a time to pursue the drug.</li> <li>• CPS workers frequently investigate maltreatment reports in homes barren of furniture and appliances that have been sold to purchase crack and other drugs.</li> <li>• The absence of food in the refrigerator or cupboards is evidence of parental inability to attend to a child's most basic needs.</li> <li>• Some parents will do whatever</li> </ul>

		<p>it takes to pursue their habit, even if it means sacrificing the health and well-being of loved ones.</p> <ul style="list-style-type: none"> <li>• Crack can contribute to a significant increase in sexual abuse of young children in two ways: <ul style="list-style-type: none"> <li>○ The heightened physical sensations induced by crack can lead users to seek out sexual encounters. A child who is available and unprotected by a functioning adult, as when children accompany parents to so-called crack houses, is an easy target for sexual abuse by an individual high on crack.</li> <li>○ Very young children, even babies, can be prostituted by their crack-addicted parents desperate to obtain the drug.</li> </ul> </li> </ul>
Heroin	<ul style="list-style-type: none"> <li>• Highly addictive drug leading to serious, even fatal health conditions.</li> <li>• Injecting, snorting, or smoking heroin causes initial euphoria, followed by an alternately wakeful and drowsy state.</li> <li>• Tolerance to the drug develops with regular use, meaning that the abuser must use more heroin to produce the same effect. Physical dependence and addiction develop, and withdrawal can occur as soon as a few hours after the last use.</li> </ul>	<ul style="list-style-type: none"> <li>• A parent may forget or neglect to attend to parenting responsibilities.</li> <li>• Parents may leave children alone while seeking, obtaining, or using the drug.</li> <li>• Parents may "nod out" while under the influence of heroin and be unable to supervise or protect their children.</li> <li>• Parents may expose their children to heroin dealers, other users, and hence unsafe and dangerous situations.</li> </ul>
Methamphetamine	<ul style="list-style-type: none"> <li>• Releases high levels of dopamine, which stimulates brain cells, enhancing mood and body movement.</li> <li>• Smoking or injecting methamphetamine causes a euphoria that is notable for its intensity and length. Snorting or ingesting methamphetamine produces a milder and less intense euphoria.</li> <li>• Following the initial euphoria, the user "crashes" into an irritable, anxious, paranoid, aggressive, or empty feeling.</li> </ul>	<ul style="list-style-type: none"> <li>• Methamphetamine is an increasing problem among parents in the child welfare system.</li> <li>• Parents may not supervise children or provide for their basic nutritional, hygienic, or medical needs.</li> <li>• Violence, aggression, and paranoia may lead to serious consequences for children of meth abusers.</li> <li>• Additional risks to children can be quite extreme if the drug is being "cooked" in their</li> </ul>

	<p>The user may continue to use methamphetamine to regain the euphoric state.</p> <ul style="list-style-type: none"> <li>• Severe withdrawal symptoms may include psychotic episodes and extreme violence.</li> <li>• Methamphetamine use can quickly lead to addiction and is linked to long-term brain damage, and cardiovascular and other major health problems.</li> </ul>	<p>residence. These risks include fire and explosions as well as unintentional absorption of the drug from the home environment.</p>
<b>MARIJUANA</b>		
Marijuana	<ul style="list-style-type: none"> <li>• It slows down the nervous system function, producing a drowsy or calming effect</li> </ul>	<ul style="list-style-type: none"> <li>• A parent may forget or neglect to attend to parenting responsibilities.</li> <li>• Parents may leave children alone while seeking, obtaining, or using the drug.</li> <li>• Parents may fall asleep while under the influence of marijuana and be unable to supervise or protect their children.</li> </ul>
<b>PRESCRIPTION DRUGS AND PAIN MEDICATIONS</b>		
Opioids (usually prescription pain medications)	<ul style="list-style-type: none"> <li>• They block the transmission of pain messages to the brain and produce euphoria followed by drowsiness.</li> <li>• Chronic use can result in tolerance, dependence, and withdrawal.</li> <li>• Methadone, buprenorphine, and naltrexone are synthetic opioids used to treat heroin addiction.</li> </ul>	<ul style="list-style-type: none"> <li>• A parent may forget or neglect to attend to parenting responsibilities.</li> <li>• Parents may leave children alone while seeking, obtaining, or using the drug.</li> <li>• Parents may "nod out" while under the influence of opioids and be unable to supervise or protect their children.</li> <li>• Parents may expose their children to dealers, other users, and hence unsafe and dangerous situations.</li> </ul>
Stimulants, including amphetamines and methylphenidate (prescription drugs)	<ul style="list-style-type: none"> <li>• They are stimulants to the central nervous system, which increase alertness, attention, and energy.</li> <li>• A stimulant user may feel energetic with very little sleep.</li> </ul>	<ul style="list-style-type: none"> <li>• Because their own sleep-wake cycles are so distorted by the drug, parents on amphetamines may be unable to attend to a child's need for structure and pattern.</li> <li>• The parent may become impatient or irritated with the child, who is unable to adapt to the parent's level of energy.</li> </ul>

		<ul style="list-style-type: none"> <li>• When a parent is not hungry, due to appetite-suppressive effects of stimulants, and therefore is not preparing meals for herself, she may also fail to consider a child's hunger and therefore ensure that he is fed on a regular basis.</li> </ul>
Central nervous system depressants	<ul style="list-style-type: none"> <li>• They slow down the nervous system function, producing a drowsy or calming effect.</li> <li>• Stopping high dosage/prolonged usage of these drugs may lead to withdrawal symptoms, including seizures.</li> </ul>	<ul style="list-style-type: none"> <li>• A parent may forget or neglect to attend to parenting responsibilities.</li> <li>• Parents may leave children alone while seeking, obtaining, or using the drug.</li> <li>• Parents may fall asleep while under the influence of depressants and be unable to supervise or protect their children.</li> </ul>
Adapted from Dore, 1998; Gold, 1992; National Institute on Drug Abuse (NIDA), 2001; NIDA, 2003		

## **Issues Specific to Methamphetamine and the Manufacturing of Drugs in the Home**

The number of users and producers of methamphetamine has continued to increase over the past several years. While the majority of the methamphetamine laboratories and treatment admissions for methamphetamine addiction have been located in the west and mid-west parts of the county, there has been a gradual progression across the country with southern and eastern States reporting increasing impact of methamphetamine on their communities.

Methamphetamine is inexpensive and easy to make and the ingredients are easy to obtain. The chemicals, production process and the waste generated by the production of methamphetamine in clandestine labs pose serious dangers to public safety and the environment. Some of these dangers are toxic poisoning, chemical and thermal burns, fires, and explosions. One pound of methamphetamine produces six pounds of toxic waste and this waste may be introduced into the environment by burning or dumping.

Child welfare workers must be aware of the potential of chemical exposure during home visits and ensure that their own personal safety is protected. Workers, especially in areas hit hard by methamphetamine use, need to be aware of the signs that methamphetamine is being manufactured in the client's home. These signs include the presence of manufacturing equipment, pills containing ephedrine or pseudoephedrine, a large variety of chemicals, and a chemical odor.

For more information about methamphetamine abuse, and for supporting worker safety when working with families potentially affected by methamphetamine use or addiction, see the information prepared for the Illinois Department of Children and Families:

Crowell, D.J. and Webber, J.R. Signs of Client Methamphetamine Use and Caseworker Safety Procedures. <http://www.drugfreeinfo.org/PDFs/strengthensupervision.pdf>

## Case Study: Lisa Participates in Intensive Outpatient Treatment



During her first few weeks in the day treatment program, Lisa appeared to be increasingly engaged in the recovery process. She initially denied the impact of her substance use on her sons' well-being. Since then, she admitted, first to her counselor and then in a group session, that her substance use may be affecting her ability to provide Ian and Ricky with a healthy home environment. She stated that her goals for Ian and Ricky are to be sure they don't end up using drugs.

Lisa's family advocate is able to help her understand that by focusing on her recovery, and the issues related to her substance use, she will be better able to parent Ian and Ricky, and less likely to have them removed from her care.

Because of the supportive environment of the treatment program, and Lisa's realization that she is surrounded by women who have had similar life experiences, she has a breakthrough. She admits for the first time that she was molested as a young girl by a neighbor. Within the safety of the treatment environment, Lisa is able to explore how childhood sexual abuse, her early home environment, parental substance abuse, and abuse by her first husband, all contributed to her substance use. She also recognizes that she did not have healthy role models to teach her how to effectively parent her children.

After Lisa's initial 30 days in the intensive outpatient program, Ian and Ricky begin attending sessions with Lisa at the treatment program after school. Both boys are assessed using a variety of screening and developmentally appropriate tools.

Ian fits a typical profile of children of substance abusers who have serious behavioral problems. He is aggressive, manipulative, oppositional, and defiant. He is below grade level in most academic areas and has rapidly destroyed several toys and property belonging to other children at the program. Ricky, who was prenatally exposed to methamphetamine, has early signs of attention-deficit/hyperactivity disorder (ADHD) and other neuro-behavioral complications. He has difficulty following instructions, is easily frustrated, and has poor motor skills and frequent angry outbursts.

### Questions to Ask Yourself:

How can Molly support Lisa's goal to keep Ian and Ricky from using?

What role did Lisa's childhood play in her substance use?

Do you think Lisa may have a co-occurring post-traumatic stress disorder?

## **Working with Families: Developing Case Plans**

Developing effective case plans that address underlying problems can help child welfare professionals assess the safety and well-being of children of substance-abusing parents throughout the life of the case. It can also help motivate parents to enter and continue treatment.

Child welfare professionals already know the importance of establishing an initial relationship with parents that demonstrates an interest in and concern about their well-being. They also know how to use social work competencies, such as documentation, observation, and interviews, to determine what has happened to the parents and children, and to establish a case plan.

**Adapt existing skills.** Child welfare workers can use these techniques with parents and children to explore issues relevant to substance use disorders, focusing especially on the parents' feelings about safety and their experiences with trauma. Some child welfare agencies may already have specific protocols and procedures in place, which can then be expanded to incorporate some of these issues, as appropriate.

## Working with Families: Issues to Explore with Children

Most children who have experienced child abuse or neglect need interventions to appropriately adjust to separation from their parents and may have mental health service needs related to traumatic experiences.

### **Learn More: Access resources on trauma-informed services**

Children of substance abusers have specific risk factors that should be included in child welfare's assessment of the family's strengths and needs.

Risks to children can stem from both prenatal substance exposure and post-natal environments. Assessment and intervention with children are addressed in Module 4; however, during initial screening processes in child welfare, some special situations for children need specific screening.

Fetal alcohol syndrome (FAS) is characterized by a pattern of neurological, behavioral, and cognitive deficits that affect growth, learning, and socialization. It consists of four major components:

- A characteristic pattern of facial abnormalities, including small eye openings, indistinct or flat philtrum (the midline groove in the upper lip that runs from the top of the lip to the nose), and a thin upper lip;
- Growth deficiencies, including low birth weight;
- Brain damage, including a small skull at birth, structural defects, and neurologic signs such as impaired fine motor skills, poor eye-hand coordination, and tremors; and,
- Maternal alcohol use during pregnancy.

The term Fetal Alcohol Spectrum Disorder (FASD) is used to describe individuals with FAS as well as those with behavioral, cognitive, and other deficiencies who do not have the physical facial abnormalities of individuals with FAS. FASD is not a clinical diagnostic term but refers to FAS, Alcohol-Related Birth Defects, and Alcohol-Related Neurodevelopmental Disorder (ARND).

Many of the deficiencies seen in individuals with ARND are similar to those seen as a result of exposure to other substances. Studies have shown that effects of prenatal substance exposure can manifest in multiple areas, including:

- Physical health consequences
- Lack of secure attachment
- Psychopathology
- Behavioral problems
- Poor social relations/skills
- Deficits in motor skills
- Cognition and learning disabilities

The deficits or delays exhibited by children who have been substance exposed may arise at different times in the child's development. For example, many of the physical health issues are likely to be noticed in an infant, while cognitive and learning disabilities are more likely to become apparent in school-aged children.

There is no consensus on how short term effects may translate into longer term consequences. The symptoms exhibited by a newborn infant do not predict long term dysfunction. Outcomes for children will depend upon a variety of dynamics, including the child's postnatal environment and exposure to other risk factors.

## **Working with Families: Involvement of Fathers**

Wherever possible, fostering healthy relationships between fathers and children is integral to addiction recovery and developing parenting skills. Both parents should be involved in the lives of their children, to the extent that children remain safe and protected. Although the parent in treatment is most often the mother, and may be reluctant to involve the father, both parents should be involved with services provided through the child welfare and treatment systems.

**Services for fathers.** Child welfare professionals are usually directed by courts and attorneys to seek and involve absent parents, especially fathers. Inattention to the father's needs may disrupt progress that the mother may be making. Services for fathers need to include:

- Outreach strategies for fathers who do not initially respond to opportunities to participate in the lives of their children
- Screening for substance use disorders and, when appropriate, referral for further assessment and treatment
- Casework services that address specific needs of fathers, including motivational counseling to motivate participation in treatment, if needed, and to understand the fathers' importance in the lives of their children
- Enhancement of the father's own support system for recovery, including opportunities to create social support networks with fathers-only support groups and activities
- Participation in visitation with children and in other parental responsibilities, as appropriate
- Participation in planning for reunification or termination of parental rights

**Learn More:** Visit the **Children's Bureau Website** regarding fatherhood concerns

## Enhancing Clients' Motivation

*How can child welfare professionals motivate parents to seek and engage in appropriate treatment?*

**Encourage treatment.** Once a screening suggests the potential for a substance use disorder and an assessment has confirmed the diagnosis, child welfare workers have a key responsibility to motivate parents to seek treatment and help them find the most appropriate treatment option. Child welfare workers can use motivational enhancement strategies to encourage parents' willingness and commitment to engage in treatment. Collaborative work with attorneys and courts can assist in motivating parents.

**Encourage retention.** As treatment begins, in coordination with treatment counselors, child welfare workers can use motivational enhancement strategies to encourage parents to stay in treatment, respond appropriately to relapse, and sustain recovery. They can help parents understand the consequences of not meeting the requirements of the dependency court and provide assurance that their children are safe and in good care.

## Motivational Enhancement Strategies

*Why is it important to use motivational strategies with substance-abusing parents who have children in the child welfare system?*

Parents in the child welfare system need assistance with motivation to engage in and maintain treatment because the requirements of Federal and State statutes do not allow for much time to be lost in relapse.

Change is a process. The process has multiple stages. Child welfare professionals can enhance the motivation of clients to move from one stage to the next.

**The change process.** As people change, they go through six stages of change. People often begin at the precontemplation stage and work through the remaining stages (contemplation, preparation, action, and maintenance), with a final exit at the maintenance stage to enduring recovery. Because motivation is a cyclical process that changes over time, and people move back and forth among different stages, it is important to help parents:

- Understand where they are in the stages of change
- Discover what will help them move to the next stage

Although the primary responsibility for motivating parents in treatment rests with the treatment program, child welfare professionals also play a key role in helping parents maintain the motivation to meet the court's timetables so that they have the best possible opportunity to regain custody of their children. Often, during the precontemplation and contemplation stages, the child welfare worker is the primary motivator, especially if the parent has not yet begun to participate in treatment.

## The Stages of Change

Change, such as adopting healthy behaviors, is rarely a single, sudden event that occurs during a moment of transformation. More frequently, change is a process. It occurs gradually in stages or cycles, such as the following stages of change (Prochaska and DiClemente, 1982):

- **Precontemplation**—no perception of having a problem or needing to change
- **Contemplation**—initial recognition that a problem exists
- **Preparation**—conscious decision to make changes in recognition of a problem
- **Action**—taking initial steps to change
- **Maintenance**—working on sustaining changes over time
- **Relapse**—return to previous problem behavior for some period of time

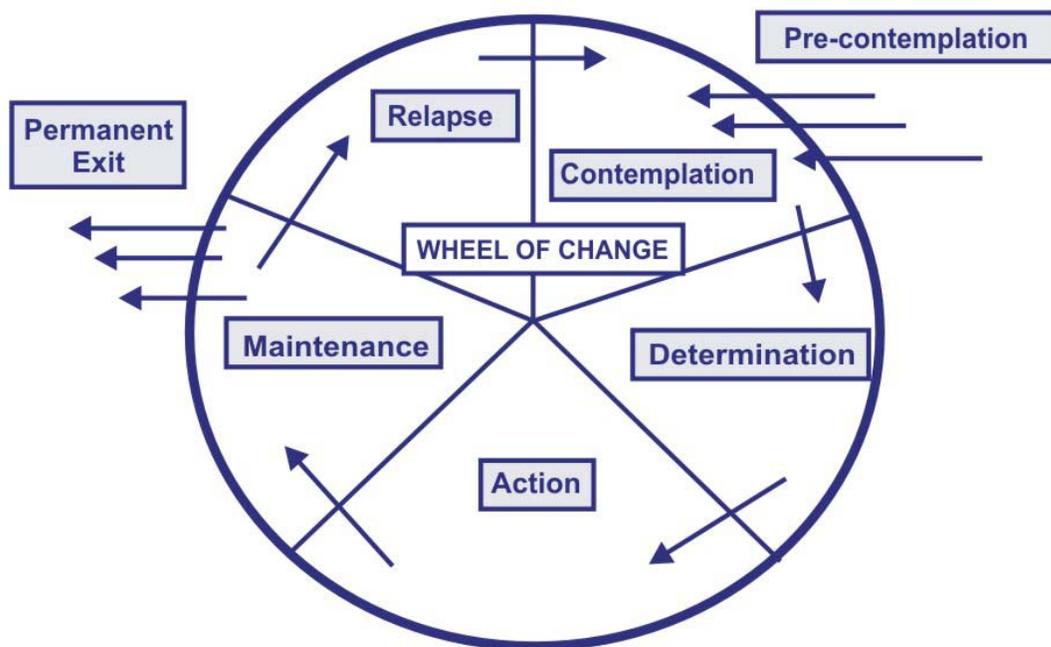
Motivation to change and motivational interventions go hand in hand with readiness to change and the change process. It may be helpful to view change as a circular, multi-level process, as reflected in the Stages of Change model. During the change process, it is normal to fluctuate between stages. A key reason this model of change is helpful for parents with substance use disorders is that relapse, which occurs in the majority of cases, is built in as part of the process.

## The Change Process

As illustrated below, the stages of change can be understood as a wheel made up of wedges. Change often begins at the precontemplation stage and continues through contemplation, preparation, action, and maintenance stages. Ideally, clients have a final exit at the maintenance stage to enduring recovery.

The change process is cyclical. Individuals typically move back and forth between the different stages. Different people will move through the stages at different rates. It is uncommon for people to linger in the early stages.

## Six Stages of Change



## More About the Stages of Change

**The Precontemplation Stage.** At this stage, clients are not considering change and do not intend to change behaviors in the foreseeable future. They may be unaware that a problem exists, that they should make changes, or that they need help to do so. They may be unwilling or too discouraged to change their behavior.

**The Contemplation Stage.** As individuals become aware that a problem exists, they may perceive that there is cause for concern and reasons to change. However, they may be *ambivalent* and simultaneously have reasons to change and not change.

**The Preparation Stage.** When individuals perceive that the advantages of change and the adverse consequences of continued risky behaviors outweigh the positive features of these behaviors, the *decisional balance* tips in favor of change. When this occurs, the emerging commitment to change is strengthened.

**The Action Stage.** Individuals in this stage have chosen a strategy for change and are pursuing it. They are actively changing their habits and environment while making significant life changes. They may be faced with especially difficult psychosocial challenges such as relationship issues, which may be perceived as barriers to change.

**The Maintenance Stage.** During this stage, individuals make efforts to sustain gains achieved during the action stage. For example, they may work to avoid high-risk situations. They may learn how to identify and guard against dangerous situations that may prompt them to engage in risky behaviors.

## The Effects of Relapse

It is important for child welfare workers to differentiate between a “lapse” and “relapse.” A lapse may include a temporary return to substance use but the parent returns to treatment, re-engages in the recovery process and does not return to a pattern of drug-seeking behaviors and detrimental consequences. Many parents in child welfare lapse and when child safety has not been compromised, the lapse can be used as a critical intervention point in the parent’s longer-term recovery.

