

Appendix C

Understanding the Needs of Children in Families Involved in the Child Welfare System Who Are Affected by Substance Use Disorders

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Introduction and Purpose

The impact of parental alcohol and drug use and abuse on children creates complex and sometimes controversial issues. Research on the effects of prenatal and postnatal exposure to alcohol, tobacco, and other drugs has produced limited and conflicting results. A key challenge to this research has been determining the impact of prenatal exposure versus postnatal environmental risks, as well as differentiating the effects of specific substances and specific doses of substances. Despite these challenges, there is substantial evidence that children who are prenatally substance exposed or experience postnatal environments impacted by parental substance use disorders (SUDs) are at risk for poor developmental outcomes. (The term “substance use disorders (SUDs) is more precise and indicates diagnostic criteria of the *Diagnostic and Statistical Manual (DSM)* of substance abuse or dependency.) In addition, increases in the number of children in out-of-home care throughout the late 1980s and 1990s have been attributed to increased drug use among pregnant women (Lester, Andreozzi, & Appiah, 2004).

This appendix highlights how parental substance use disorders can affect children both prenatally and postnatally, how to improve screening of children by raising awareness of signs to look for in children, and provides information about potential referral sources for assessments and services.

Most studies have estimated that 10% to 20% of children who were prenatally exposed to alcohol and/or drugs enter the child welfare system around the time of birth and about one-third of them enter out-of-home care within the first few years (U.S. Department of Health and Human Services [DHHS], 1999). These children are more likely to have mothers who have had previous involvement with the child welfare service system and to have siblings in foster care (McNichol, 1999). In addition, once in foster care, children from families with substance use disorders are more likely to remain there than are maltreated children from families without those disorders (DHHS, 1999). Inconsistent parenting and a chaotic family life can be a primary effect of substance use disorders, which result in children lacking safe, predictable home environments.

Importance of Federal Legislation

Major pieces of legislation highlight the importance of timely screening and intervention with children whose parents have substance use disorders, as well as the importance of communicating the needs of children across service systems.

There are several provisions in the Adoption and Safe Families Act (ASFA) of 1997 regarding the timing of case processing. Two provisions that have potential impact on families with substance use disorders are (1) that child welfare agencies develop a permanency plan within 12 months after a child enters foster care, and (2) that States initiate proceedings to terminate parental rights if the child has been in out-of-home care for 15 of the most recent 22 months. Although 12 or 15 months is a long time in the life of a child, it is a relatively short time in the recovery process of a parent who is emerging from a history of years, or even decades, of alcohol and/or drug abuse. Without intervention, the child’s unaddressed needs may impede a parent’s recovery or interfere with the timely resolution of the child’s permanent plan. In addition to the time limits on reunification under ASFA, the Federal legislation’s “fast track” provision gives States the option of bypassing efforts to reunify families in certain egregious situations. Depending on how a State views parental substance use disorders, there is the possibility that they will