A relapse is characterized by an on-going pattern of continued alcohol or drug use despite experiencing negative consequences.

**For the treatment professional**—relapse can be seen as a step toward sobriety and can be an integral part of the treatment process. Parents may need to work their way toward increasing periods of sobriety despite experiencing relapses.

**For the child welfare professional**—relapse presents a serious risk to the parents' ability to have children remain in the home. Relapse may mean the parents have not yet demonstrated sufficient reliability to care for their children and that the parents may not meet the court deadlines for doing so. Child welfare professionals are concerned that children may not be safe when being cared for by parents who are abusing substances. Although the presence of a relapse plan for their children may mitigate these concerns, it may not completely alleviate them.

**What they have in common**—are parents who are likely to feel guilty when they relapse because they have not yet demonstrated the ability to care for their children. While they may have taken steps forward in treatment and in planning for relapse, they have taken steps backward in reunification. These conflicting messages can confuse and discourage parents who are trying to get their whole lives together through participation in treatment.

Relapsed parents and their family members can experience depression, anxiety, helplessness, distrust, and self-blame. Social workers should be alerted to such effects and prepared to provide support. Doing so can prevent problem escalation.

## Enhancing Parents' Motivation for Treatment

Child welfare and treatment professionals can use specific strategies to enhance parents' motivation to begin and maintain treatment and recovery efforts. They can intervene with parents during each of the six stages of change to motivate them to:

- Continue to work toward meeting the requirements of the dependency court
- Maintain the safety and well-being of their children
- Develop the parenting skills needed to retain or regain custody of their children

**Encourage change.** The child welfare worker, substance abuse counselor, and significant persons in the life of a substance-abusing parent can promote and support motivation to change. Motivation is enhanced when using a nonconfrontational and nonjudgmental approach that supports the parent and facilitates relationship building. Many of the skills of motivational interviewing are based on the social work practices of expressing empathy and using reflective listening strategies.

The table on the next page describes the stages of change and identifies motivational tasks for the child welfare worker to address with the substance-abusing parent. The child welfare professional should work in partnership and collaboration with the substance abuse counselor.

<b>Parent's Stage of Change and Motivational Tasks for Child Welfare Workers</b>		
<b>Parent's Stages of Change</b>		<b>Motivational Tasks for Child Welfare Worker</b>
Precontemplation	No perception of having a problem or need to change	Increase parent's perception of the risks and problems with their current behavior; raise parent's awareness about behavior
Contemplation	Initial recognition that behavior may be a problem and ambivalence about change	Foster and evoke reasons to change and the risks of not changing; help parents see that change is possible and achievable
Decision to Change	Makes a conscious determination to change; some motivation for change identified	Help parent identify best actions to take for change; support motivations for change
Action	Takes steps to change	Help parent implement strategy and take steps
Maintenance	Actively works on sustaining change strategies and maintaining long-term change	Help parent to identify triggers and use strategies to prevent relapse
Lapse or Relapse	Slips (lapses) from a change strategy or returns to previous problem behavior patterns (relapse)	Help parent re-engage in the contemplation, decision, and action stages
Adapted from Breshears, Yeh, & Young (2004).		

## **Motivational Strategies for the Precontemplation Stage**

When parents are in the precontemplation stage on a specific issue, child welfare professionals can use the following motivational strategies to help move them to the next stage:

- Establish rapport and build trust
- Raise concerns about a parent's substance-related risk behaviors to self and children
- Elicit the parents' perceptions of their level of risk
- Elicit the parents' perceptions of their children's level of risk with respect to safety, well-being, and health
- Explore the benefits and risks of risky behaviors and treatment, including the timetable of the dependency court
- Express concern and remain available

## **Motivational Strategies for the Contemplation Stage**

When parents are in the contemplation stage on a specific issue, child welfare professionals can use the following motivational strategies to help move them to the next stage:

- Help parents understand that ambivalence about change is normal
- Elicit and weigh their reasons to change and not to change, including the consequences for the child if the parent does not meet the requirements of the dependency court
- Emphasize parents' free choice, responsibility, and self-efficacy for change
- Elicit self-motivational statements of intent and commitment from parents
- Elicit ideas regarding parents' perceived self-efficacy and expectations
- Summarize self-motivational statements
- Elicit ideas for the child's well-being and safety

## Case Study: Lisa Receives Motivational Enhancement



At the 30-day mark, Sarah, Lisa's substance abuse counselor, calls Molly, Lisa's child welfare worker, to inform her of Lisa's progress. Molly is pleased to hear that Lisa is engaged in treatment and that she has had all clean drug tests since entering treatment. Sarah shares with Molly that introducing Ian and Ricky into the treatment plan has resulted in some stress for Lisa. For the first 30 days, Lisa's attention had been focused on her recovery, and now the issues of parenting and her sons' needs are being addressed.

Sarah and Molly strategize about how to use the children as a motivating force for Lisa. Sarah explains to Molly that threats about losing her children in the future often don't work with addicted women, particularly those who have been using methamphetamine, because they need more immediate incentives and sanctions based on their behavior. Molly understands that it will not be as effective to tell Lisa, "You better remain sober, or you will lose your kids" and that negative approaches will likely cause more stress, which could prompt a lapse or relapse.

Rather, Sarah and Molly decide to use a motivational enhancement approach with the message, "Your goals for your children include your being available to them to help them and to watch them grow up as their mom. You have worked hard. You have used several good strategies to get this far in recovery and you have done well. If you can't continue with these strategies and to work on maintaining your recovery, you will not be able to be there for them as they need you to be."

At Lisa's next meeting with Molly, she approaches Lisa from a motivational enhancement perspective regarding her children rather than from a punitive one. She begins the session by saying, "I am here to work with you through this difficult time. What is your goal in this situation? How can I help you get to where you would like to be?" Molly elicits self-motivational statements of intent and commitment from Lisa in regard to improving her efforts to provide a safe home for Ian and Ricky. Molly learns that Lisa is worried about being able to support her children and to provide the mental health and medical care that they need. Lisa tells Molly that she feels overwhelmed with all the pressures of work, treatment, parenting and handling Ian who is beginning to act out more than he had in the past.

Molly assures Lisa that she will work with her about her concerns and tells her that she can use a benefits calculator that is available in a State-customized version from **Wider Opportunities for Women**, which checks possible eligibility for more than a dozen income-related benefits for a single mother with children. She determines that Lisa is eligible for child care assistance for her children as well as for low-cost health coverage for her children through the State's Child Health Insurance Program (CHIP). Lisa begins to see Molly as less of a threat and more of a help to her and her children.

### Questions to Ask Yourself:

What are the strengths that Lisa is demonstrating at this point in her recovery?

Why does Sarah think that Ian and Ricky are adding stress to Lisa's recovery?

Do you think using a non-confrontational approach with Lisa is the right way for Molly to intervene?

**Learn More:** Visit the **Wider Opportunities for Women Website**

## **Motivational Strategies for the Preparation Stage**

When parents are in the preparation stage on a specific issue, child welfare professionals can use the following motivational strategies to help move them to the next stage:

- Clarify the parents' own goals and strategies for change
- Offer a menu of options for change or treatment
- Offer expertise and specific guidance, with permission
- Make sure that parents follow through on referrals for treatment assessment
- Help negotiate a change or treatment plan and behavior agreement
- Consider how to help parents lower their barriers to change
- Help parents enlist social support
- Explore the parent's treatment expectations
- Elicit from the parent what has or has not worked in the past
- Have the parent publicly announce plans to change
- Explore legal and social consequences to the parent and the child
- Help parents make plans for dependent children

## **Motivational Strategies for the Action Stage**

When parents are in the action stage on a specific issue, child welfare professionals can use the following motivational strategies to help move them to the next stage:

- Support a realistic view of change through small steps
- Acknowledge difficulties for the parent in early stages of change
- Help the parent find new reinforcers of positive change
- Help parents assess whether they have strong family and social supports, and how these can be used to support child safety and well-being
- Help parents engage community supports
- Reflect on appropriate legal and social interactions and gains

Social workers should be honest with parents about the ASFA timelines. They should inform parents about what lies ahead in relation to the court process. Learning about substance abuse treatment and developing relationships with treatment providers can improve social workers' understanding of treatment options and ways to advocate for optimal and individualized treatment for their clients.

## **Motivational Strategies for the Maintenance Stage**

When parents are in the maintenance stage on a specific issue, child welfare professionals can use the following motivational strategies to help them sustain the benefits that they have achieved:

- Support parents' lifestyle changes
- Affirm parents' resolve and self-efficacy
- Support parents' use of new communication or coping strategies
- Maintain supportive contact and availability
- Sustain parents' resolve to meet statutory timetables
- Review long-term goals with parents
- Advocate for legal and community supports and rewards
- Help parents make plans for dependent children
- Help parents, kin caregivers, and children recognize risk factors and behaviors involved with substance abuse

## **Motivational Strategies for the Relapse Stage**

Many clients will not immediately sustain new changes they are attempting to make. Substance use after a period of abstinence may be common in early recovery. Clients may go through several cycles of the stages of change to achieve long-term recovery.

Relapse should not be interpreted as treatment failure or that the client has abandoned a commitment to change. With support, these experiences can provide information that can facilitate subsequent progression through the stages of change and identify new areas in which treatment and case plans can be enhanced. When parents lapse or relapse, child welfare professionals have an especially important role helping parents to reengage by using the following strategies:

- Help parents to reenter the change cycle
- Explore the meaning of relapse as a learning opportunity
- Maintain nonjudgmental, supportive contact
- Help parents find alternative coping strategies
- Keep parents' attention focused on the social and legal consequences of relapse for themselves and for their children

## Motivational Enhancement Tools: FRAMES

Based on the stages of change, there are simple motivational enhancement interventions that can be easily incorporated into child welfare services. While simple and practical, these strategies were identified by research as being common to effective brief motivational enhancement interventions.

These brief motivational interventions are called the FRAMES strategies: **F**eedback, **R**esponsibility, **A**dvice, **M**enu, **E**mpathy, and **S**elf-Efficacy.

The FRAMES Strategies	
<b>F</b>	<b>Feedback</b> regarding the parent's impairment or risk behavior
<b>R</b>	<b>Responsibility</b> for change is the parent's
<b>A</b>	<b>Advice</b> (guidance) to change is provided by the social worker
<b>M</b>	<b>Menu</b> of treatment and self-help alternatives is offered to the parent
<b>E</b>	<b>Empathy</b> and non-blaming style is used by the social worker
<b>S</b>	<b>Self-efficacy</b> or positive empowerment is facilitated in the parent
Hester & Miller, 1989.	

## Case Study: Lisa Tests Positive for Methamphetamine



As a requirement of the treatment program, Lisa must submit to random drug testing 3 days per week. Shortly after her first 30 days in the program, Lisa tests positive for methamphetamine. The treatment program's drug testing method provides instantaneous results at the time of testing, rather than sending each test to a lab. As a result of having the results immediately, Sarah is able to talk to Lisa in an individual session that afternoon. However, since Molly is also relying on those drug tests, she tells Lisa that she will be sending out the specimen for laboratory confirmation as required by the court.

During the counseling session, Lisa cries. She states that she had thought that she was holding it all together and was able to manage her treatment, her job, and her parenting classes. She says that although it had been tough to attend the treatment sessions and parenting classes, and work at night, she felt motivated to remain clean and kept pushing on.

She reveals to Sarah that the boys' father, Dan Sr., had shown up last night right before she had to leave for her shift at the coffee shop. He was recently released from prison and was asking if he could move back in with her and the boys. Lisa said that she had to go to work and that they could talk about it later. When she got to work, she was exhausted and stressed out by Dan showing up, and one of her coworkers came over with some meth—"It was just too easy to give in, knowing that I wouldn't be stressed and would get through my shift without falling asleep on my feet."

Sarah and Lisa discussed the situation, with Sarah noting that Lisa has exhibited strong motivation for recovery by remaining clean and sober for more than 30 days, despite working in an environment where drugs are readily available. However, Sarah notes that with the increased stress of parenting classes, and with Dan returning, Lisa is not able to hold up against the temptation. They are able to discuss what this lapse means in regard to potential risks to Ian and Ricky.

Sarah uses Lisa's lapse as a therapeutic tool, getting her to look at her current situation—stressors, protective factors, and motivation—and to determine what must change for Lisa to get back on track with her treatment. Together they plan to call Molly to let her know.

### Questions to Ask Yourself:

Do you think Lisa's drug use was a lapse or a relapse?

Are there strategies that Sarah and Molly could have used to help prevent Lisa's drug use?

What should Molly do about the drug use?

How does Lisa's drug use affect her prior safety assessment for Ian and Ricky?

## Motivational Tasks During Treatment and Recovery

*What are the responsibilities of child welfare professionals to continue to enhance parents' motivation for remaining engaged in treatment and recovery?*

When parents in the child welfare system are also in treatment, child welfare and treatment professionals must work closely together. Through collaboration, they can ensure that children remain safe and that parents are able to meet the requirements of the dependency court, while still achieving their treatment and recovery goals. Because many needs and issues may arise during the treatment process, child welfare workers must work closely with treatment professionals to learn about any needs that are identified and to ensure that referrals are being made and parents are participating in services. For example, parents are likely to need assistance to:

- Identify personal and family issues related to their substance use disorders where they need help
- Access and follow up referrals made by child welfare workers and/or treatment professionals

## Helping Parents and Families

Child welfare professionals can use motivational enhancement approaches to help parents obtain needed services. Working in partnership with treatment professionals, child welfare workers can assist parents in the following ways:

- Actively engage with the parent and children to identify additional needs
- Emphasize behaviors that develop the trust of parents
- Ensure continued, frequent, and safe visitation between parents and children

**Visitation.** Visitation is vital for both children and parents, and every effort needs to be made to encourage and support positive visitation experiences between children and parents. Dependency courts usually take into serious consideration the extent to which parents make the effort to visit their children, and a lack of visitation could harm a parent's movement toward reunification. It is important that visitation is not presented as a "reward" for "good behavior" by parents or as a punishment tool against parents.

## Examples of Ways to Earn Trust

Child welfare professionals can do the following activities with parents that will help to accomplish needed tasks and also earn the trust of parents and families:

- Identify community resources that can help parents with various types of issues and problems. Include details about access, types of services, requirements for participation, costs, availability, location, transportation, and childcare.
- Refer parents to services by helping them make contact, obtaining transportation and childcare assistance, and following up to learn whether they contacted the organization, received the service, and whether they were helped.
- Develop a safety plan for children with the parents if needed.
- Keep all appointments you make with parents and update them promptly on any changes in your schedule. Return all phone calls and follow through by providing any promised resources.
- Inform the parents of procedures to communicate with treatment professionals. Let them know when you communicate with other treatment professionals and review the content of those conversations and plans.
- Have joint meetings with the client, substance abuse treatment professional and child welfare professional to discuss goals and plans together.

## Engaging Fathers

Fostering engagement for parents is a critical child welfare task and fostering healthy relationships between fathers and their children is integral to the family's recovering from substance use disorders and developing parenting skills. Child welfare professionals can support this through outreach, screening and referral to assessment and treatment, casework, and engaging fathers in permanency planning.

**Understand needs and services.** Child welfare professionals should understand key issues regarding substance use treatment for fathers. They need to know how to help fathers obtain appropriate treatment and support optimal outcomes for children and families. The next two pages describe several key considerations.

## Strategies for Motivating Fathers to Engage With Children

In addition to motivational strategies with both parents, fathers often need specific interventions to foster their engagement in the child welfare services and treatment for their substance use disorders.

- It is critical to debunk the attitude fathers may have that "the mother (alone) will deal with the children."
- It is important to establish that the father needs to take responsibility and recover "for his children."
- It is essential to portray recovery as separate from the child welfare case. Stress that recovery does not automatically result in reunification; however, reunification will not occur without recovery. Reunification is a byproduct of recovery, rather than the sole impetus.
- Regardless of a mother's case plan or her attempts to reunify, the father has responsibility for the children.
- If both parents have substance use disorders, each parent needs his or her own gender-specific counselor, and they should be in separate treatment programs.
- Fathers-only groups and activities provide opportunities to create social support networks.
- Emphasize that the father should not use the mother as the focus of co-dependency or as a sole support system. Rather, the father needs to use his own support system.
- It is critical for fathers to have opportunities to continue reaching out to counselors, regardless of life circumstances.
- Outreach strategies must be available for fathers who do not initiate treatment, including meeting with the fathers in their homes and communities.

## **Conclusion to Module Two**

Child welfare professionals have important roles to help parents engage in and remain engaged in substance abuse treatment and recovery. This can begin by conducting substance-related screenings of all clients and developing collaborative relationships with addiction treatment professionals.

Through these collaborations, parents can receive comprehensive substance-related assessments. Similarly, substance-related treatment needs can be identified, and a treatment plan can be developed.

Child welfare professionals can use several motivational enhancement strategies to help clients move from one stage of change to the next. Child welfare professionals can use these strategies at all stages of change and throughout the treatment and recovery process.

# Module Three: Substance Abuse Treatment and Recovery

## Participant Objectives of Module Three

After reviewing this module, child welfare professionals will be able to:

- Understand what parents in substance abuse treatment encounter during the treatment and recovery processes
- Gain knowledge about treatment services, approaches, settings, and outcomes
- More fully understand treatment services for American Indian communities
- Use this information to manage cases and improve outcomes for children
- Identify the unique issues and gender-specific needs faced by women with substance use disorders, including child-related concerns
- Understand the effects of co-occurring disorders, domestic violence, and trauma issues experienced by many women with substance use disorders
- Discuss what research has to say about effective treatment programs for women

## What This Module Covers

This module will help child welfare professionals more fully understand the treatment and recovery processes experienced by parents with substance abuse disorders. While fathers certainly play an important role in their children's life, the majority of parents with active case plans in the child welfare system are mothers. Women with substance use disorders often have unique considerations, including issues related to children. This module addresses areas child welfare professionals need to be aware of to fully address the needs of their dependent children, including the following:

- What is treatment for substance use disorders and how can child welfare professionals help parents obtain appropriate treatment?
- What are the different levels of treatment and what are the key methods used to assess substance use disorders?
- What types of treatment services, approaches, and settings may parents experience?
- What treatment services are available to American Indian communities?
- What happens as people go through the treatment process and what steps are included in the continuum of substance abuse treatment?
- What are the key goals for parents in treatment and what do they face during discharge and recovery?
- What are the issues for child welfare workers related to treatment monitoring and drug testing.
- Does treatment work? What are the outcomes people experience and what can child welfare professionals expect of a parent after treatment?
- Who pays for substance abuse treatment?
- What are the unique considerations of women with substance use disorders?
- How do co-occurring disorders, trauma, and domestic violence relate to women's substance abuse?
- What are key research-based approaches to treatment for women?
- 

**Reminder:** This course includes a glossary of special terms and their definitions. To view the glossary, click on the "Resources" tab above and select "Glossary."



## What is Addiction Treatment?

There are many substances that people can use and abuse. Treatments for specific substances can differ. Treatment also varies depending on the characteristics of the person.

**Variation is common.** Problems associated with an individual's drug addiction vary significantly. People who are addicted to drugs come from all walks of life. Many experience mental health, health, or social problems that make their substance use disorders much more difficult to treat. Even when there are few associated problems, the severity of the substance use disorder itself can range widely among people.

**Treatment is varied.** There are a variety of scientifically based approaches to treatment. Treatment can include behavioral therapy (such as counseling, cognitive therapy, or psychotherapy), medications, or their combination. Behavioral therapies offer people strategies for coping with their cravings, teach them ways to avoid substances and prevent relapse, and help them deal with relapse if it occurs. When people's substance-related behavior places them at higher risk for AIDS or other infectious diseases, behavioral therapies can help to reduce the risk of disease transmission. Case management and referral to other medical, psychological, and social services are crucial components of treatment for many patients.

**Individualized treatment.** The best programs provide a combination of therapies and other services to meet the unique needs of the individual patient, which are shaped by such issues as age, race, culture, sexual orientation, gender, pregnancy, parenting, housing, and employment, as well as history of physical and sexual abuse and other trauma (NIDA, 1999).

**Learn More:** Review **NIDA's Principles of Drug Addiction Treatment.**

## Helping Parents Obtain Treatment

*How can child welfare professionals help parents obtain the appropriate treatment?*

As discussed in Module Two, child welfare professionals can use motivational techniques to help a parent to enter treatment. Child welfare professionals must be familiar with the aspects of effective treatment programs to provide an optimal level of support for the parent's treatment and recovery.

**Learn More:** Review CSAT's **Quick Guide to Finding Effective Alcohol and Drug Addiction Treatment**

## Locating Treatment Programs

Please ensure that parents are aware of the following options to help them identify and contact substance abuse treatment programs:

1. Use the SAMHSA **Substance Abuse Treatment Facilitator Locator**
  - Once you enter the Website, select either "Detailed Search" or "List Search" from the menu, and check the boxes for "sliding fee scale" and "other assistance."
  - Phone the facilities listed to determine their policies.
2. Contact your State Substance Abuse Agency
  - Select "State Substance Agencies" from the menu. Most have Websites, and they all have contact information, such as phone numbers.
3. Call one of the CSAT/SAMHSA Referral Helplines:
  - 1-800-662-HELP
  - 1-800-662-9832 (Spanish language)
  - 1-800-228-0427 (TDD)

## **When Treatment is Unavailable**

Limited local resources may cause a temporary inability to secure a treatment space. Should this occur, there are several things that social workers can do:

Provide parents with lists of local 12-Step meetings and encourage them to go

Help parents develop safety plans to not drink or use drugs while waiting for treatment

Develop a plan to regularly speak and meet while waiting

Remain familiar with the various levels of care in the local community

Suggest lower levels of care while waiting for the optimal level of care

## The Treatment Process

Treatment is an individualized and dynamic process designed to meet the specific and unique treatment needs of each client. As a client's treatment needs change, different treatment services are provided to meet those individualized treatment needs. The availability of treatment services is related to local resources. Thus, to best serve parents and their families, you should become familiar with treatment services available in your community.

Some common processes happen as an individual begins treatment. These include:

**Screening**—identifies individuals who have or are at risk for developing substance-related problems and individuals who require a formal assessment. The basis of screenings consists of brief, rapidly administered screening tools that can be administered by social workers, counselors, and treatment professionals.

**Brief Substance Abuse Assessment**—conducted by substance abuse treatment professionals. This assessment is a basis for subsequent diagnosis of substance use disorder.

**Diagnosis**—of the substance use disorder, made by a substance abuse treatment professional, according to DSM-IV criteria for "substance abuse" and "substance dependence."

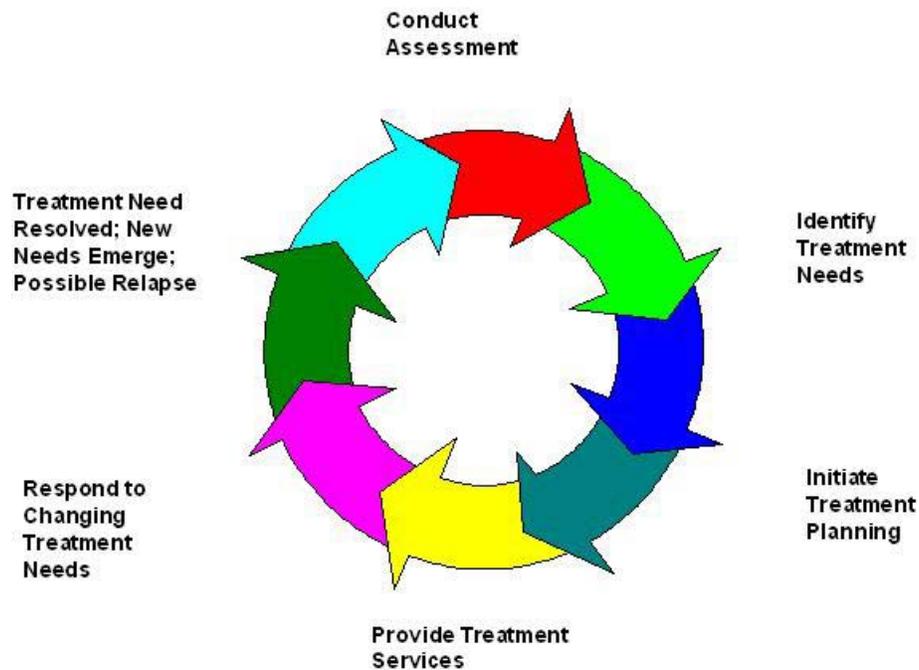
**Comprehensive Assessment**—conducted by substance abuse treatment professionals. Comprehensive assessments are biopsychosocial in nature and conducted many times throughout treatment. These assessments are designed to determine current treatment needs and level of care, which need monitoring to determine if the level of care needs to be changed, and which drive the treatment process at that point in time.

**Development of Treatment Plan**—ongoing assessments of treatment needs clarify the treatment priorities at different points in time. Treatment planning encompasses treatment needs, recommended level of care, proposed interventions, and plans for continuing care after the client has completed that particular phase of treatment. The treatment plan is a living document, reflecting the dynamic and changing nature of addiction, treatment, and recovery.

**Learn More: A Guide to Substance Abuse Services for Primary Care Clinicians**

## Treatment is dynamic

As illustrated below, treatment begins with assessments that identify treatment needs. With this information, treatment plans can be developed that identify treatment services that best meet the client's treatment needs. Treatment needs change over time, and as they are resolved, new treatment needs emerge. As this occurs, additional assessments are conducted to continue the process until the major treatment goals and objectives have been met.



## How is Treatment Placement Determined?

Two issues must be considered in determining which treatment program will meet the person's needs: treatment placement and treatment approaches. Treatment placement refers to the level of structure and support offered in the program and settings can be thought of as a continuum of intensity, from medically-managed inpatient hospitalization (most intense) to outpatient sessions (least intense). Treatment approaches refers to the type of clinical intervention utilized, such as behavior modification or medication assisted therapy.

Placing patients in the appropriate level of addiction treatment involves matching the patients' treatment needs with treatment services designed to specifically meet those needs. This process can be guided by using patient placement tools. The tool most widely used to determine the appropriate treatment placement is the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC) (ASAM, 1996). The ASAM PPC describes several levels of treatment services, as described below.

### **Level 0.5: Early Intervention**

Settings for this level of treatment may include clinical offices or permanent facilities, schools, worksites, community centers, or an individual's home (ASAM PPC: Page 49).

### **Level I: Outpatient Services**

Organized non-residential services provided by professional clinicians are included in this level of intervention (ASAM PPC: Page 55).

### **Level II: Intensive Outpatient/Partial Hospitalization Services**

A structured day or evening program that may be provided before or after work or school is covered at this level (ASAM PPC: Page 63).

### **Level III: Residential/Inpatient Services**

This level consists of residential settings designed to achieve stability and foster recovery skills (ASAM PPC: Page 77).

### **Level IV: Medically Managed Intensive Inpatient Services**

Intensive, 24-hour care in a medically managed setting is the foundation of this level of intervention (ASAM PPC: Page 107).

### **Opioid Maintenance Therapy**

This category covers various pharmacologic and nonpharmacologic treatment modalities, and is a separate service that can be provided at any of the previously discussed levels of care (ASAM PPC: Page 115).

**Treatment needs change.** Importantly, clients often progress from a more intensive setting to a less intensive setting as their treatment needs are met, and according to their financial resources and the limits of their insurance coverage. Clients who do not have insurance or money to pay for treatment have several options to find affordable treatment services.

## Case Study: Lisa Agrees to Attend Residential Treatment



During their discussion of Lisa's lapse, Lisa explains to Sarah that she believes her job at the coffee shop is a risk to her recovery. She also feels that she doesn't have any other job skills or employment options. Although she is unsure about her future with Dan, she wants him to be part of their sons' lives—as long as he's not using drugs. She says that she hopes that his prison-based drug treatment will help him stay clean now that he's been released.

Sarah commends Lisa for recognizing that she cannot keep this job and maintain recovery. She suggests a higher level of treatment and recommends the agency's 90-day residential treatment program. After initial resistance, Lisa agrees this may be the only way that she can achieve lasting recovery and be able to care for her sons. Sarah and Lisa develop a plan for Lisa to ask her oldest daughter if she and her husband can take the sons for the next 3 months while Lisa goes to the residential program. Sarah explains that Lisa may be eligible for temporary income assistance through TANF and can participate in the treatment program's vocational services and job-training classes.

Sarah phones Lisa's child welfare caseworker to inform her about Lisa's drug use and arranges a meeting. At the meeting, Lisa and Sarah present to Molly an action plan for Lisa to go to residential treatment where she can get intensive substance abuse services and job training. Molly is pleased that Sarah and Lisa have come to her with a proactive approach to Lisa's use. She explains that a visit to Lisa's daughter and son-in-law's home must be conducted. If it reveals that they are an appropriate kinship placement for the boys, the plan may work out fine. Molly explains that if Dan wishes to be involved with his sons, he will need to meet with her.

In a meeting with Molly, Dan expresses his desire to be a part of his sons' lives. Molly explains that since his conviction was drug-related, he needs to be referred to a treatment program for assessment in order to have visitation with his sons. Dan agrees and is referred to a different program from the one Lisa has been attending. Molly learned from her treatment colleagues that couples should not be in the same program, and she also knows of a program that provides gender-specific treatment for fathers.

### Questions to Ask Yourself:

What role did Lisa's job play in her drug use?

Do you think residential care was needed at this point in Lisa's recovery?

Do you think Dan needs to be in treatment?

## Overview of Treatment Services

Substance-related treatment services can be described in relation to the setting and locations in which services are provided, the types of services provided, and other characteristics. The exhibit below describes major categories of treatment settings, grouped from most to least intensive.

Treatment Settings, Services, and Locations			
Setting	Services Provided	Locations	Notes
Outpatient treatment	1-8 hours per week; pharmacotherapy, health and psychosocial individual and group therapy; case management; drug testing	Freestanding facility Hospital Community based health or social service agency	Levels of intensity and frequency vary, depending on treatment needs
Intensive outpatient treatment	9-70 hours of treatment per week (8-10 hours/day) to patients who do not live onsite Group therapy, medical and psychosocial therapy, pharmacotherapy, relapse prevention training, individual counseling, family involvement, withdrawal management; case management; drug testing	Community based agency Homeless shelter Jail Prison Hospital	Weekend and/or evening programs may be available for working individuals.
Residential treatment	24-hour care and/or support for clients who live on premises Structured individual and group therapy, pharmacotherapy, stringent behavioral norms and expectations, and increasing task responsibility to accomplish with associated privileges; drug testing as needed		
Therapeutic community	Shared sense of responsibility, loose structure, and emphasis	Therapeutic Community: <ul style="list-style-type: none"> <li>• Live-in facility</li> </ul>	Therapeutic Community: Professional staff and

Transitional living facility	on support and rehabilitation	<ul style="list-style-type: none"> <li>• Freestanding facility</li> <li>• Component of correctional facility</li> </ul> <p>Transitional Living:</p> <ul style="list-style-type: none"> <li>• Small, home-like settings; may include quarterway and halfway houses and extended care facilities</li> </ul>	<p>group leaders (often program graduates)</p> <p>Transitional Living:</p> <p>Some have professional staff and offer formal treatment; others provide only peer support</p>
Inpatient hospitalization	<p>24-hour services for:</p> <ul style="list-style-type: none"> <li>• Short-term detoxification</li> <li>• Medical and psychiatric crisis management</li> <li>• Psychosocial rehabilitation</li> <li>• Combination of above</li> </ul>	<ul style="list-style-type: none"> <li>• General medical hospital</li> <li>• Psychiatric hospital</li> <li>• Freestanding addiction treatment program facility</li> </ul>	<p>Stringent safety measures and monitoring, especially for clients who may harm themselves or others</p>
Adapted from Landry, 1995			

## Case Study: Lisa Enters Residential Treatment



In her first few days in residential treatment, Lisa's new counselor, Jill, explains what she can expect from the program. At successful completion, Lisa will be eligible to attend outpatient treatment and then aftercare. Visitation with her sons will be limited during the first 30-day period. While she has had 30 days in outpatient treatment already, with her relapse and increased level of treatment, Lisa needs to strongly focus on her own sobriety and recovery during this first stage.

After a successful 30-day period, a regular visitation schedule will be created with increasing levels of contact with her sons and decreased levels of supervision during those contacts. At 30 days, parenting classes will be introduced into Lisa's program. At 60 days she will enter the job-training program. The job-training program, along with other support services, will continue during the outpatient and aftercare program.

Jill explains that the importance of Lisa focusing on her recovery at this stage and the progressive schedule of visitation and other services has been explained to and approved by Molly at child welfare.

Shortly after entering the residential program, Lisa has a child welfare court hearing. She is nervous about it because of her lapse in abstinence and the fact that she has gone into residential treatment. She worries that the judge might believe she couldn't take care of her kids.

### Questions to Ask Yourself:

How do you feel about visitation with Ian and Ricky being restricted during the first 30 days of residential treatment?

Would that be different if Lisa's child was an infant?

## **Contact with Children**

While in treatment, parents may or may not have contact with their children. This often depends on the guidelines of the treatment program. In cases in which the court has jurisdiction, court orders may or may not allow visitation, or may put restrictions on supervision, frequency, or duration of visits. Visitation is important to both the children and the parents, and research suggests that interventions designed to break the cycle of substance abuse, child neglect, and maltreatment are more effective when they are family-centered (Magura & Laudet, 1996).

## The Issues of Monitoring Treatment and Drug Testing

Monitoring treatment and assessing the parent's progress in recovery is one of the critical pieces related to decision making in child welfare practice. There are several factors to determining if parents are making progress and reports from treatment agencies should include information on these issues, including:

- Participation in treatment services
- Knowledge gained through substance abuse education
- Participation in recovery support systems
- Child welfare services plan compliance
- Visitation with children (when appropriate)
- Parental skills/parental functioning
- Interpersonal relationships
- Abstinence

Monitoring abstinence can be accomplished through drug testing. There are many biological specimens that can be collected and tested to detect drug use, including urine, hair, sweat, and blood. Each of the specimens and testing methods detect use over various lengths of time. But generally they only detect recent use and cannot measure frequency or patterns of use or the route of consumption.

Drug testing is used in a variety of settings and for various purposes. It is frequently an appropriate adjunct to treatment services and is used to reinforce positive behaviors and to ensure that the parent is able to maintain abstinence in the treatment setting and structure that he or she is participating in.

An area of case coordination that is often needed between child welfare and the treatment agency is agreement on the type, frequency and duration of the drug test.

The frequency of drug testing required by child welfare case plans may vary based on the type of program that the parent is participating in. For example, many residential programs only use drug testing when the client has been away from the residence or when staff suspect that there has been drug use. Outpatient programs often set up random drug testing procedures and base the frequency of the testing on the phase of treatment or length of abstinence that has been achieved.

Learn More: Specifics of drug testing

<http://www.ncjrs.org/pdffiles1/ojp/181103.pdf>

## Case Study: Molly and Jill Meet with Lisa at the Residential Program



Molly makes a visit to the residential program and meets with Jill. They review Lisa's treatment notes, abiding by their agencies' disclosure guidelines. Molly gets a better picture about how Lisa is dealing with her substance use. Molly understands how Jill and the center's staff are supporting her.

Molly and Jill meet with Lisa, and Molly is impressed with Lisa's acceptance and determination. She seems to have gotten over the shame and guilt of returning to drug use and starting over by reentering treatment. This was largely due to the quick motivational response by the counselor at the outpatient center. Molly had wondered whether Lisa would ever be able to properly care for her children, but she's cautiously optimistic now.

With input from Jill and after observing Lisa, Molly determines that the treatment progress is sufficient and feels comfortable with Lisa's treatment plan. Like all child welfare workers, Molly's main concern is for the children's safety and well-being. Molly is comfortable with Ian and Ricky being cared for temporarily by Lisa's daughter, but she is also concerned whether Lisa can provide that for her children if she has cycles of relapse and treatment.

Jill helps Molly understand how relapse is common during the recovery process and that it is more effective than framing it punitively or as something that may cause her to lose her rights committed to getting her life together and keeping her children. However, Molly recognizes

At the regular court hearing to assess her progress, Lisa, Molly and her court-appointed attorney have a pre-hearing meeting, Lisa is ensured that her motivation to deal with her substance abuse issue is made clear by her willingness to enter a more intensive level of treatment. Her court-appointed attorney ensures her that he will present this information in court to help the judge see this as substantial evidence that she is taking the appropriate steps to provide her sons with a safe and permanent home.

Questions to Ask Yourself:

What are strategies you might use to acknowledge the shame and guilt a mother experiences after a relapse?

What signs would you look for in your interview with Lisa to assess her commitment to her recovery plan?



## **Addiction Treatment for American Indian Communities**

A Federal trust relationship exists between Federally recognized Tribes and the Federal Government. Services that include substance abuse treatment are available in some locations through the Indian Health Service (IHS) delivery network or an Indian nonprofit agency under contract with the IHS.

Most tribes operate their own child welfare services, which may range from having a family advocate position to operating a full-service child welfare agency. Native Americans who are enrolled members of Federally recognized Tribes may receive these services in coordination with other community resources that are not designated as IHS. Child welfare workers should ask questions about the child's ethnicity in order to determine whether the ICWA should be used in the event that the case is opened after investigation.

**Learn More:** Review treatment services for American Indian Communities

**National Indian Health Board  
Indian Health Service  
One Sky Center  
SAMHSA**

## **Types of Treatment Approaches**

*What types of approaches may parents encounter in treatment?*

Clients may receive many different types of approaches, therapies and associated services throughout the treatment process. Each client's unique treatment needs, the treatment program's resources, regional resources, and insurance limitations drive the number, type, and intensity of treatment services. These may include any or a combination of the following—known as an "integrated" approach (CSAT, 1997; Landry, 1995).

### **Pharmacotherapies**

Components: Medications to manage withdrawal, medications to discourage substance use, drug replacement and maintenance therapy; management of other mental disorders (e.g., anxiety, depression)

### **Psychosocial or Psychological Interventions**

Components: Individual therapy, group therapy, family therapy

### **Behavioral Therapies**

Components: Behavioral contracting/contingency management, relapse prevention, behavioral relationship therapy, stress management

### **Mutual Support Groups**

Components: 12-step programs and other group sessions providing peer support

**Learn More: Review information about the use and effectiveness of different treatment approaches from NIDA**



## **The Special Issues of Medications for Opiate Addiction**

Heroin users who are parents may present specific challenges for child welfare workers. These include risks associated with IV drug use and HIV infection. It is important for child welfare workers to understand the use of medications for heroin and other opiates addiction.

Treatment for opiate addiction is one of the most researched areas of substance abuse treatment, with multiple studies over 35 years demonstrating the effectiveness of opiate replacement therapy. These studies have shown that an effective treatment for heroin dependency is methadone maintenance. Individuals on methadone maintenance demonstrate reduced levels of HIV risk behavior, crime and violence as well as improvements in child rearing and employment. Methadone is highly regulated by Federal and State laws; it may only be dispensed by Federally-approved Opioid Treatment Programs (e.g., methadone clinics).

One of the most misunderstood issues about methadone is that many people will say that methadone is just another addiction. Both heroin and methadone create a dose-dependent physical dependence and tolerance (i.e., there are physical withdrawal symptoms upon reduction), However, methadone is not associated with the behavioral syndrome of addiction which is characterized by the repeated, compulsive seeking or use of a substance, despite adverse consequences.

Methadone does not produce the behaviors associated with addiction and compulsive use.

More recently, other medications have been approved to treat opiate addiction. These include LAAM and Buprenorphine. In 2000, Federal laws were changed so that these medications can be prescribed and dispensed by qualified physicians who have been specially trained to work with this population. These physicians may work in Opioid Treatment Programs or may see patients in their private practices.

Risks to children of medication assisted parents should be assessed in the context of the other safety and risk factors associated with child abuse and neglect.