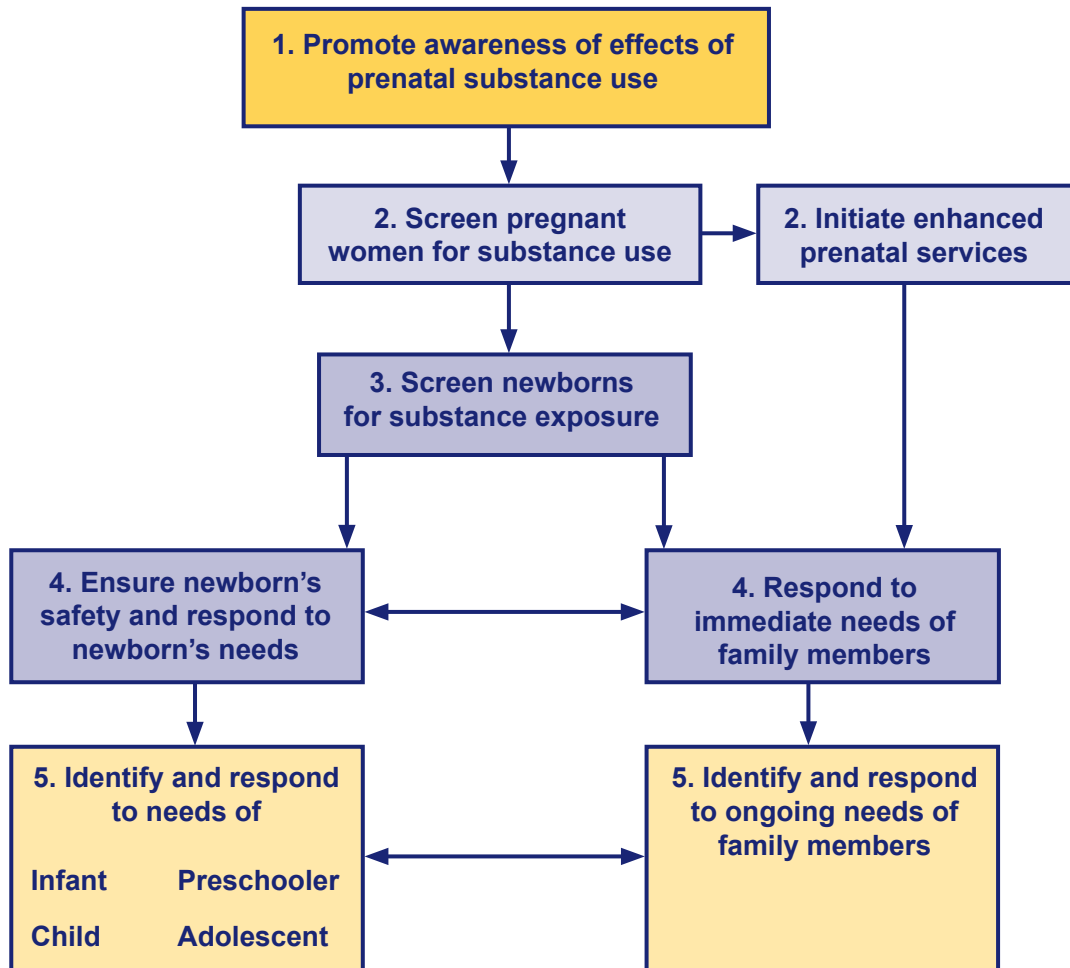
fast track termination of parental rights for these families, particularly those in which an infant has been prenatally exposed to illicit drugs.

Another recent legislative change with implications for screening and assessment of children is the Child Abuse Prevention and Treatment Act (CAPTA), as reauthorized in the Keeping Children and Families Safe Act of 2003. CAPTA amendments include new requirements for responding to the identification of infants known to be prenatally exposed to drugs. States must assure through a certification that they are operating a statewide program relating to child abuse and neglect, or have in effect a State law, which includes policies and procedures for appropriate referrals to child protection service systems. The State law also includes policies and procedures for other appropriate services that address the needs of infants born and identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure. This law further includes a requirement that health care providers involved in the delivery or care of such infants notify the child protective service system. CAPTA amendments state that such notification shall not be construed to establish a definition under Federal law of what constitutes child abuse, or require prosecution for any illegal action. However, they require the development of a plan of safe care for the infant. Even though screening of infants is generally conducted by hospital personnel, child welfare agencies will require access to effective screening and assessment information so that the plan of care can be developed and implemented.

Multiple Opportunities for Interventions

Figure 1 (below) illustrates the intervention points for services and supports needed by children and their families: (1) pre-prenatal (i.e., health and conditions of parents prior to pregnancy); (2) prenatal; (3) the birth event itself; (4) the perinatal period of newborns; and (5) infancy, preschool, middle childhood, and adolescence. At each of these intervention points, there is an opportunity to intervene to achieve a healthy birth, progress in child development, and parents' recovery. If the opportunity is missed at one stage—for example, if prenatal care does not result in a non-substance-exposed birth—the challenge is to seek another opportunity at the next stage.