## The Goals of Treatment

*What happens as people go through the treatment process?*

Substance abuse treatment typically occurs with a range of biopsychosocial services, delivered in an array of intensities, provided in a variety of settings, and with recognizable steps that generally occur at various junctures.

Although substance abuse treatment needs to be individualized for the unique treatment needs of each client, treatment programs generally share common overall goals, including the following (Landry, 1995; Schukit, 1994; APA, 1995; CSAT, 1997):

- Improvements in biopsychosocial functioning
- Reductions in substance use and increases in sobriety
- Prevention or reduction of the frequency and severity of relapse

**Learn More:** Review **Addiction Treatment Outcome Measures**

## What Services Do Parents in Treatment Need?

Addiction treatment should be individualized. However, there are services that most parents in the child welfare system will need at various points in the treatment process. Child welfare professionals can work with treatment providers to ensure that the following critical services are provided for parents in treatment:

- Access to physical necessities, such as food, housing, and transportation
- Medical care
- Substance abuse prevention counseling
- Parenting and child development training
- Support in sustaining frequent and continued visitation with children
- Training in childcare techniques (e.g., bathing, holding, packing a diaper bag, giving medication)
- Social services and social support
- Psychological assessment and mental health care
- Family planning services
- Child care
- Family therapy and health education
- Life skills training in such areas as financial management, assertiveness training, stress management, coping skills, home management, anger management, conflict resolution, and communication skills
- Training in language and literacy
- Planned, continuing care after program completion
- Consistent, frequent, and safe visitation with their children

### **Case Management**

For substance abuse treatment professionals, case management refers to identifying treatment and community resource needs; developing, implementing, and revising the treatment plan; and providing linkages to a full range of service providers.

## Identifying Treatment in Your Community

*What treatment services are available in your community?*

1. Visit the **SAMHSA Substance Abuse Treatment Facility Locator**
2. Select the "Detailed Search" tab and enter the city, street, and/or zip code of the area in which you would like to identify treatment programs and resources.
3. Once you have done so, select the "Continue" button. This brings you to a page in which you can select specific treatment services. These include type of treatment services, type of care, special populations, special languages, and forms of payment.
4. Next, select the "Search Now" button. The Website will inform you how many programs have been identified, generate a map illustrating where these programs are located, and provide a list of the programs with contact information, Website if available, primary focus, services provided, types of care, and forms of payment accepted.
5. Print out these program descriptions and create a notebook of local treatment resources.
6. Alternatively, use the **Treatment Program Worksheet** that we have provided to document information about each treatment provider.

Create a worksheet for each treatment program. As you compile the worksheets into a binder, the information will become a ready reference to help you recommend appropriate treatment placements for clients with substance use disorders and other mental health needs. This will help you to make referrals and recommendations more efficiently.

## Treatment Program Worksheet

**Program Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Name/Phone:** \_\_\_\_\_

### Primary Focus of Provider

- Substance abuse treatment services
- Mental health services
- Mix of mental health and substance abuse services
- General health services

### Levels of Care Provided

- Outpatient
- Medication Assisted Treatment for Opiate Addiction
- Partial hospitalization/Day treatment
- Residential short-term treatment (30 days or less)
- Residential long-term treatment (more than 30 days)
- Hospital inpatient

### Special Populations or Groups Served

- Adolescents
- Persons with co-occurring mental and substance abuse disorders
- Persons with HIV/AIDS
- Gay and lesbian
- Seniors/older adults
- Pregnant/postpartum women
- Women
- Men
- Criminal justice clients

### Special Programs or Services Provided

- Trauma services
- Parenting
- Residential beds for clients' children
- Child care
- Vocational services
- DUI/DWI education

### Special Language Services

- ASL or other assistance for hearing impaired
- American Indian and Alaska Native languages
- Spanish
- Foreign languages other than Spanish

### Forms of Payment Accepted

*(NOTE: Check with facility for details. Applicability varies according to individual circumstances.)*

- Medicaid
- Medicare
- Private health insurance
- Military insurance (e.g., VA, TRICARE)
- Self-payment

**Payment Assistance**

*(NOTE: Check with facility for details. Applicability varies according to individual circumstances.)*

Sliding fee scale (fee based on income and other factors)

Payment assistance

## Key Questions to Consider When Selecting a Program

1. Does the program accept the parent's insurance? If not, will they work with the parent on a payment plan or find other means of support for the parent?
2. Is the program run by State-accredited, licensed, and/or trained professionals?
3. Is the facility clean, organized, and well-run?
4. Does the program encompass the full range of the individual's needs (medical, including infectious diseases; psychological, including co-occurring mental illness; social; vocational; legal; etc.)?
5. Does the treatment program also address sexual orientation and physical disabilities as well as provide age, gender, and culturally appropriate treatment services?
6. Is long-term aftercare support and/or guidance encouraged, provided, and maintained?
7. Is there ongoing assessment of an individual's treatment plan to ensure it meets changing needs?
8. Does the program employ strategies to engage and keep individuals in longer term treatment, increasing the likelihood of success?
9. Does the program offer counseling (individual or group) and other behavioral therapies to enhance the individual's ability to function in the family/community?
10. Does the program offer medication, such as methadone and other opiate treatment options, as part of the treatment regimen, if appropriate?
11. Is there ongoing monitoring of possible relapse to help guide patients back to abstinence?
12. Are services or referrals offered to family members to ensure they understand addiction and the recovery process to help them support the recovering individual?

From: The Substance Abuse and Mental Health Services Administration, *A Quick Guide to Finding Effective Alcohol and Drug Addiction Treatment*.

**Learn More:** Review *NIDA's Principles of Drug Addiction Treatment*

## Case Study: Lisa's Recovery Grows and Strengthens



During the first 30 days in the residential program, Lisa continues to make progress dealing with the issues related to her previous traumatic experiences of sexual abuse, an abusive alcoholic father, an emotionally unavailable mother, and an abusive marriage. She is increasingly able to open up to her counselor and peers in treatment about how these experiences affected her substance use and inability to properly parent her sons.

Seeing Lisa's progress, Jill feels comfortable integrating parenting classes and visitation with Ian and Ricky into Lisa's treatment program. As the weeks go on, Lisa is able to continually increase her visitation with her sons.

After 60 days in the residential program, Lisa continues to thrive in treatment. In a meeting to review her progress with her child welfare case plan, her caseworker, Molly, tells Lisa that she is looking great, healthy, and happy. Molly notices that Lisa's hair is clean and shiny, her skin has a healthy glow, and that Lisa has on a bright summer dress. She thinks to herself that Lisa looks like a different person than 3 months ago.

Molly is happy to hear from Lisa that she will be starting the job-training program at the residential program. Lisa has not had any contact with Dan, but learns from Molly that he is doing well in treatment and will soon be having supervised visits with the boys. Molly explains that Dan appears motivated to be a father to Ian and Ricky, and knows that he won't be able to do this unless he continues to work on his recovery.

Questions to Ask Yourself:

What signs should you look for to indicate progress in treatment?

## Developmental Model of Recovery

The Developmental Model of Recovery describes stages and tasks as part of recovery (Gorsky & Kelley, 1996). Recovery stages and associated support strategies child welfare professionals can emphasize include the following:

Stages of Treatment or Recovery and Tasks for Child Welfare Professionals	
Stages	Tasks
<b>Transition stage</b> —The parent recognizes that her or his attempts to "control" or stop substance use are not working	During this stage, the child welfare professional can foster strong linkages between parent and appropriate assessment and treatment resources, emphasizing a need for children's protection and family involvement.
<b>Stabilization stage</b> —The parent goes through physical withdrawal and begins to regain control of her or his thinking and behavior	During this stage, the child welfare professional can ensure the parent knows the children are being cared for, thus allowing the parent to focus on securing needed help for her or his addiction.
<b>Early recovery stage</b> —The parent changes addictive behaviors and develops relationships that support sobriety and recovery	During this stage, child welfare professionals can help parents begin rationally considering the safety and nurturing needs of their children and the timetables and requirements he or she must meet. Also, child welfare professionals can assist with frequent and ongoing visitation between parents and children.
<b>Middle recovery stage</b> —The parent builds a lifestyle that is more effective and repairs lifestyle damage that occurred during substance use	During this stage, the child welfare professional can support the family's transition to parent-child reunification or placement of the children through ongoing family interventions.
<b>Late recovery stage</b> —The parent examines her or his childhood, family patterns, and beliefs that supported a dysfunctional lifestyle. The parent learns how to grow and recover from childhood and adult traumas	During this stage, the child welfare professional can facilitate access to continuing educational opportunities for parenting improvement and family strengthening.
<b>Maintenance stage</b> —The parent learns to cope in a productive and responsible way without reverting to substance use	During this stage, the child welfare professional can continue supporting linkages with appropriate resources, such as housing, self-help groups, employment, which were discussed in more detail earlier in this module.

## **Does Treatment Work?**

National research has demonstrated that substance abuse treatment is effective. The National Treatment Improvement Evaluation Study (NTIES) was one of the largest and most rigorous studies of substance abuse treatment ever conducted. Commissioned by CSAT, NTIES revealed that:

- Clients served by CSAT-funded programs significantly reduced their alcohol and other drug use.
- Treatment has lasting benefits. Significant reductions in drug and alcohol use were reported a full year after treatment. Reductions were noted regardless of the amount of time spent in treatment or the amount of treatment received.
- Clients reported increases in employment and income, improvements in mental and physical health, decreases in criminal activity, decreases in homelessness, and decreases in behaviors that put them at risk for HIV infection 1 year after treatment.

NIDA indicates that 90 days of residential or outpatient treatment is generally the minimum for effective outcomes. For methadone maintenance, 12 months of treatment is usually the minimum. People may need more than one treatment episode to achieve success, and these treatment experiences can have a cumulative effect for many people.

**Learn More: NTIES Highlights**

## Does Treatment Work: DATOS

The Drug Abuse Treatment Outcome Studies (DATOS), another large-scale study funded by NIDA, studied the effectiveness of different treatment modalities. These included (1) Outpatient Methadone Treatment; (2) Long-Term Residential Treatment; (3) Outpatient Drug-Free Treatment, and (4) Short-Term Inpatient Treatment. Key findings from the 1-year follow-up are shown in the following graphs:

- **Outpatient Methadone Treatment**
- **Long-Term Residential Treatment**
- **Outpatient Drug-Free Treatment**
- **Short-Term Inpatient Treatment**

**Learn More:** Review details about **the DATOS study**

### **Parenting Training and Education**

Some parents may receive parenting training and education and related interventions as a part of substance abuse treatment. Examples include anger management and assertiveness training. Ask yourself how you can help support parents' treatment and parenting goals for the benefit of children and families.

## Discharge From Treatment

When a client has demonstrated significant progress in achieving treatment goals, and other associated supports are in place, he or she may be ready for discharge. The following criteria can be used to evaluate a client's readiness for discharge:

- Substantial progress in achieving individual treatment goals
- Sobriety, with evidence that the client knows how to avoid relapse and live a sober life, such as having a sponsor or regularly attending Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings
- Stabilization or resolution of any serious medical or mental health problems, with appropriate plans for continuing or reentering treatment, as needed
- Demonstration of appropriate parenting skills, including discipline and affection
- Evidence that the parent can take responsibility for himself or herself and the children. Evidence that the children will live in a safe environment (including approval from CPS if the parent has an open custody case) with arrangements for appropriate child care and continuing medical appointments, as necessary
- Promotion through the program's treatment phases, at least to a specified level
- Evidence of a well-developed support system that may include positive relationships with a spouse or significant other, family members, and/or friends
- Employment or enrollment in a program for adult education, literacy, or vocational training
- A legitimate income source, sufficient money saved to meet immediate expenses, a budget, and a savings plan
- Safe, affordable housing
- A self-developed exit plan that specifies activities in which the client expects to participate (including aftercare services provided by the grantee), other arrangements with community-based agencies, and goals for the future
- Evidence that the parent is linked with, or can find, needed family services, and negotiate for these with community agencies and other resources

## Continuing Care or Aftercare

Following discharge, people enter the stage of change known as maintenance, and formal treatment gives way to continuing care or aftercare. In practice, many programs do not offer formal continuing care. In many cases, continuing care is an ongoing process of self-management.

**Support recovery.** There are a number of ways to provide support for recovery. Substance abuse counselors and child welfare professionals play key roles in connecting parents and families to needed services that can support recovery and family healing. Important services that staff professionals may link parents to include:

- Alumni group meetings at the treatment facility
- Home visits from counselors
- Case management
- Parenting education and support services
- Employment services
- Safe and sober housing resources
- Legal aid clinics or services
- Mental health services
- Medical and healthcare referrals, including HIV testing and prevention programs
- Dental health care
- Income supports, including the **earned income tax credit**
- Self-help groups, including 12-Step programs, such as AA and NA
- Individual and family counseling

Use the following **Recommended Resources Worksheet** to help document resources that your clients should contact, the points of contact, and the actions that they should take.

## Recommended Resources Worksheet

Based on your individual needs, the following resources are recommended for your successful recovery and sobriety, and for the health of your family:

- Alumni group meetings
- Home visits from counselors
- Case management
- Parenting education and support services
- Employment services
- Safe and sober housing resources
- Legal aid clinics or services
- Mental health services
- Medical and healthcare referrals, including HIV testing and prevention programs
- Dental health care
- Income supports, including the earned income tax credit
- Self-help groups, including 12-Step programs, such as AA and NA
- Individual and family counseling

Resource: \_\_\_\_\_  
Contact: \_\_\_\_\_  
Action: \_\_\_\_\_

## Post-Treatment Expectations

*What can a child welfare professional expect of a parent after treatment, in the recovery stage?*

Maintaining sobriety and sustaining a life of recovery is a fundamental and profound biopsychosocial and spiritual process for an individual. The individual in recovery is making lifestyle changes to support healing and regain control of his or her life, and accepting responsibility for his or her behavior. He or she may have a new job, a different living situation and/or location, and a new set of friends. Their new friends may be peer and self-help group members instead of a former substance-using friends.

The possibility of relapse is present, as recovery is a dynamic process. It is thought of as one day at a time, for the rest of a person's life.

### **Providing Ongoing Support**

The importance of a range of on-going services, including economic support, vocational and employment services, housing, parenting skills, medical care, and community and social supports for a parent in early recovery and through the stresses associated with reunification cannot be underestimated.

Ask Yourself: What kinds of supports to parents need to reinforce their treatment experience and support their recovery as they regain their parenting responsibilities?

## Case Study: Lisa Graduates from Residential Treatment



Ian and Ricky are tugging on Lisa's leg. They want to go outside and play with the other kids. Lisa tells them that they will be able to go in a few minutes, but first mommy has to do something really important. Jill asks Lisa to come to the front of the room to accept her graduation certificate. Lisa has successfully completed 90 days in residential treatment. Lisa and the other graduates embrace and wipe tears from their eyes. Lisa thinks, "It's been a long road, and I have an even longer road ahead of me, but my boys are worth it, and I am worth it." As Lisa begins to transition to the aftercare program, she meets with Molly. Molly praises Lisa for her success in the residential program and asks her about her plans for outpatient services and aftercare and maintaining her sobriety now that she will be living with her children again.

Lisa explains that she will participate in three groups and one individual session each week at the treatment program. She will continue with the job-training program, which will help her to find a new job. In the meantime, her TANF benefit will cover the rent for the new apartment she found. Molly asks if she has arranged other support groups and resources. Lisa says that she will look for a Narcotics Anonymous (NA) group near her new apartment, but she is concerned about being away from her boys so much of the time. Molly hands Lisa a list of NA groups near her new apartment, highlighting the ones that have onsite childcare services.

Lisa tells Molly that she is concerned about her son's developmental and behavioral issues. She is concerned that without the proper resources and supports she will not be able to manage all of their needs. Molly puts Lisa in touch with a local child care agency, where she was able to enroll Ricky, her younger son. This agency has a contract with a local child guidance clinic, which provides developmental assessment services and monitors the progress of the children in the center. In addition, Molly refers Lisa to a home visitor employed by the child welfare-funded Family Resource Center in her new neighborhood.

As Lisa leaves, Molly is pleased that Lisa has done so well. She is confident that at the 6-month hearing, the judge will note this progress and continue the in-home support services. Ian and Ricky will be able to stay with their mom. And time will tell if Dan will be as successful and fulfill his role as a father.

### Questions to Ask Yourself:

What other questions would you ask to determine Ian and Ricky's safety as they return home to live with Lisa?

Do you think the aftercare plan is appropriate? Are there other services that you would recommend?

## **The Unique Needs of Women with Substance Use Disorders**

While fathers certainly play an important role in their children's lives, the majority of parents with active case plans in the child welfare system are mothers. Women with substance use disorders often have unique considerations, including issues related to children. This module addresses areas child welfare professionals need to be aware of to fully address the needs of their dependent children, including the following:

- What are the unique considerations of women with substance use disorders?
- How do co-occurring disorders, trauma, and domestic violence relate to women's substance abuse?
- What are key research-based approaches to treatment for women?

## **Unique Considerations: Lower Threshold**

Women tend to have a lower threshold for experiencing the physical effects of and becoming addicted to alcohol and other drugs than men (CSAT, 2001; NIDA, 2000; CSAT, 1999; Blanchard, 1998). In many cases, women use alcohol or other drugs for a shorter time than men before becoming addicted.

**Physiological differences.** Why does this occur? Using alcohol as an example, women absorb and metabolize alcohol differently than men. In general, women have less body water than men of similar body weight, so that women achieve higher concentrations of substances in the blood after consuming equivalent amounts. In addition, women appear to eliminate alcohol from the blood faster than men.

**Learn More:** Review **NIAAA Alcohol Alert on women and alcohol**

## Unique Considerations: Connected Issues

Women may have many experiences and life events that are connected to their substance abuse, including childhood abuse, trauma, domestic violence, and co-occurring mental health disorders.

**Childhood abuse.** Women with substance-related problems are more likely to report a history of childhood abuse—physical, sexual, and/or emotional—than are women without substance-related problems (Covington & Kohen, 1984; Miller, et al., 1993; Rohsenow, et al., 1988; Hein & Scheier, 1996; Langeland & Hartger, 1998; CSAT 1997a).

Trauma and post-traumatic stress disorder (PTSD) are important considerations for women. Among people with substance abuse problems, those with histories of childhood abuse are more likely to meet diagnostic criteria for PTSD (Brady, et al., 1994; Hien & Levin, 1994; Bernstein, 2000). Many women with substance use disorders have experienced physical or sexual victimization in childhood or in adulthood, and thus may suffer from PTSD. Alcohol or drug use may serve as a form of self-medication for people with PTSD and other mental health disorders.

**Learn More:** Review **trauma-informed information at the** National Trauma Consortium [www.Nationaltraumaconsortium.org](http://www.Nationaltraumaconsortium.org)

## **Domestic Violence**

Women who abuse substances are more likely to become victims of domestic violence (Miller, et al., 1989). Victims of domestic violence are more likely to become dependent on tranquilizers, sedatives, stimulants, and painkillers and are more likely to abuse alcohol (Start & Flitcraft, 1988a).

State laws vary in the degree and definition of the mandatory involvement of the family if substantiated domestic violence is a factor in the child welfare cases.

## Co-Occurring Disorders

In the substance abuse treatment field, co-occurring disorders refers generally to coexisting mental health and substance-related disorders.

**Common examples.** Conditions associated with childhood abuse and neglect, which may co-occur with substance use disorders, include anxiety, depression, substance abuse, and PTSD, as well as dissociative disorders, personality disorders, self-mutilation, and self-harming (CSAT, 2000). Among individuals with substance abuse problems, more women than men have a second diagnosis of mental illness (CSAT, 2001).

**Unique needs.** Women may experience any one of these conditions, or a combination of several. Findings from the SAMHSA/CSAT Women, Co-Occurring Disorders, and Violence Study highlight the need to acknowledge women's roles as parents, provide coordinated services, tailor treatment to integrate women's children and provide parenting education, and focus on strengths.

**Integrating services.** In addition, a recent SAMHSA report to Congress highlights the need for integrated services that include medications and psychosocial treatments to address co-occurring disorders. Evidence-based practices for treating people with co-occurring disorders are emerging, with an emphasis on identifying co-occurring disorders through thorough screening and assessment, specialized integrated services tailored to the individuals being treated, and partnership-building between substance abuse and mental health programs.

**Learn More:** Review [recommendations about co-occurring disorders and violence](#)

**Learn More:** Review [SAMHSA Report to Congress on co-occurring disorders](#)

## Parenting Role

The parenting role of women with substance use disorders is a complex matter that cannot be separated from their treatment. Many of these women have not learned to be good parents, may not know about normal child development, and may have unrealistic expectations of their children (Kassebaum, 1999).

Others may have been positive parents. However, their positive parenting abilities may have been compromised because of the loss of balance and wellness caused by the addiction and as the substance abuse cycle intensified.

When a parent has a substance use disorder, numerous safety considerations arise for the children, which child welfare professionals need to address. These issues are discussed in Module Five.

Treatment programs that accommodate women and children are generally more successful establishing trust and engaging mothers. It is essential for women to feel safe and assured that their children are being cared for during the treatment process.

## **CSAT Women and Children Programs: Highlights**

Characteristics of effective treatment programs that serve women and their children include:

- Comprehensive and holistic
- Coordinated with transition services, such as housing and employment, that can assist with relapse prevention
- Nurturing environment with peer and staff support
- Professionally trained staff
- Individualized and flexible treatment services
- Long-term residential
- Phased treatment
- Other approaches (e.g., case management, group emphasis, cultural and gender-appropriate focus, and family-focused)

**Learn More:** Review highlights from the **Residential Substance Abuse Treatment for Pregnant and Parenting Women**

## Summary of Women's Unique Issues

People with substance-related problems experience many similarities related to the addiction, treatment, recovery, and relapse processes. However, there are important exceptions. Of particular note, women with substance-related disorders have unique considerations. Women have a lower threshold for substance use and addiction than men.

Many women with substance-related problems have experienced childhood abuse in the form of physical, sexual, and/or emotional trauma. These experiences often lead to PTSD or other mental health problems that require professional interventions.

Women in treatment for substance-related problems may also have co-occurring mental health problems that require professional treatment. In addition, women with substance-related disorders have an increased likelihood of becoming victims of domestic violence, and women victims of domestic violence have an increased likelihood of having substance-related problems. In addition, women in treatment often need to address parenting issues, which may have been compromised because of their substance use.

Relationships are integral to recovery. For women in treatment, relationships with counselors and therapists, peer relationships with other women, and relationships with a higher power are major contributors to recovery.

## Conclusion to Module 3

Child welfare professionals have a responsibility to understand what parents in substance abuse treatment encounter during the treatment and recovery processes. They should gain knowledge about treatment services, approaches, settings, and outcomes. They should more fully understand treatment services for American Indian communities. They can use this information to manage cases and improve outcomes for children.

### **The Personal-Professional Dimension of Substance Abuse**

Many of us know someone who has a substance use disorder. We all bring our personal perspectives, including views and experiences regarding addiction, from our families of origin. Consider how your own viewpoint may affect the way you view parents with substance use disorders.

Remember that each person's experience with substance use disorders is unique and that what worked for you or for your family may be different from what will work for your clients.

Discuss this issue with your supervisor, to ensure that your own experiences do not interfere with your ability to work objectively with your clients. Recognize that this work is difficult, and it is normal for your work to bring out emotions or feelings about past experiences.

Importantly, do not stop yourself from acknowledging your personal experience and feelings, but be able to identify them and discuss them with your supervisor so that they do not interfere with your professional work.

# Module Four: Special Considerations for Children Whose Parents Have Substance Use Disorders

## Participant Objectives of Module Four

After reviewing this module, child welfare professionals will be able to:

- Learn strategies that child welfare professionals can use to help children experiencing parental substance abuse
- Gain additional knowledge of the responsibilities of the child welfare professional for children who are in the system and who have parents with substance use disorders
- More fully understand children's needs and experiences connected to having a parent with a substance use disorder
- Learn ways child welfare professionals can enhance case planning, safety planning, and linkages to other services for children experiencing parental substance abuse

## What This Module Covers

This module covers information and strategies that child welfare professionals can use to help children who are affected by parental substance abuse. It answers the following questions:

- What are the two key responsibilities of child welfare professionals for children in the child welfare system?
- What are the common experiences of children whose parents have substance use disorders?
- What are the typical needs of children from homes where parents have substance use disorders?
- How can the needs of children be met by child welfare workers through a partnership with substance abuse counselors?
- What are the key elements that must be addressed in a child welfare case plan to ensure the children's needs are met?
- What are the key tasks of child welfare professionals in meeting the safety and well-being needs of children whose parents have substance use disorders?
- What are the appropriate services that child welfare workers need to be able to access so that they can respond to the children's needs?
- How can the worker conduct positive and safe visitation that promotes and supports the child-parent relationship?

## Introduction

Not all children of substance-abusing parents have been abused or neglected. Most parents in treatment are not in the child welfare system. However, for those parents with substance use disorders who are involved in the child welfare system, protecting children from harm often involves more than physical safety.

**Address consequences.** Parental substance abuse is often associated with specific risks to children's well-being. These risks may include developmental problems, mental health issues, lack of medical care, the need for educational support, and other issues in the children's lives. Addressing these factors ensures the children are able to achieve their potential.

**Address child's needs.** While the child is in the custody of or under the protection of the State, the child's needs related to the parent's substance abuse problem become the responsibility of the child welfare agency. It must take appropriate measures to meet these needs.

## **Development, Cooperation, and Communication**

**Disrupted development.** Each child is on an individual child development path. Children of substance-abusing parents often do not progress through the normal child developmental milestones. Their family experiences may interfere with typical physical, emotional, and educational development, and may diminish their ability to integrate difficult developmental experiences necessary for their movement forward to the next developmental task.

**Understand needs.** Child welfare workers understand the need to provide assistance and support to the children and youth of substance-abusing parents. They know to address children's developmental needs in the context of potential separation and loss of parents, abuse or neglect, and potential experiences with trauma. However, when parents are in treatment, child welfare workers must also work in a close partnership with substance abuse counselors to ensure the ongoing safety and well-being of the children, and to motivate parents to carry out the responsibilities that will enable them to meet the requirements of the dependency court.

**Educate.** Child welfare workers must help children develop a foundational understanding regarding substance abuse in terms that are nonjudgmental and supportive. Information must be conveyed in a way that defines the disorder, not the person. It helps children if the information they receive is appropriate to their developmental stage and age.

## Three Key Responsibilities

Child welfare professionals have three key responsibilities related to children of substance-abusing parents who are in the child welfare system:

- Ensuring a child's safety
- Developing a permanency plan
- Providing for the child's well-being

Working with substance abusing parents involved in the child welfare system can be challenging but rewarding. It requires understanding both the child welfare and addiction treatment systems goals, and processes. Child welfare professionals are in a unique position to make critical contributions to the health, safety, well-being, and permanency of children and families.

## **Key Responsibility: Ensuring Children's Safety**

Safety is the core responsibility of the child welfare worker. When investigating charges of child abuse and neglect, the worker must determine whether, and to what extent, child maltreatment is occurring, and ensure the safety of children.

**Evaluate extent.** Determining the extent of substance use and its relationship to child safety issues is a primary function for child welfare. As has been noted in other modules, the child welfare worker needs to establish a partnership with the treatment counselor so that they can work together to ensure the ongoing safety of children.

## **Key Responsibility: Developing a Permanency Plan**

Developing a permanency plan for the family is at the core of a child welfare worker's responsibility. Successful implementation has life-long consequences for children and parents.

**Protect and help heal.** When children have been removed, or are under consideration for removal, the child welfare professional must work with the parents, the treatment system, and the dependency courts to determine what will best protect children from harm, and help them heal from the harmful effects of parental substance use disorders.

**Permanency plan.** The permanency plan becomes the statutory framework of requirements within which these activities occur. The permanency plan must describe specific services and supports that will be provided for children and parents. Careful attention to these substance abuse issues can help to ensure a smoother reunification of parents and children or better prepare children for other permanency options, depending on the plan. If these issues are not addressed, youth may repeat their parents' behavior patterns as adults.

## Developing Support Systems

When developing support systems for the children, child welfare workers need to do the following:

- Ensure that the child receives a comprehensive assessment including their developmental progress, neurodevelopmental effects of potential prenatal substance exposure, learning disabilities, health and mental health care needs. Services to intervene and treat children for these potential effects of parental substance abuse or child abuse and neglect are critical. They are often delivered by a variety of agencies and disciplines through agreements with the child welfare agency. It is important that referrals to these agencies include information about the parent's status in treatment. This is particularly important for foster parents who may be responding to special needs of foster children. Foster parents may require special training regarding the neurodevelopmental effects of prenatal substance exposure or postnatal environments, including exposure to violence, to provide effective care giving.
- Help children develop an understanding of substance abuse that is supportive and nonjudgmental. Information about their parents' substance abuse must be conveyed in a way that defines the disorder, not the person, and is appropriate to their developmental stage and age.
- Where appropriate to the permanency plan, develop an effective visitation program between parents and children. The visitation program should enhance the children's understanding of what is occurring in their lives, and give them an opportunity to safely and positively maintain a relationship with their parents.

## ICWA Requirements

**Stricter requirements.** The Indian Child Welfare Act (ICWA) provides specific and stricter safeguards for Indian families with respect to removing a child from the family. For example, the court may not issue an order effecting a foster care placement of an Indian child unless clear and convincing evidence is presented, including the testimony of one or more qualified expert witnesses, demonstrating that the child's continued custody with the parents or Indian custodian is likely to result in serious emotional or physical damage to the child.

**Specific conditions.** Evidence that shows only the existence of community or family poverty, crowded or inadequate housing, alcohol abuse, or nonconforming social behavior does not constitute clear and convincing evidence. Rather, the evidence must show the existence of specific conditions in the home that are likely to result in serious emotional or physical damage to the child. It must also show the casual relationship between the conditions that exist and the damage that is likely to result.

**Clear and convincing.** A child may not be removed simply because there is someone else willing to raise the child who is likely to do a better job or because it would be "in the best interests of the child" for him or her to live with someone else. A placement or termination of parental rights cannot be ordered simply based on a determination that the parents or custodians are "unfit parents." It must be shown that it is dangerous for the child to remain with his or her present custodians. Evidence for removal must meet the legal standard of "clear and convincing." Evidence for termination of parental rights must be "beyond a reasonable doubt" (Bureau of Indian Affairs, 1979).

## **Minimum Sufficient Level of Care for Children**

The practice concept known as "minimum sufficient level of care" is a basic practice guide for child welfare and child protection workers. It applies to all children and is an important concept that helps prevent the child welfare system from not overly intruding in families' lives. It is intended to stop workers from imposing subjective or rigid standards. It is also intended to recognize that a top priority in "well-being" is the relationship with the parent.

The removal of a child from a parent by the State is the greatest intrusion into a family's life and civil liberties next to incarceration. It cannot be done without due process, which includes a judicial finding regarding the minimum sufficient level of care for a child.

**Key ASFA Timetables.** ASFA child welfare requirements are organized around a series of timetables that come into play as decisions are made about children who are moving along the child welfare continuum into situations of greater risk. For each step in the timetable, the child welfare system provides services representing reasonable efforts to prevent the placement of a child or to facilitate the return of a child to the home as soon as possible. Abused or neglected children of substance-abusing parents often end up in foster care placement. **The following information describes the key steps and timetables.**

## Summary of Key ASFA Timetables

Some children initially remain with their parents and receive in-home services that will prevent removal. States determine the timetable for these services. Most of these children are in and out of the child welfare system within 3 months. Some may return several times for in-home services and may eventually move into foster care. Some States require that these cases be brought to the court's attention after a certain period of time if services are not successful.

The Federal foster care requirements follow a series of timetables that are estimates of the length of time it takes to ensure a reasonable decision can be made about the best interests of the child to either return to the family or move into an adoption status. The timetables are built into the service plans that are developed with parents and represent conditions that parents must successfully meet to have their children returned to their care. The timetables are supervised by, and parents are under the jurisdiction of, the dependency courts as these decisions are made:

Time-limited family reunification services are those provided to a child and family where the child has been removed and placed in foster care. Family reunification services must be provided in the first 15 months from the date the child enters foster care.

Each child must have a case plan that places the child in a safe environment that has the least restrictive (most family-like) setting available and is in close proximity to the parents' home, consistent with the best interests of the child. A case review is conducted on the status of each child in foster care no less than once every 6 months, either by a court or by the child welfare agency, to determine: safety of the child, continuing necessity for placement, extent to which the parents have complied with the case plan, progress toward alleviating the circumstances that required placement, and projection of a likely date by which the child may be returned.

Each child must have a permanency hearing, usually held in a family or juvenile court, no later than 12 months after the child enters foster care and not less than every 12 months thereafter during continuation of foster care, depending on the State Statute. This hearing determines the permanency plan for the child.

When a child has been in foster care for 15 of the most recent 22 months, the State must file a petition to terminate parental rights, unless one of the following three conditions applies: (1) a relative is caring for the child, (2) there is a compelling reason that termination would not be in the best interests of the child, or (3) the State has not provided the family the needed services within the required deadlines.

## Exceptions to ASFA Requirements

The ASFA legislation provides exceptions to its requirements to provide assistance and services to parents to prevent removal and reunify children. The exceptions are:

- The parent has subjected the child to aggravated circumstances, such as abandonment, torture, chronic abuse, and/or sexual abuse
- The parent has committed or aided in the murder, voluntary manslaughter, or felony assault of another child
- The parental rights to a sibling have been involuntarily terminated

Under these exceptions, as permitted by State statute, the child welfare and court systems may determine there is reason to suspend the requirement to make reasonable efforts to provide assistance and services to parents, and move more quickly toward an alternative placement for the child.

**Consider aggravated circumstances.** In assessing the ongoing safety of a child, child welfare workers should consider the extent to which a child of substance-abusing parents has been subjected to any of the aggravated circumstances. This will help them weigh the severity of the addiction and consequent parental behavior in the context of prior abuse and neglect, and provide the court with valuable information about the potential for reunification.

## Childhood Experiences of Parental Substance Abuse

*What are the common experiences of children whose parents have substance use disorders?*

Many experiences of children whose parents have substance use disorders can be grouped into prenatal exposure or postnatal family environments.

**Prenatal exposure.** Children may have experienced prenatal exposure to alcohol and/or other drugs that has interfered with normal growth and development.

**Postnatal family environments.** Children may have experienced postnatal family environments that lack the resources to meet their needs. Children may suffer from inconsistencies in relationships with or support provided by their parent. They may also lack in the steady presence of care-giving persons.

## **Prenatal Effects of Substance Abuse**

Children may have experienced prenatal exposure to alcohol and/or other drugs that has interfered with normal growth and development. Child welfare workers must explore as much information as possible about the substance use of the mother and the condition of the child at birth.

Children under age 3 should be seen by a pediatrician and referred to the community's provider of services under the Individuals with Disabilities Education Act (IDEA) Part C, Early Intervention Services (the local school district will be able to refer you to the Early Intervention Service Provider in the child's neighborhood). The Early Intervention Service Provider will be experienced in the assessment and treatment of children who were prenatally exposed to alcohol and/or other drugs, and will make a determination of the child's eligibility for services based on the type and severity of the developmental delay.

Older children should also be seen by a pediatrician and may qualify for specialized pre-school programs and interventions provided by the local school district through IDEA Part B services. A referral to a school district should state that the social worker is requesting a determination that the pre-school or school-aged children qualifies for services under Part B.

Learn More: Information and Infant and Children's Special Education Services  
<http://edworkforce.house.gov/issues/109th/education/idea/ideafaq.pdf>

## **Prenatal Exposure: Federal Law**

There are new Federal requirements for serving substance-exposed infants. The 2003 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) has new requirements for responding to the identification of infants who are identified to be prenatally exposed to drugs.

**Promotes service availability.** The amendments to CAPTA were developed to ensure that children who have been exposed in utero and their parents have access to the treatment and intervention services that they need. The goal of these requirements is to ensure that timely and appropriate services are made available to newborns who are identified as substance affected.

**State responses.** The law allows for variation in State practice and does not mandate a child abuse or neglect report, only notification of CPS when a child is identified. It is the responsibility of each State CWS to decide how to incorporate this required notification into their system, and develop a plan of safe care for these infants.

## **Prenatal Exposure: State Requirements**

*What are key State requirements for responding to reports of substance-exposed infants?*

States must operate a Statewide program relating to child abuse and neglect that has two components: policies and procedures, and a plan of safe care.

**Policies and procedures.** States must develop policies and procedures (including appropriate referrals to CPS systems and for other appropriate services) to address the needs of infants who are identified at birth as affected by illegal substance abuse or who have withdrawal symptoms resulting from prenatal drug exposure. These policies and procedures must require health care providers involved in the delivery or care of such infants to notify the CPS system about these infants (although not in the form of a child abuse or neglect report, or to prosecute).

**Plan of safe care.** States must develop a plan of safe care for the infant born and identified as being affected by illegal substance abuse or having withdrawal symptoms.

**Understand your State's response.** Child welfare workers must know how their States have responded to these requirements. They must know what provisions they have made for developing a plan of safe care for newborn infants who have been prenatally exposed. Some States have developed responses involving more than the referral of a drug-exposed infant to CPS. These State responses coordinate with other agencies, such as maternal and child health, developmental disabilities, children's mental health, and child care.

## **Prenatal Exposure: Plan of Safe Care**

The goal of the CAPTA amendments in relation to ensuring that infants who are identified as substance affected are referred to child welfare is to address their needs and to ensure their safety. While these referrals are not synonymous with child abuse and neglect, they may indicate a potential problem. Screening and developmental assessments will reveal that some children need medical and developmental interventions in addition to assurance of their safety.

## **Prenatal Exposure: CPS Responses**

Notifying CPS can mean a routine report is received and filed. Or, it can mean that priority treatment is given, with a specific time limit for response, using a screening instrument that reviews safety and risk issues in depth.

Some States and localities use structured decision-making tools to assess risk and safety factors that assist workers in making informed decisions about their safety responses. A "dual-track" or differential system has been implemented in some States in response to drug-exposed infants. In this approach, CPS assesses reports of positive substance-exposed births without a traditional investigation. Hospital referrals of positive substance-exposed births would result in CPS family assessment for services, and investigations would be undertaken only in those cases in which it is believed that the child is at risk of child abuse or neglect.

## **Prenatal Exposure: Promising Practices**

**Treatment and safety plans.** In some States, the birth of a substance-exposed infant triggers several events aimed at ensuring child safety and the mother's recovery. These include developing a substance abuse treatment plan that is linked through an interagency protocol with a formal safety plan.

**Interagency protocols.** In some States, an interagency protocol governs the information that CPS, treatment, and other agencies can share about the family's history once a prenatally exposed child is identified. This includes prior births of drug-exposed children, any available information on prenatal care, and any prior CPS reports for abuse or neglect.

**Home services.** Once a substance-exposed child has been identified, some States immediately begin voluntary or involuntary home visiting services, using trained nurses, paraprofessionals, or other personnel. They may provide services that emphasize mother-child attachment and parenting skills, the benefits of quality child development services, nutritional education, and information about the full array of family income support programs available for parents of children with special needs.

**Referrals.** In some States, a referral for a developmental screening and assessment is made for all children known to be born drug-exposed, and eligibility for services is based on the prenatal exposure rather than type and severity of developmental delay.

## Postnatal Effects of Substance Abuse

Children may have experienced postnatal family environments that exhibit a lack of resources to meet their needs or suffer from serious parental inconsistencies in relationships with or support of a child. Or, they may lack the steady presence of care-giving persons.

The following are examples of typical experiences of children whose primary caregiver abuses substances (Breshears, Yeh & Young, 2005):

- The home life may be chaotic and unpredictable.
- There may be inconsistent parenting and a lack of appropriate supervision.
- Substance-abusing adults may provide inconsistent emotional responses to children, or they may provide inconsistent care, especially to younger children.
- Parents may have abandoned children physically and emotionally.
- Parents may emphasize secrecy about home life.
- Parental behavior may make the child feel guilt, shame, or self-blame.