Figure 1: Policy and Practice Intervention Points for Children and Families



This context of *sequences of multiple opportunities* highlights the critical importance of prenatal services, but the fact is that most prenatally exposed infants' exposure is not detected and the great majority of these infants go home with their birth mothers. This reality underscores the importance of ongoing screening, as well as effective links among the several agencies involved in prenatal and pediatric care and their connections to interventions for parents. Effective screening practices and communication among multiple agencies, as noted in all the sections of the SAFERR guidebook, are the key to success with children's services as well.

Of equal importance, however, is the difficulty of separating out substance abuse effects from the many other effects of poverty, parental mental illness, violence and trauma, and other co-occurring issues in

the family. Intervention must be aimed at the right problem, and sometimes, when multiple issues need to be addressed, a single-focused program approach can become part of the problem itself, by ignoring critical facets of the child’s and family’s reality.

Prenatal Substance Exposure: Extent of the Problem

The latest Federal data available from the National Survey on Drug Use and Health (NSDUH) report on 2003 to 2004 annual averages of substance use by pregnant women. As summarized in Table 1, the NSDUH found that 4.6% of pregnant women aged 15 to 44 used illicit drugs in the past month. Rates varied by length of gestation, however, with 8% of first trimester women, 3.8% of second trimester women, and 2.4% of third trimester women reporting past month illicit drug use.

Alcohol use was reported by 11.2% of pregnant women, with 22.2% of women in their first trimester reporting alcohol use and the rates then declining to 7% and 4.9% in the second and third trimesters, respectively. Binge drinking, five or more drinks on the same occasion, was reported by 4.5% of pregnant women. Again, rates varied by length of gestation, with 10.6% of first trimester women, 1.9% of second trimester women, and 1.1% of third trimester women reporting binge drinking (Substance Abuse and Mental Health Services Administration [SAMHSA], 2005).

Projecting these percentages to the approximately 4 million infants born each year results in a wide range of estimated substance-exposed infants depending on substance and trimester of use.

Table 1: Substance Use by Pregnant Women by Length of Gestation, and Estimated Number of Infants Exposed (2003-2004 annual average)			
<i>Substance Used (past month)</i>	<i>1st Trimester</i>	<i>2nd Trimester</i>	<i>3rd Trimester</i>
Any Illicit Drug	8.0% women 327,440 infants	3.8% women 155,534 infants	2.4% women 98,232 infants
Alcohol Use	22.2% women 908,646 infants	7.0% women 286,510 infants	4.9% women 200,557 infants
Binge Alcohol Use	10.6% women 433,858 infants	1.9% women 77,767 infants	1.1% women 45,023 infants

From the same NSDUH data set, cigarette use was reported by 18% of pregnant women. In contrast to other substance use, which declines as the pregnancy progresses, cigarette use by trimester went from 22.7% in the first trimester, down to 13.4% in the second trimester, and then increased to 18% in the third trimester (SAMHSA, 2005). Prior studies based on this annual survey have found similar rates of substance use. For example, Ebrahim and Gfroerer (2003) estimated that in 1998 there were 202,000 pregnancies exposed to illicit drugs, 1,203,000 pregnancies exposed to cigarettes, and 823,000 pregnancies exposed to alcohol; the study used data from the 2000 National Household Survey on Drug Abuse.

Rates of substance use among pregnant women also varied by age groups, with past month illicit drug and alcohol use highest among teenagers. For instance, 16% of pregnant teens aged 15 to 17 reported past month illicit drug use, compared to 7.8% of those aged 18 to 25 and 2.1% of pregnant women aged

26 to 44. The trend was similar for alcohol use, though the differences were not quite as stark: 14.9% of pregnant teens aged 15 to 17 drank alcohol in the past month, compared to 10.6% of young women aged 18 to 25 and 11.3% of those aged 26 to 44. And more than one-fourth (26%) of pregnant teens aged 15 to 17 and 28% of young women aged 18 to 25 reported past month cigarette use, compared to 11.7% of pregnant women aged 26 to 44 (SAMHSA, 2005).

It is important to note that these estimates of alcohol and drug use during pregnancy and the number of substance-exposed infants are likely lower than what actually occurs, due to individuals underreporting substance use and limited screening and testing done by physicians and hospitals. In one large-scale study of newborns in a high-risk urban obstetric population, 44% tested positive for illegal drugs, while only 11% of mothers admitted to illegal drug use (Ostrea, Brady, Gause, Raymundo, & Stevens, 1992).