Because of their life experiences, children may have developed feelings, such as:

- Believing they have to be perfect
- Believing they have to become the parent to the parent
- Difficulty with trusting others
- Difficulty with maintaining a sense of attachment
- Difficulty with achieving self-esteem
- Difficulty with achieving self-autonomy
- Feelings of extreme shyness or aggressiveness

## Special Considerations for Children of Parents who Use or Produce Methamphetamine

Children are particularly vulnerable when living in a home where methamphetamine is being used or produced. It is important to understand the different ways in which children can be affected by environmental exposure to methamphetamine and the possible associated risks to their safety and well-being. Each of the groups of children are likely to experience separation from their parents due to the potential that parents will be incarcerated at some point.

### Type of Exposure

- Children of parents operating a “Super Lab” manufacturing large quantities of drugs
- Children of parents who are manufacturing drugs in the home
- Children of parents who distribute or sell drugs
- Children of parents who are methamphetamine users

### Implications and Potential Risks

Children are less likely to be in these settings but may experience environmental exposure and parents will be incarcerated

This group of children are most at-risk for contamination and need for medical interventions

Children are at increased risk due to persons frequenting the home who are purchasing and/or using drugs

Children experience many of the same risks as other drug users and may be less likely to have parents incarcerated

Children who are living in a home in which methamphetamine or other drug manufacturing is occurring may need to go through a decontamination process facilitated by law enforcement, emergency medical services or other public health agency staff. Law enforcement officials should be on-site and should assess the need for medical interventions for children based on their knowledge of the extent of contamination in the home. Workers need to be aware of the child’s clothing, toys, blankets and other personal items that may not be safe to take with the child to his/her placement outside of the home.

The children should be assessed by a physician for any immediate health or safety concerns. The physician should screen for drug and chemical exposure so necessary treatment can be delivered. This screening may include but is not limited to obtaining a urine sample within 2 to 4 hours, taking the children’s vital signs, liver and kidney functioning tests, baseline blood tests and a pediatric physical exam.

The children may not need to be decontaminated if they have been out of the home for 72 hours, but they will need to be examined by their physician. If the children are at school, the risk is minimal that they may have contaminated other children or school personnel because most of the chemicals dissipate in the air once the child is out of the area where the manufacturing is conducted.

Source: North Carolina Department of Health and Human Services. On-Line  
Publications: Drug Endangered Children.  
[http://info.dhhs.state.nc.us/olm/manuals/dss/csm-65/man/CSs1000-05.htm#P125\\_20496](http://info.dhhs.state.nc.us/olm/manuals/dss/csm-65/man/CSs1000-05.htm#P125_20496)

## **Postnatal Exposure: Talking With Children**

### **How to Talk to Children About Their Parents' Addiction**

The child welfare professional's role can include talking to a child about his or her parent's substance abuse. The child welfare professional can help the foster parent or kinship care provider talk to the children in his or her care about the parent's substance use or dependence. Use the following four talking points to help guide these discussions:

**Addiction is a disease.** Your parent is not a bad person. She has a disease. The alcohol or other drugs cause your parent to lose control. When they drink or use drugs, parents can behave in ways that do not keep you safe or cared for.

**You are not the reason your parent drinks or uses drugs.** You did not cause this disease. You cannot stop your parent's drinking or drug use.

**There are a lot of children like you.** In fact, there are millions of children whose parents are addicted to drugs or alcohol. Some are in your school. You are not alone.

**Let's think of people whom you might talk with about your concerns.** You don't have to feel scared or ashamed or embarrassed. You can talk to your teacher, a close friend, or to an adult in your family that you trust.

## Postnatal Exposure: The 7 Cs of Addiction

The **National Association for Children of Alcoholics** developed the 7 Cs of Addiction, which can help children to understand that they are not responsible for another person's addiction to alcohol or other drugs.

### Remember the 7 Cs

Some children with moms and dads that drink too much think that it is their fault. Maybe you are one of those children. Well, it's not your fault and you can't control it. But, there are ways that you can deal with it. One important way is to remember the 7 Cs.

I didn't **Cause** it.  
I can't **Cure** it.  
I can't **Control** it.  
I can **Care** for myself by  
**Communicating** my feelings,  
**Making** healthy **Choices**, and  
By **Celebrating** myself.

Reproduced with permission from the National Association for Children of Alcoholics.

**Learn More:** Review **You Can Help: A Guide for Caring Adults Working With Young People Experiencing Addiction in the Family**

## **Postnatal Exposure: Needs of Children**

What are the typical needs of children from homes where parents have substance use disorders?

- Children need the opportunity to identify and express feelings with a safe and trusted adult.
- Children need information about substance abuse and the disease of addiction so that they know they are not to blame.
- Children need to be screened for developmental delays, medical conditions, mental health problems, substance abuse problems, and appropriate follow-up needs to be provided.
- Children may need to participate in counseling or support groups.
- Children need consistent, ongoing support systems and caregivers who will keep them safe and help them recover over the long period of time.

## Postnatal Exposure: How Workers Can Help

*How can the needs of children be met by child welfare workers through a partnership with substance abuse counselors?*

Child welfare and substance abuse treatment services need to work together to address the entire family, rather than separately addressing the needs of children in the child welfare system and the needs of parents in the treatment system.

**Ongoing process.** Addressing family needs is an ongoing process. It begins with the initial screening and assessment for child abuse and neglect, and screening for substance use disorders. It continues throughout the family's participation in the child welfare system, during which:

- The parents receive treatment
- Child welfare staff and the dependency court monitor the progress of parents to meet both goals of sobriety and establishing their capacity to take care of their children
- Parents continue to relate to their children through regular visitation in appropriate settings
- The child welfare worker and treatment counselor partner to meet the needs of parents and children to support a positive outcome

## Case Plans and Children's Needs

*What are the key elements that must be addressed in a child welfare case plan to ensure the children's needs are met?*

Child welfare workers must develop detailed case plans that specifically address the children's needs. The development of these case plans will require the child welfare workers to:

- Oversee the assessment of the child's health, mental health, educational, social, behavioral, and emotional needs
- Arrange for interventions that address the assessed needs of the child
- Determine the strengths and limitations in the family's capacity to meet the child's needs, and which unmet needs require special services
- Specify the services that are needed by parents, as they progress through treatment, that will enable them to better meet their children's needs
- Collaborate with school or childcare systems to best determine how to provide support

Using this information, the child welfare worker can supervise and monitor the progress of children to address improvements in their development and health that parallel the efforts that are being made by and for the parents in treatment.

## Meeting Children's Needs: Relapse Plan

Child welfare workers must work with treatment professionals to ensure there is a safety plan for children of substance-abusing parents in the event of a parent's relapse. The plan could include the following:

- Persons who will regularly check on the well-being of children, such as family members or neighbors
- Persons or locations, agreed upon ahead of time, where the child can stay if the parents abandon the children or are unable to provide a safe environment
- Monitoring of trigger behaviors that would bring safety plans into play
- Identified safe havens where parents can send children if they feel they are going to start using substances or relapse into inappropriate behavior around and toward children

**Promote skills.** Child welfare workers must provide opportunities for children to participate in substance abuse prevention programs that will give them strategies and skills to avoid repeating the substance-abusing behaviors of parents.

**Promote expression.** Child welfare workers must link children to safe and trusted adults who can help them learn to identify and express their feelings in healthy ways, and can provide age-appropriate messages about substance abuse and the disease of addiction.

## **Model Programs Dissemination Project**

The Substance Abuse and Mental Health Services Administration (SAMHSA) is committed to bringing effective substance abuse prevention and behavioral health promotion programs to every community. For more than 10 years, SAMHSA's Center for Substance Abuse Prevention (CSAP) has developed the Model Programs National Dissemination System, which promotes the development, identification, and use of evidence-based prevention and treatment initiatives.

SAMHSA Model Programs offer services suitable for use with children, youth, and families involved with the child welfare system. Some of these programs are available in some communities and can accept child welfare referrals. In other communities, the child welfare program may need to partner with other groups and organizations to establish these programs, so that they are accessible to better meet the needs of child welfare families.

**Dissemination project.** The SAMHSA Model Programs Dissemination Project (MPDP) is central to the National Dissemination System. It organizes, manages, and advances the information and education that make evidence-based programs visible and accessible to the agencies, organizations, and communities that the programs are designed to serve.

**Model programs.** After an evidence-based program is designated an "effective" program by the National Registry of Effective Programs (NREP), MPDP staff determine whether it has the additional components required of a Model Program. These include program developers with the desire and ability to provide quality materials, training, and technical assistance to practitioners seeking to adopt their program. If an "effective" program meets the additional criteria, it becomes a Model Program. Programs that have not undergone the rigor of NREP are not considered ineffective; rather, their developers are encouraged to submit their additional or updated materials for NREP review.

To learn more about the MPDP, visit the **Model Programs Website**.

## Fifteen SAMHSA Model Programs

<b>Characteristics of the 15 SAMHSA Model Programs</b>	
<p>They target troubled behavior of children and youth, such as:</p> <ul style="list-style-type: none"> <li>• Conduct disorder</li> <li>• Substance use</li> <li>• Violence</li> <li>• Aggression</li> <li>• Trauma</li> <li>• Stress</li> <li>• Emotional problems</li> <li>• Academic problems</li> </ul>	<p>They target parent needs for skills in parenting, such as:</p> <ul style="list-style-type: none"> <li>• Family management</li> <li>• Parent-child conflicts and family interaction</li> <li>• Communication and expectations</li> <li>• Discipline</li> <li>• Problem solving</li> </ul>
<p>They provide support services needed by child welfare families, such as:</p> <ul style="list-style-type: none"> <li>• Intensive therapy</li> <li>• Counseling</li> <li>• Training</li> <li>• Mentoring</li> <li>• Group work</li> <li>• Case management</li> </ul>	<p>They have been delivered at a wide variety of referral sites used by child welfare systems, such as:</p> <ul style="list-style-type: none"> <li>• Mental health clinics</li> <li>• Treatment centers</li> <li>• Alternative schools</li> <li>• Adolescent residential substance abuse and/or mental health treatment centers</li> <li>• Foster care facilities for troubled youth</li> <li>• Community-based programs to prevent child abuse and neglect</li> <li>• Most can be added to the array of ongoing community programs through the provision of training and certification programs for appropriate staff.</li> </ul>

## **Matrix of SAMHSA Model Programs**

We have prepared a matrix of 15 SAMHSA model programs that are suitable for use with children, youth, and families in the child welfare system. This matrix provides the following information:

- Program name
- Type of program or focus (e.g., therapy, prevention, family strengthening)
- Type of individuals who are served (e.g., children, parents, teachers)
- Type of youth who are targeted (e.g., urban, sexually abused, at-risk children)
- Application in child welfare settings (e.g., homeless shelters, child protection offices, foster parent training)
- Cost (e.g., training costs, material costs)

I would like to view the **matrix of 15 SAMHSA model programs**.

## **Gather and Maintain Information**

Workers need to gather information and keep updated files about community prevention, early intervention, and treatment services provided by the mental health and medical systems, the schools, child care programs, and community-based organizations. In particular, they need to have ready access to the following:

- Individual counseling services for children who are having mental health or substance abuse problems
- Substance abuse prevention and early intervention programs to support children and youth in developing healthy lifestyles that are free of the use of alcohol and other substances
- Support groups, such as Children of Alcoholics, that can assist children with the behavioral consequences of having substance-abusing parents (e.g., self-blame, guilt, parenting the parent, etc.)
- Medical screenings and care so that physical conditions associated with learning, development, and stress are addressed
- Ongoing, daily, quality childcare (whether from kin, foster care, or child care programs) that addresses their developmental needs
- Regular contacts with special education teachers and schools to ensure that children with learning disabilities are receiving the necessary special education services, and to help prevent behavioral problems that arise from untreated medical or learning problems
- Counseling and other service referrals for children whose families are in recovery and who have returned home, to ensure they continue to have access to ongoing support

## Resources for Children with Disabilities

**Provide IDEA services.** Research links prenatal use of alcohol and illegal drugs with learning disabilities, including ADD. There is a wide range of possible effects, both from prenatal drug exposure and from the impact of alcohol and drugs on the family environment. These may be severe, such as Fetal Alcohol Syndrome or alcohol-related neurodevelopmental effects. They may also be relatively mild experiences with learning problems. It is critical to supply these children with resources provided by the Individuals with Disabilities Education Act (IDEA) as early as possible in their lives and to provide them with family and caretaker environments that work with and nurture children with these needs. Services will be tailored to the needs of the child and may include such programs as speech and language, sensory integration, occupational therapy, and fine and gross motor skill development. The child's local school district can direct you to the appropriate provider for these services.

**ADDA, service plan, and LEA.** For children under 3, child welfare workers can request diagnostic assistance from the Area Developmental Disability Agencies (ADDA), the organizations designated to provide these services for a geographical area. States may provide these early intervention services through State agencies devoted to developmental disabilities, school districts or non-profit organizations. When a disability is confirmed, the child and family participate in the development of an Individualized Family Service Plan, which provides services to the child and the family at the earliest possible age, and assists with the transition to preschool services. For children 3 or older, these services can be continued or initiated by working with the Local Education Agency (LEA), the designated special education units located in each school district.

**Diagnostic services.** Child welfare workers must know the local agencies that provide these services for their families and they must request diagnostic services at the earliest possible age. Parents and/or caretakers must participate in the diagnostic and planning services, and work together with schools and preschool programs to help each child achieve his maximum potential.

## Conclusion to Module Four

Child welfare workers must be aware of the special considerations for children whose parents have substance use disorders. Child welfare workers have critical responsibilities for ensuring children's safety and developing a permanency plan. They also play an important role in helping to develop support systems for children, including ensuring that they are evaluated and treated for problems that arise because of parents' substance abuse.

Child welfare workers should be knowledgeable about ICWA requirements and the stricter safeguards for Indian families with respect to removing a child from the family. In the event the children are protected by ICWA, notification of their tribe is a requirement. Download and use this **list of Federally recognized tribes**.

Workers should understand prenatal exposure to alcohol and other drugs and be familiar with the Federal and State laws and policies regarding reporting prenatal exposure. They should know how their State has responded to the Federal requirement to develop policies and procedures, and to develop plans of safe care. Workers should understand the potential postnatal effects of substance abuse, and ways to speak with children and caregivers about them.

Workers should understand the needs of children exposed to parental substance abuse, know how to partner with treatment professionals, develop case plans that address the children's needs, and ensure that there is a safety plan in case of parental relapse.

# **Module Five: Partnering Strategies in Service to Child Welfare Families Affected by Substance Use Disorders**

## **Participant Objectives of Module Five**

After reviewing this module, child welfare professionals will be able to:

- Identify key approaches for child welfare professionals to collaborate with treatment counselors and other service providers at different stages in the treatment and recovery processes
- Identify the treatment confidentiality requirements that child welfare professionals may encounter
- Understand how to close a child welfare case involving substance abuse and how to support recovery after cases are closed

## What This Module Covers

This module reviews information and strategies that child welfare professionals can use to partner with treatment counselors and other programs that are working with substance-abusing parents in the child welfare system.

The stages of treatment include preparing to enter treatment, participating in treatment, and moving from treatment to life-long recovery. During each stage, child welfare professionals should engage in partnering activities that help parents to access community resources and support systems. Thus, this module answers the following questions:

- How do child welfare workers ensure adherence to treatment confidentiality requirements?
- What are the characteristics of successful collaboration between professionals?
- How can child welfare workers partner with treatment programs to prepare parents for their participation in treatment?
- How can child welfare workers partner with treatment counselors to improve outcomes for parents with substance use disorders?
- Within agency protocols, how do you decide when to close a child welfare case?
- How can child welfare workers assist parents to prepare for and sustain life-long recovery after their child welfare cases are closed?

**Reminder:** This course includes a glossary of special terms and their definitions. To view the glossary, click on the "Resources" tab above and select "Glossary."

## Introduction

To improve outcomes for families, child welfare workers must work with professionals from all the other systems with which the families are involved. When working with substance abuse treatment professionals, keep in mind:

**Differing perspectives.** Child welfare workers and the substance abuse counselors have different types of knowledge about the substance-abusing parents they both serve, and different experiences and relationships with them. Child welfare and substance abuse treatment systems each have their own requirements and strategies.

**Share understandings.** To maximize the potential of both systems to assist parents, it is important that the two key professionals share knowledge about the resources of the two systems, their practices, and the needs and experiences of the parents while respecting each other's professional and ethical concerns and statutory mandates. This will enable both professionals to support each other's requirements and the desired outcomes for the parents.

## Case Study: Molly and Jill Expand Their Collaboration



Lisa's review hearing goes well. The judge seems satisfied with the way Lisa immediately responded to the relapse by agreeing to enter residential treatment, and with the progress she's making with Jill and the treatment center's team. The judge orders continued in-home support services for Lisa and her children.

Molly and Jill decide to hold regular monthly meetings to monitor the progress of Lisa and other clients who are at the center where Jill works. They also decide that, whenever possible, Jill will accompany Molly on home visits. In addition, Molly received the contact information from Jill for their new methamphetamine addiction program and is consulting with that center's staff regarding another client's case.

### Questions to Ask Yourself:

What information should Molly ask Jill to send her as regular updates about Lisa's progress?

Are there certain facts that might lead to increased risk to Ian and Ricky and should be communicated to Molly immediately?

## Working Together: Tasks for Counselors, Workers, and Judges

Child welfare and substance abuse treatment professionals must accurately represent to the parents the requirements of the dependency court that must be met for parents to retain their children or have their children returned to them. The following exhibit illustrates the responsibilities that treatment counselors, child welfare workers, and dependency court judges have when working with child welfare parents who are in treatment.

<b>Tasks for Counselors, Workers, and Judges</b>		
<b>Treatment Counselor</b>	<b>Child Welfare Worker</b>	<b>Dependency Court Judge</b>
<p>Help parents end their denial and envision a positive life without substance dependence.</p> <p>Help parents understand how their substance abuse has affected their lives and the lives of their families and friends.</p>	<p>Conduct investigations to assess the safety of children.</p> <p>Conduct casework and case management to provide a nurturing environment for children while helping parents heal and develop needed capacities to care for their children.</p>	<p>Assess information to make judicial decisions that lead to permanency for children who are in the child welfare system.</p> <p>Follow the procedures and timetables specified in the State statute and the Federal law (Adoption and Safe Families Act).</p> <p>Preside over a series of hearings that examine whether reasonable efforts have been made by the child welfare agency to provide needed services to prevent removal and/or to achieve reunification.</p>

## **Collaboration: A Continuum**

What are the characteristics of successful collaboration between professionals?  
There is a continuum of opportunities for collaboration, ranging from full systems collaboration, to agency collaborations, to collaborations between two professionals.

Full system collaboration takes considerable time and effort, and requires the support of organizations as well as individuals. For example, organizations can collaborate to exchange information on a regular basis, develop joint projects, and consider joint plans to change rules.

## **Collaboration: Workers and Counselors**

Although system and agency collaboration does not always occur, there are levels of networking, coordination, and cooperation that can be successfully carried out by individual child welfare and treatment professionals who are working with the same parents. Collaboration can involve levels of increasing and more comprehensive interaction between child welfare workers and treatment counselors, such as:

- Networking between professionals to exchange information about resources, systems, requirements, and clients
- Coordination between professionals to schedule activities and requirements with each other's requirements in mind
- Cooperation between professionals to work toward common outcomes for specific clients by developing a common or joint plan
- Collaborative strategies between workers to carry out a commonly defined and supported set of agency or system outcomes

Many Federally recognized tribal governments and States have agreed to provide child welfare services through intergovernmental agreements. The knowledge and use of these agreements can provide a level of communication and collaboration of functions to assist both systems.

## Case Study: Molly and Jill Review Their Collaboration



Molly and Jill meet with their individual supervisors to discuss the improvements in their case management process. Molly's supervisor asks her to host a brown bag lunch to share ideas with other child welfare workers in her division. Jill and Molly share their success stories and introduce one another to colleagues and supervisors.

Over time, the agencies develop formal memoranda of understanding (MOUs) to address issues such as disclosure. The collaboration becomes a model that other treatment centers and the child welfare agency replicate and adapt. The collaboration results in many benefits, such as better coordination, time-saving, and resource streamlining. Molly and Jill couldn't have imagined how their small efforts could grow into cross-agency partnerships. And the biggest beneficiaries of all are the children and families struggling with addiction, such as Lisa and her children, Ian and Ricky.

Questions to Ask Yourself:

What are the barriers that you encounter working with substance abuse agencies?

Are there strategies that you can use to build a better bridge between your agencies and substance abuse services?

## **Creating a Collaborative Environment**

To work together, child welfare and treatment professionals need to establish an environment where effective problem solving can be achieved. This environment needs to include opportunities for the following rapport and interactions to occur:

- Development of mutual respect, understanding, and trust
- Honest and frequent communication, both formal and informal
- Recognition that collaboration is in the self-interest of both workers
- Understanding of shared values and instances where values differ
- Development of a mutual sense of ownership and planning for the success of specific parents
- Identification of jointly developed concrete and attainable objectives for specific parents

## **Collaborative Values Inventory**

Many collaborations begin their work without much discussion of the underlying values on which their members agree or disagree. The Collaborative Values Inventory is a neutral way of assessing how much a group shares ideas about the values that underlie its work. It can be used to identify and discuss values between entire child welfare and treatment staffs. It can also be used by a child welfare worker and a treatment counselor who are working together with a particular family.

After reviewing the results from a collaborative group's scoring of the Inventory, it is important to discuss the areas of common agreement and divergent views. When the Inventory identifies differing values, it is important to discuss the divergent views and develop common principles that workers can share.

For information about this tool, visit the **Children and Family Futures Website** and select "Collaborative Values Inventory."

## **Help Parents Prepare: Know Resources**

*How can child welfare workers partner with treatment programs to prepare parents for their participation in treatment?*

Child welfare workers need to know about treatment resources, organizations, and practices in their communities. With this information, they can establish successful partnering relationships with treatment counselors regarding their jointly shared clients. They need to:

- Know the extent and range of treatment resources available to parents in their communities
- Understand the characteristics of the various treatment programs
- Understand the services that the programs provide
- Understand the requirements, expectations, and conditions for participating in treatment

## **Help Parents Prepare: Gather Information**

Workers should develop a knowledge base about treatment programs to which parents are referred. Gather information about the following areas in relation to both the child welfare and treatment programs that are collaborating regarding specific parents:

- Mission of the programs
- Policies, rules, procedures, and statutes that must be followed to deliver services (especially confidentiality requirements and procedures)
- Time commitment expected of participants
- Funding sources and limitations of spending
- How success is defined and measured
- Language, terms, and acronyms (develop a common understanding of each other's language and meaning of words)
- Staffing structure of organizations and who makes decisions about which issues
- Formal and informal communication within the programs
- What programs can offer each other in a collaborative relationship

## **Help Parents Prepare: Referrals and Expectations**

Child welfare workers should help parents with the treatment program referral process. They can provide parents with contact information and recommendations, and assist them in following through with the referrals.

**Prepare parents.** Child welfare workers should develop an understanding about treatment programs' services, expectations, and requirements. The workers should convey this information to parents to help them know what to expect and what to do.

**Work with specialists.** Child welfare workers are not expected to be treatment specialists. Once a parent has received an initial referral to treatment, the treatment program receiving the parent will conduct additional assessments and determine if it is the best available choice or whether the parent needs to be referred to a more appropriate treatment resource.

## Use the Treatment Facility Locator

The **SAMHSA Substance Abuse Treatment Facility Locator** is a searchable directory of substance abuse treatment programs throughout the country. This easy-to-use online resource includes more than 11,000 addiction treatment programs, including residential treatment centers, outpatient treatment programs, and hospital inpatient programs for drug addiction and alcoholism.

The screenshot shows the SAMHSA Substance Abuse Treatment Facility Locator website. At the top left is the SAMHSA logo with the text "Substance Abuse & Mental Health Services Administration U.S. Department of Health and Human Services". To the right is the title "Substance Abuse Treatment FACILITY LOCATOR". Below the title is a navigation menu with buttons for "home", "about the locator", "quick search", "detailed search", "list search", "file download", "state substance abuse agencies", "frequently asked questions", "links", "comments or questions", "mental health services locator", and "buprenorphine physician locator". The "quick search" button is highlighted. To the right of the menu is a "Quick Search with Map It" section with a link "Learn How to Use All The Locator Search Features". Below this is a text box: "To locate the drug and alcohol abuse treatment programs nearest you, find your State on the map below and click on it." To the right of the text is a map of the United States with state abbreviations labeled. The map is blue with white outlines for state boundaries.

You can choose "Quick Search" and search for treatment programs within a specific city, street, and/or zip code. You can choose "Detailed Search" to search for specific treatment services, type of care, special programs and groups, special language services, forms of payment accepted, and payment assistance.

## Help Parents Prepare: Suggestions

**Parents receiving in-home services.** When helping parents who are receiving in-home services, provide parents with opportunities to improve parenting skills and interactions with children. Help parents set up a household that offers stability and continuity to the lives of their children. Develop safe arrangements for children when parents are having difficulty being available to children because of alcohol or drug use.

**Parents with children in foster care.** When helping parents whose children are in foster care, support parents' participation in treatment so that they can meet dependency court requirements and participate fully in visitation rights. Help parents get help to set up a household once treatment is well underway and dependency court requirements are being met. Collaboratively work with treatment providers to address relapse.

**Treatment providers.** Keep treatment providers informed about the dependency court schedule of hearings and their outcomes, information the court needs about parental progress in treatment, and problems that the judge is addressing throughout this process. When possible and appropriate, invite treatment counselors to hearings, and offer testimony.

## Measuring Progress

Treatment counselors and child welfare workers have similarities and differences in the ways in which they measure and define progress among shared clients.

**Substance Abuse Counselors' view.** For treatment counselors, progress is measured in two ways. First, whether the client's treatment is resulting in increased periods of sobriety and decreased periods of relapse. Second, by the scope and durability of changes the client is able to make in other areas of life so that sobriety will be maintained.

**Child Welfare Workers' views.** For the child welfare workers and dependency court judges, progress may be assessed similarly. Progress is measured by whether the parent is fully participating in treatment and all the services being offered. However, the parent has the added requirement to accomplish these outcomes within the strict statutory deadline established by the court to achieve sobriety and provide a safe and nurturing home for the children.

**Shared views.** Workers and counselors depend on parental treatment participation to accomplish the basic goals required by each system. Both depend on parents' motivation to achieve the conditions that will result in retaining or reuniting with children. As they work on their respective system goals for parents, both professionals are also working toward a larger, common goal of restoring health to the parents and their families.

## **Confidentiality Procedures for Sharing Information**

In general, both the substance abuse counselor and the child welfare worker have confidentiality procedures that require permission from the parent to share specific information across agencies or with other services.

Typically, the treatment consent forms, rather than the child welfare forms, need to be used, as they are designed to conform to Federal Government regulations (42CFR, Part II and HIPAA Privacy Act) that address the key treatment confidentiality requirements for sharing information. They are likely to be more guarded and specific in the types of information that can be shared.

## Treatment Confidentiality Requirements

*How do child welfare workers ensure adherence to treatment confidentiality requirements?*

Workers must understand that adhering to substance abuse treatment confidentiality requirements is a core responsibility of a treatment professional. It is on a par with a child welfare worker's responsibility to ensure that information about a person who has filed a child abuse report is held to the highest standard of confidentiality.

**Purpose of regulations.** Treatment confidentiality requirements are strict to encourage people to enter treatment without fear of public judgment that could bring about harmful results. These include being fired, losing housing, being denied benefits or services, or losing parental rights.

**Obtain permission.** Because confidentiality requirements for addiction treatment are very stringent, the worker/counselor team must work with parents to obtain permission to share information about the type and progress of substance abuse treatment.

**Positive outcomes.** This information sharing must follow very strict procedures. However, it can help both of the professionals ensure that children are safe, determine whether parents are meeting the dependency court requirements, and provide appropriate support for the parents throughout the treatment process. Guidance for sharing this information must adhere to Federal Government regulations 42CFR, Part II and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

## **Information Needed by Child Welfare Workers**

Information needed by the child welfare worker from the treatment provider includes:

- Whether the parents are actually involved in a treatment program
- The degree of parental participation: whether they are regularly attending, not missing appointments, and demonstrating a willingness to engage in treatment
- When parents are experiencing relapse or have left treatment
- The continuing care plan of the parents if they are in residential treatment

## **Information Needed by Substance Abuse Treatment Counselors**

Information needed by the treatment provider from the child welfare worker includes:

- Whether the family is an in-home case or if the child has been removed from the home
- Whether some children have been removed while others remain at home
- Whether it is a voluntary case or is court involved
- The permanency goal for the child
- Whether reunification is a goal
- Whether there is a concurrent plan for both foster care and adoption
- The court requirements and deadlines for specific hearings and achieving necessary outcomes

## Obtaining Confidential Information

A good summary of Federal confidentiality issues for treatment can be found in the CSAT Technical Assistance Publication (TAP 24) called **Welfare Reform and Substance Abuse Confidentiality**. We recommend that you read Section Three. This section reviews disclosure between the treatment and welfare systems, client revocation of consent, reporting relapse, combined case planning, and qualified service organization agreements.

We have developed and provided a **Confidentiality Packet** that includes rules for obtaining patient consent to disclose treatment information, patient consent for the release of confidential information, a multiparty consent form, and the prohibition on redisclosure of information concerning clients in alcohol or drug abuse treatment.

## Collaboration Approaches

Child welfare professionals can use several strategies to facilitate helpful collaborative outcomes for parents. Sometimes these can be implemented by caseworkers. Sometimes they will need the facilitation and support of supervisors or agency administrators. When necessary, discussing these issues with supervisors or administrators can lead to positive changes in the organization, as well as the individual casework of the child welfare workers. Collaboration strategies include:

- Developing a common understanding with a treatment counselor about his or her specific expectations, requirements, and practices
- Identifying and working out joint strategies to address specific, identified problems, such as safety plans for children when parents relapse, difficulties in accessing needed support or treatment services, and difficulties arising from placement of children in foster care or visitation practices
- Working out collaborative interventions by both professionals to re-engage parents in treatment and to reassess the safety of children

Another strategy is to implement joint case planning and case management. In doing so, the joint plan needs to consider the following approaches:

- Focus initially on "one day at a time" steps pertaining to the child welfare requirements until the parents are able to address longer range issues
- Use family group conferencing strategies to ensure that all the key family participants understand the treatment and child welfare goals for the parent, and are working on ways they can support these goals
- Specify various responsibilities of other agencies that will be involved in the case plan, such as mental health, health, and education

## Case Planning With Treatment Partners

Child welfare professionals normally prepare case plans with families that include activities, objectives, and service strategies that will help parents meet child welfare and dependency court requirements for the safety and well-being of their children. When workers are collaborating with other professionals, case plans need to incorporate joint goals and activities that are mutually supportive and informative. When workers and counselors collaborate, case planning activities need to:

- Incorporate objectives related to parents' treatment and recovery
  - Ensure that child welfare case plans and treatment plans do not conflict
  - Include joint reviews of the case plans with treatment staff and family
  - Share case plans with treatment providers
  - Regularly review parents' progress to meet the qualitative and quantitative goals of the case plan, and especially when critical events occur
  - Contain indicators of parents' capacities to meet the needs of their children and outcome data pertaining to the case plans
  - Be regularly monitored and shared with treatment counselors
  - Share new information with treatment staff when there are changes that might create stresses for the parents or affect the parents' participation in treatment.
- Examples.**

### Examples

Visitation with children is being increased or unmonitored visits with children are being instituted

Meetings are scheduled with the social workers

The family's case is being transferred to a new child welfare worker or to a different unit

Unanticipated changes occur in any additional services that are part of the case plan

The schedule of court hearings and any changes that occur in the court calendar

## Closing a Child Welfare Case

How do you decide when to close a child welfare case?

Treatment completion is not the only condition that is considered when closing a child welfare case. Dependency courts and child welfare agencies are also concerned that parents have established the capacities to provide ongoing safety and well-being for their children.

**Different clocks.** Also, a parent's progress in the child welfare and treatment systems may not be parallel—their 12-month permanency hearing might occur before they have completed treatment. This is typically a compelling reason not to terminate parental rights. In such instances, if a judge makes the decision to return children while parents are still in treatment, reunification does not necessarily mean that court ends jurisdiction over the parent. It is especially important to work out relapse prevention strategies, child safety plans in case relapse occurs, and plans to re-engage treatment if it is needed.

**Conduct joint case review.** When considering whether a child welfare case involving parental substance abuse is ready to be closed, child welfare workers must conduct a joint case review with the treatment counselor that ensures child safety and well-being at a minimum sufficient level of care for a particular child. They must meet with agency attorneys to ensure that State statutes and agency protocol are followed.

## **Joint Case Review**

The joint case review needs to address whether:

- Parents demonstrate the capacity to meet the needs of their children, appropriate to their age, development, and special requirements
- Children show evidence of improved care and development
- Parents have completed the recommended treatment program at an acceptable level, or it is proceeding well enough to know that children are not at risk
- A safety assessment of the children ensures there are no remaining unsafe conditions or other conditions that pose a risk to them
- Any additional reports of child abuse or neglect have been indicated
- The family has established positive family supports and community links that are available when needed
- The parent has demonstrated the ability and willingness to use community supports when needed
- The children have a safe, stable, and appropriate permanency goal of reunification, adoption, or another planned permanent living arrangement.

## Helping Parents Prepare for Recovery

How can child welfare workers assist parents to prepare for and sustain life-long recovery after their child welfare cases are closed?

Recovery from substance abuse is an ongoing, life-long process. During the early months of recovery, addicted clients are especially vulnerable to relapse. Many clients may need to return to a more intensive level of treatment. Parents will need help and support for the following activities:

- Maintaining sobriety
- Adjusting their lifestyles to avoid situations that contributed to the substance abuse
- Finding basic services that will help them re-establish their lives, jobs, and families
- Acknowledging the loss of relationships with the child welfare worker and the substance abuse treatment worker.
- Finding and connecting with new support systems and resources in the community that will continue after termination of the relationships with the child welfare and treatment counselors.

## Helping Families Leaving the Child Welfare System

When working with parents during the case closure phases and helping them develop life-long recovery strategies, child welfare workers must consider developing and using the following resources:

**Encourage 12-Step participation.** Use motivational enhancement interventions to encourage ongoing participation in the 12-Step programs and to obtain a 12-Step sponsor.

**Know resources.** Maintain a directory of local community- and faith-based organizations and social support services. Obtain relevant contact information (e.g., phone numbers, addresses, hours of service, and referral requirements). Establish relationships with organization representatives to make ongoing, informed referrals for parents, as needs arise.

**Identify individualized services.** Work with the substance abuse counselor to determine the specific services that parents will need for themselves and their families during the recovery period

## **Helping Families Leaving: Support and Safety Planning**

Help families establish a community network of support and safety planning for parents and children on which they can rely when the case is closed. This network needs to provide linkages, relationships, and benefits.

**Linkages.** Help promote linkages with community-based organizations and resources that will provide ongoing support and assistance to families about issues for which they need help. Reinforce the linkages with contacts, arrange for initial visits while the family is still in the child welfare system, and have follow-up discussions to determine how effectively the linkages met family needs.

**Relationships.** Help families establish relationships with family members, friends, churches or temples, or other social support groups that can support the family members as they make their way through recovery.

**Benefits.** Ensure that parents are receiving the full income and other benefits from the State's Temporary Assistance for Needy Families (TANF) Program and are participating in the Earned Income Tax Credit.

**Learn More:** Review the IRS page on **Earned Income Tax Credit**

## **Conclusion to Module Five**

Child welfare workers, addiction treatment counselors, and dependency court judges have shared and distinct responsibilities. Given the distinct and often conflicting timelines imposed on parents, the need for collaboration among workers and counselors is critical. The confidentiality requirements for child welfare workers and addiction treatment providers may also differ. Workers and counselors must learn and adhere to these Federal, State, and agency requirements.

Collaboration ranges from full-system and agency collaborations to worker-counselor collaborations on individual cases. Professionals can take numerous steps to promote all levels of collaboration. This can include establishing an environment conducive to collaboration, developing and analyzing a collaborative values inventory, and taking steps to help parents through the processes.

Workers can help clients by knowing about local resources, helping clients access resources, and helping them understand the requirements mandated by treatment and child welfare. Workers and counselors must seek to share valuable information, engage in case planning with treatment partners, and collaborate as appropriate. Workers should prepare clients for closing a child welfare case, conduct joint case reviews, support the recovery process, and provide support and safety planning.

**Congratulations! You have finished the course. Please take the Knowledge Assessment.**

## Resource Websites

The **Administration for Children and Families** (ACF), within the Department of Health and Human Services (HHS) is responsible for federal programs that promote the economic and social well-being of families, children, individuals and communities. The Administration provides funding to state, territory, local, and tribal organizations to provide family assistance (welfare), child support, child care, Head Start, child welfare, and other programs relating to children and families.

The **Child Welfare Website** provides a gateway to information related to the well-being of children. This site contains an electronic journal called the Child Welfare Review, access to the Children and Youth Services Review print journal, a library with information on a variety of related subjects and links to major journals and research organizations, a section on children and the Internet, and an Oxford University Press series providing serious analysis of child welfare practice, policy, and research.

The **Court Appointed Special Advocate** (CASA) volunteers are everyday people who are appointed by judges and specially trained to advocate for the best interests of abused and neglected children. A CASA volunteer remains with a child until he or she is placed into a safe, permanent, and nurturing home. The National CASA Website provides information about the CASA program and includes a search function to identify local CASA resources.

The **Child Abuse and Neglect Test** contains 25 true-or-false questions that can help you determine how much you know about this important subject. The test comes from the Ohio Department of Human Services, and it is used in their training sessions. At the end of the test is a collection of links, including one to a site that provides a definition of child abuse and neglect.

The **Federal Interagency Forum on Child and Family Statistics** hosts a Website that offers easy access to Federal and State statistics and reports on children and their families, including population and family characteristics, economic security, education, health, and behavior and social environment. Also available on the site are comparisons of children in America to those in other parts of the world and a search engine to help find international, national, and State-level statistics on children's well-being from other Federal or non-Federal sites.

**Head Start** is a comprehensive program designed to foster the healthy development of young children from low-income families. Head Start provides children from low-income families with daily nutritious meals and many opportunities for social, emotional, and intellectual growth that can prepare them for success in school and in life. The program also connects children to a health care source and provides vital support services to their families. The Website provides a wealth of useful information regarding the national program and contact information for local programs.

The **National Institute of Child Health and Human Development** is a subdivision of the National Institutes of Health that conducts and supports research into the reproductive, neurologic, developmental, and behavioral processes that determine and maintain the health of children and adults. The Institute's Website also contains several sources of information on health topics and research findings in child development.

The **National Resource Centers and Clearinghouses of the Children's Bureau**, within the Administration on Children, Youth and Families, the longest standing Federal agency dedicated to children's issues, offers information on numerous topics.

The **National Clearinghouse on Child Abuse and Neglect Information** helps professionals locate information on child abuse and neglect, as well as related issues. A service of the Children's Bureau within the Administration on Children, Youth and Families, the site also offers the Nation's largest database on child maltreatment and related materials; summaries and analyses of State laws on child welfare; online access to publications, fact sheets, and searchable databases; and the Children's Bureau Express, an online digest of news and resources.

The **National Center on Substance Abuse and Child Welfare** is an initiative of the Department of Health and Human Services and jointly funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the Administration on Children, Youth and Families (ACYF), Children's Bureau's Office on Child Abuse and Neglect (OCAN).

NCSACW's goals are to develop and implement a comprehensive program of information gathering and dissemination, provide technical assistance, and develop knowledge that promotes effective practice, organizational, and system changes at the local, state, and national levels.

The NCSACW is implemented by staff from **Children and Family Futures (CFF)** under contract with **CSAT**.

A consortium of organizations has been developed to support the implementation of the NCSACW. The consortium members are national associations and organizations who have been invested in these issues for several years and who represent the various stakeholder populations of the NCSACW. They bring invaluable expertise and resources to the work of the NCSACW and facilitate access to an enormous constituency base for information gathering and dissemination. Consortium member organizations represent families, professionals, national leaders on practice and policy issues in substance abuse, child welfare and family courts, the tribes, and policymakers. Consortium members include:

**American Public Human Services Association (APHSA)** Founded in 1930, APHSA is a nonprofit, bipartisan organization of individuals and agencies concerned with human services. Our members include all state and many territorial human service agencies, more than 1,200 local agencies, and several thousand individuals who work in or otherwise have an interest in human service programs. APHSA educates members of Congress, the media, and the broader public on what is happening in the states around welfare, child welfare, health care reform, and other issues involving families and the elderly.

**Child Welfare League of America (CWLA)** The Child Welfare League of America (CWLA) is the Nation's oldest and largest membership-based child welfare organization. CWLA's mission is to engage people everywhere in promoting the well-being of children, youth, and families and protecting every child from harm. CWLA's almost 1,200 public and private nonprofit member agencies serve 3 million abused and neglected children and their families each year. Agencies look to them for practice standards, cutting-edge

publications, expert training and technical assistance, authoritative data and research, and legislative advocacy. CWLA is the largest publisher of child welfare materials in the world.

**National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD)**

NASADAD is a private, not-for-profit educational, scientific, and informational organization. The Association was originally incorporated in 1971 to serve State Drug Agency Directors, and then in 1978 the membership was expanded to include State Alcoholism Agency Directors. Today, all States have combined State Alcoholism and Drug Agency Directors.

**National Council of Juvenile and Family Court Judges (NCJFCJ)**

Founded in 1937, the NCJFCJ is the oldest national judicial membership organization in the United States. The NCJFCJ's primary purpose is the education and training of state and local judges of juvenile and family jurisdiction and the employees of such courts. There are more than 1,800 dues-paying members, including judges, juvenile law enforcement officers, attorneys, child protective services, and probation personnel. In 1969, the NCJFCJ moved its headquarters to the University of Nevada campus in Reno, Nevada, and established its National College of Juvenile and Family Law.

**National Indian Child Welfare Association (NICWA)**

NICWA is dedicated to the well-being of American Indian children and families. Its vision is that every American Indian child has access to community-based, culturally appropriate services, which help them grow up safe, healthy, and spiritually strong and free from abuse, neglect, sexual exploitation, and the damaging effects of substance abuse. NICWA defines its primary constituencies as tribal governments and urban Indian social service programs that serve Indian children and families. NICWA is the only national Indian organization, either public or private, that is focused on child abuse and neglect issues that impact Indian children and families.

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The **National Data Archive on Child Abuse and Neglect (NDACAN)** is a service of the Children's Bureau, U.S. Department of Health and Human Services. It seeks to facilitate ongoing analysis of research data by making it available on its Website, which also contains: publications, including the NDACAN Update newsletter and an investigator's handbook; information on training institutes and workshops; an email list for child maltreatment researchers; announcements regarding events and research funding; and links to other resources on the Web.

**Parents Anonymous** encourages all parents to ask for help early to effectively break the cycle of abuse. Parents Anonymous groups meet in local community centers, churches, schools, housing projects, shelters, and prisons. Parents Anonymous also operates local 24-hour hotlines. The Website provides contact information for local Parents Anonymous groups.

The **Permanency Planning for Children Department (PPCD)** of the National Council of Juvenile and Family Court Judges was established to support and facilitate dependency court teams and by provide education and technical assistance to enable courts nationwide to meet their goals to improve practice in child abuse and neglect cases. The PPCD established the Child Victims Act Model Courts Project that has grown

to become a nationwide network of 25 Model Courts, pioneering systems changes and court engagement in innovative collaborations in their jurisdictions. Their Website includes useful information about the Child Victims Act Model Courts, a Technical Assistance Bulletin on the Child Victims Act Model Courts Project, and links to the Victims Act Model Court Sites and their respective lead judges.

The **Substance Abuse and Mental Health Services Administration (SAMHSA)** administers and funds a portfolio of grant programs and contracts that support States' efforts to expand and enhance prevention programs and to improve the quality, availability and range of substance abuse treatment and mental health services in local communities. SAMHSA's vision is *A life in the community for everyone*. The vision is based upon the principle that people of all ages with or at risk for mental illnesses or substance abuse disorders should have the opportunity for a fulfilling life that includes a job, a home, and meaningful relationships with family and friends. To make this vision a reality, SAMHSA promotes and supports services which improve outcomes that matter most in people's lives - the ability to hold a job, to have a safe and stable place to live, to complete schooling, and to be an integral part of a community. SAMHSA promotes resilience and recovery - a full life in a supportive community.

The **Welfare Information Network** hosts a Website that includes summaries of Federal welfare legislation, a calendar of welfare-related events, and links to more than 9,000 organizations and publication pages containing program information, policy analysis, legislative information, and best practices. The site also provides links to State agency sites and electronic versions of State TANF plans. A "Hot Topics" page highlights recent publications, planned research, and evaluation activities, as well as discussions of emerging issues.

The **Treatment Improvement Exchange (TIE)** of the Center for Substance Abuse Treatment provides an easy-to-navigate portal to the Center's Treatment Improvement Protocols, Technical Assistance Publications, TIE Communique series, and other online publications. The site also contains a directory of State alcohol and drug abuse agencies, as well as documents on a variety of special topics, including HIV/AIDS, children's health insurance, criminal justice, dual disorders, and healthcare reform.

## Online Publications

*Building Bridges: States Respond to Substance Abuse and Welfare Reform.* National Center on Addiction and Substance Abuse, 1999. Prepared in partnership with the American Public Human Services Association, this 105-page document details findings of a 2-year study of people on the "front lines" in welfare offices, job training programs, substance abuse agencies, and government organizations to find out what works and what doesn't. Of particular interest are five key factors that facilitate or inhibit integrating substance abuse treatment and welfare reform.

Contact <http://www.aphsa.org/Publications/reports.asp> for more information.

*A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice,* U.S. Department of Health and Human Services, 2002. This document provides a philosophical overview of child protection; defines child abuse and neglect in legal and operational terms; discusses the nature, extent, causes, and effects of child maltreatment; describes the Federal, State, and local responsibilities in child protection; and details the roles of the court, community agencies, and professionals in the prevention, identification, and treatment of child abuse and neglect.

Contact <http://nccanch.acf.hhs.gov/pubs/usermanuals/foundation/index.cfm> for more information.

*Promoting Resilience: Helping Young Children and Parents Affected by Substance Abuse, Domestic Violence, and Depression in the Context of Welfare Reform.* Child and Welfare Reform Issue Brief 8. National Center for Children in Poverty, 2000. This short document addresses the needs of children and families affected by welfare reform in which the adults—particularly mothers—experience substance abuse, domestic violence, and serious mental health problems.

Contact [http://www.nccp.org/pub\\_cwr00h.html](http://www.nccp.org/pub_cwr00h.html) for more information.

*Substance Abuse Treatment and the State Children's Health Insurance Program.* TIE Communique Special Issue. Substance Abuse and Mental Health Services Administration, 1999. This 28-page edition of the newsletter produced by the Treatment Improvement Exchange, as "a memo to the field," focuses on issues related to the founding of the Children's Health Insurance Program, including substance abuse and mental health treatment.

Contact <http://www.treatment.org/communique/CHIPtreatment.pdf> for more information.

*Substance Abuse Treatment Responding to Child Abuse and Neglect Issues.* Treatment Improvement Protocol Series 36. Center for Substance Abuse Treatment, 2000. The effects of childhood abuse and neglect perpetrated by family members and the intergenerational transmission of the cycle of abuse are the focus of this 181-page monograph, which concludes with recommendations on screening assessment protocols and issues for counselors.

Contact <http://www.treatment.org> for information.

*Welfare Reform and Substance Abuse Treatment Confidentiality: General Guidance for Reconciling Need to Know and Privacy.* Technical Assistance Publication Series 24. Center for Substance Abuse Treatment, 1999. This 66-page document provides assistance in resolving issues related to the confidentiality of patient/client information that are faced by workers in alcohol and other drug agencies, substance abuse treatment providers, and welfare officials.

Contact <http://www.treatment.org/taps/Tap24.pdf> for information.

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## Glossary

The following is a glossary of definitions for key terms and concepts used in this course.

**Adjudication hearing**—in child welfare proceedings, the trial stage at which the court determines whether allegations of abuse or neglect concerning a child are sustained by the evidence and, if so, are legally sufficient to support state intervention on behalf of the child; provides the basis for state intervention into a family, as opposed to the disposition hearing, which concerns the nature of such intervention; in some states, adjudication hearings are referred to as "jurisdictional" or "fact-finding" hearings.

**Adoption and Safe Families Act of 1997 (P.L. 105-96)**—on November 19, 1997, the President signed into law the Adoption and Safe Families Act of 1997 (ASFA), which amended Titles VI-B and IV-E of the Social Security Act to clarify certain provisions of P.L. 96-272. ASFA made changes in a wide range of policies established under the Adoption Assistance and Child Welfare Act to improve the safety of children, to promote adoption and other permanent homes for children, and to support families.

**Assessment in child welfare**—broadly refers to gathering information that affects a child's immediate safety, potential risk of future harm, and a family's level of functioning and well-being based on their strengths and needs. These include safety, risk, and family assessment.

**Biopsychosocial**—describes an approach or model that takes into account the biological, psychological, and social factors or perspectives, in this case, related to substance use disorders. A biopsychosocial perspective on addiction results in promoting the integration of different perspectives on the illness; explaining and preserving some common clinical dimensions; necessitating multidimensional assessment; and promoting effective matching of the client with individually prescribed treatment.

**Behavioral therapies**—are psychotherapy that aims to stop or reduce a problem behavior, in this course, substance use disorders. There are various types of behavioral therapies, including behavior modification, psychotherapy, assertiveness training, and aversion therapy, to name a few.

**Case plan**—an individualized plan of action with measurable goals and outcomes developed by a family and child welfare services worker to ameliorate risk to children and ensure their safety, permanency, and well-being.

**Child abuse**—to hurt or injure a child by maltreatment. As defined by statutes in the majority of states, the term is generally limited to maltreatment that causes or threatens to cause lasting harm to a child.

**Child neglect**—to fail to give proper attention to a child; to deprive a child; to allow a lapse in care and supervision that causes or threatens to cause lasting harm to a child; to fail to perform or discharge a duty to a child, such as medical neglect or educational neglect.

**Child protective services (CPS)**—the division within child welfare services that is responsible for maintaining a child abuse and neglect referral system and for determining whether a child is in need of protection.

**Child welfare services (CWS)**—includes the broad continuum of programs and strategies designed to protect children from child abuse and neglect and to strengthen families.

**Child welfare services staff (CWS staff)**—social workers and other personnel with specialized knowledge and skills that provide services to prevent and intervene with families at risk of and involved with child abuse and neglect.

**Dependency cases**—cases that go before a juvenile court in which allegations of child abuse or neglect are heard. The specific definition of a dependency case and a dependent child varies by State statute.

**Dependent child**—a person under the age of 18 who is subject to the jurisdiction of the court because of child abuse, or neglect, or lack of proper care.

**Diagnosis of a substance use disorder**—using criteria established by the American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision to determine if a person is classified as a substance user, substance abuser, or is substance dependent.

**Disposition hearing**—the stage of the juvenile court process in which, after finding that a child is within jurisdiction of the court, the court determines who shall have custody and control of a child; elicits judicial decision as to whether to continue out-of-home placement or to remove a child from home; service plans, treatment plans, and conditions of placement are discussed and determined.

**Family assessment**—evaluates how well a family is functioning in several domains that affect child and family well-being, including needs and strengths of the family.

**Identification of a child who is potentially a victim of abuse and/or neglect**—an awareness of behaviors, signs, or symptoms indicating that there is reasonable suspicion that a child has been the victim of abuse and/or neglect. Some health, social service and education professionals are required by law to report such suspicions to child protective services.

**Identification of a person with a potential substance use disorder**—observations or knowledge that a person's substance use is associated with adverse consequences in areas of life functioning, including interpersonal relationships, family responsibilities, employment, criminality, and/or emotional well-being.

**Intake**—refers to the step that follows referral in which a person is admitted to a treatment program, a type of "in-processing", in which a person formally enters treatment for a substance use disorder.

**Minimum sufficient level of care**—A "minimum sufficient level of care" is the point below which a home is considered inadequate for the care of a particular child. It is a practice value and decision-making guide that helps workers and judges ensure that

children are safe but also not removed from their families unnecessarily. This practice value is reinforced by Federal policy that requires the safety and well-being of children be protected under ASFA.

**Permanency planning hearing**—a special type of post-dispositional proceeding designed to reach a decision concerning the permanent placement of a child. ASFA established a permanency planning hearing within 12 months of a child's placement, rather than within 18 months as in current law. At the hearing there must be a determination whether and when a child will be returned home, placed for adoption and a termination of parental rights petition filed or referred for legal guardianship, or, when other options are not appropriate, another planned permanent living arrangement made. For children for whom a court determines reasonable efforts to reunify are not required, a permanency planning hearing must be held within 30 days of such determination.

**Pharmacotherapies**—are medications intended to ameliorate or abate the effects of a particular illness or health behavior, in this case, substance use disorders. Pharmacotherapies may be used on a short-term basis to manage intoxication, overdose, or withdrawal, or on a long-term basis to manage the addiction itself and maintain sobriety, such as with bupropion SR, nicotine gum/inhaler/spray/patch for smoking cessation, and methadone maintenance to achieve and maintain recovery from heroin addiction.

**Preliminary protective hearing**—the first court hearing in a juvenile abuse or neglect case, referred to in some jurisdictions as a "shelter care hearing," "detention hearing," "emergency removal hearing," or "temporary custody hearing," occurs either immediately before or immediately after the child is removed from home on an emergency basis; may be preceded by an ex parte order directing placement of the child; and in extreme emergency cases may constitute the first judicial review of a child placed without prior court approval.

**Reasonable efforts**—the reasonable efforts requirement of the Federal law is designed to ensure that families are provided with services to prevent their disruption and to respond to the problems of unnecessary disruption of families and foster care drift. Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980, required that "reasonable efforts" be made to prevent or eliminate the need for removal of a dependent, neglected, or abused child from the child's home and to reunify the family if the child is removed. To enforce this provision, the juvenile court must determine, in each case where Federal reimbursement is sought, whether the agency has made the required reasonable efforts. (42 U.S.C. 671(a)(15), 672(a)(1).)

ASFA expanded reasonable efforts provisions by requiring that when a court determines that reasonable efforts to reunify are not required, a permanency planning hearing must be held within 30 days of such determination. Reasonable efforts also must be made to place the child in a timely manner in accordance with the permanency plan and to complete whatever steps are necessary to finalize the plan.

**Recovery**—describes the process by which a person becomes aware of the substance use as a problem and initiates and maintains a substance-free life and, as a part of that process, generally achieves a stronger sense of balance and control of his or her life. Recovery is a life-long process that takes place over time and often in specific stages. In addition to abstinence from substance use, recovery includes a full return to

biopsychosocial functioning (HHS/SAMHSA, 1996). The Developmental Model of Recovery includes six steps: Transition; Stabilization; Early Recovery; Middle Recovery; Late Recovery; and Maintenance.

**Review hearing**—court proceedings that take place after disposition in which the court comprehensively reviews the status of a case, examines progress made by the parties since the conclusion of the disposition hearing, provides for correction and revision of the case plan, and makes sure that cases progress and children spend as short a time as possible in temporary placement.

**Referral**—describes the step that follows screening in which a person receives instructions to seek treatment for a substance use disorder.

**Relapse**—is not an isolated event, but rather a process in which an individual becomes dysfunctional or unable to cope with life in sobriety, and thus can no longer avoid using a substance. This process may lead to renewed alcohol or drug use, physical or emotional collapse, or even suicide. Predictable and identifiable warning signs, such as physical, psychological, or social distress, and seeking out social situations involving substance-using people, often begin long before the relapse occurs (HHS, 1999).

**Risk assessment**—evaluates potential future threats to the life or well-being of a child in the context of existing protective factors.

**Safety assessment**—evaluates immediate threats to the life or well-being of a child.

**Screening for substance use disorders**—a set of routinely administered observations and questions leading to a determination that a person has a potential substance use disorder. Screening is conducted by child welfare service staff as well as community-based providers, hospital staff, other health or social services agency staff, or may be a specialized service conducted by an alcohol or drug counselor.

**Screening for child abuse and/or neglect**—observations and questions leading to a determination that a child may have been the victim of abuse and/or neglect. These observations or questions are centered on issues of physical or sexual abuse, deprivation and neglect of basic needs or child's well-being.

**Substance abuse**—a pattern of substance use that results in at least one of four consequences: (1) failure to fulfill role obligations; (2) use placing one in danger (e.g., driving under the influence); (3) legal consequences; or (4) interpersonal or social problems.

**Substance abuse treatment (also treatment)**—includes the broad continuum of programs and strategies designed to prevent and treat substance abuse and dependence and ameliorate adverse consequences associated with substance use.

**Substance abuse treatment professional (also counselor, provider)**—refers to counselors and other personnel with specialized knowledge and skills to provide services that prevent, intervene, and treat substance use disorders.

**Substance dependence**—a pattern of use resulting in at least three of seven dependence criteria as specified in the DSM IV/TR: (1) tolerance; (2) withdrawal; (3)

unplanned use; (4) persistent desire or failure to reduce use; (5) spending a great deal of time using; (6) sacrificing activities to use; or (7) physical or psychological problems related to use. In this course, the term dependence is used interchangeably with addiction.

**Substance use**—the consumption of legal and/or illegal psychoactive substances.

**Substance use disorders (SUDs)**—include the spectrums of substance abuse and dependence as defined by the diagnostic criteria of the American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV/DSM-IV-TR).

**Termination of parental rights (TPR) hearing**—a hearing or trial in which severance of all legal ties between child and parents is sought, and in which the burden of proof must be by clear and convincing evidence; also referred to in some states as a "severance," "guardianship with the power to consent to adoption," "permanent commitment," "permanent neglect," or "modification" hearing. ASFA requires that a termination of parental rights petition must be filed, except in certain cases, when a child of any age is under the responsibility of the state for 15 months out of the most recent 22 months. (The clock starts to run on the date of the first judicial finding of abuse or neglect or 60 days after the child is removed from the home, whichever is earlier.) ASFA also requires that a termination petition be filed when a court has determined a child to be an abandoned infant, or in cases where a parent has committed murder or voluntary manslaughter of another child of the parent or a felony assault that has resulted in serious bodily injury to the child or another child. ASFA lists some exceptions that can be made to these requirements.

**Treatment plan**—an individualized plan of action with measurable goals and outcomes developed by a client and substance abuse specialist to reduce substance use and related adverse consequences.

**Withdrawal**—refers to the voluntary (through seeking treatment) or involuntary (through not being able to obtain the substance) absence of substance use after a tolerance has been established through prolonged and/or heavy use. When an individual is described as "going through withdrawal," she or he may exhibit mild, moderate, or severe physical and psychological symptoms depending on the level of previous use, the substance used, and the person's condition.

**Withdrawal symptoms**—refer to the physical and psychological effects of withdrawal. Mild to moderate psychological symptoms include the feeling of jumpiness or nervousness; feeling of shakiness; anxiety; irritability or excitability; emotional volatility; depression; fatigue; difficulty thinking clearly; and bad dreams. Mild to moderate physical symptoms include headache; sweating (especially palms and face); nausea; vomiting; loss of appetite; insomnia and sleep difficulties; paleness; rapid heart rate; enlarged pupils; clammy skin; hand tremors or eyelid twitching. Severe symptoms include a state of confusion and visual hallucinations called delirium tremens; agitation; fever; convulsions; and blackouts.

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