A study assessing the long-term effects of methamphetamine exposure on children recently published estimates on the prevalence of use by pregnant women. The sites included in the study are Des Moines, Honolulu, Los Angeles, and Tulsa. These cities are known to have higher rates of methamphetamine use; thus, the results are not representative of the country as a whole. Researchers used mothers' self-report or drug testing of the infant's meconium to ascertain the prevalence of substance exposure. They found that 25% of pregnant women smoked tobacco, 22.8% drank alcohol, 10% had used any illicit drug with 6% using marijuana, 5.2% used methamphetamine, and 1.3% used barbiturates (Arria et al., 2006).

Prenatal alcohol exposure can lead to changes in brain structure and have long-term consequences for the children as well as societal costs (Riley & McGee, 2005). It has been estimated that between 2,000 and 8,000 babies are born with Fetal Alcohol Syndrome (FAS) (0.2 to 2.0 per 1,000 live births) (May & Gossage, 2001). The estimate of Fetal Alcohol Spectrum Disorders is 1% of live births or approximately 40,000 babies each year (Sampson et al., 1997). The financial cost of substance use during pregnancy, attributed primarily to extended hospital stays, has been estimated at between \$22.3 million and \$125 million per year (James Bell Associates, 1993). The cost of medical care, special education, and residential care for persons with mental retardation has been estimated at \$1.6 million for each person with FAS (Lupton, Burd, & Harwood, 2004).

Screening for Use During Pregnancy (prenatal or at birth)

In an ideal situation, screening for prenatal substance exposure would happen well before birth through high-quality prenatal care, so that the use of alcohol, tobacco, and/or drugs is treated and the impact to the unborn child reduced. It has been noted that if alcohol use is detected and treated, and use stopped by the third trimester, the rate of fetal alcohol syndrome can be reduced (Little, Young, Streissguth, & Uhl, 1984). Similarly, if a pregnant woman using cocaine is able to stop her drug use, the medical complications commonly seen with prenatal cocaine exposure such as premature birth are significantly reduced (Chasnoff, Griffith, MacGregor, Dirkes, & Burns, 1989). However, the identification of use and abuse of alcohol and/or drugs by pregnant women is one of the most often missed diagnoses in prenatal care (Chasnoff, Neuman, Thornton, & Callaghan, 2001). Many factors contribute to the infrequency of detection of use and abuse during pregnancy including a physician's lack of knowledge about substance abuse and addiction or how to respond if use and/or abuse is detected; misconceptions about the liability surrounding treating pregnant women with substance use disorders; and bias in testing and a physician's personal beliefs about whether or not the patient is likely to be using or abusing substances (Chasnoff et al., 2001; Lester et al., 2004).

In addition to the physician-focused factors that reduce the likelihood of detecting substance use and/or abuse among pregnant women is the fact that many pregnant women who use drugs receive little or no

prenatal care. One key reason for this lack of prenatal care is fear on the part of the pregnant woman of punitive action and/or the possible loss of custody of the child as a result of her drug use (Lester et al., 2004). Because quality prenatal care is such a critical factor in increasing the likelihood of good birth outcomes, everything possible should be done to ensure that the physician's office is seen as a safe and supportive resource to all pregnant women.

Because of barriers regarding the identification of substance use and abuse during pregnancy, many instances of prenatal substance exposure are left undetected until birth, and whether or not it is even detected at that point is dependent on many other factors including hospital policies, medical staff bias, and methods of screening. Screening at birth can be implemented through either a universal (everyone is tested at birth) or targeted (selective testing as determined by risk factors selected by the institution) approach. Each approach has its limitations, including the possibility that a hospital using universal testing could deter use of that hospital by mothers giving birth to infants who have been substance exposed, and the significant bias possible in deciding who is screened under a targeted approach (Ondersma, Simpson, Brestan, & Ward, 2000; Lester et al., 2004).

This discussion leads to a final note about the context of screening during pregnancy: these data, combined with what is known about hospital screening practices, make clear that the great majority of children who are prenatally exposed to alcohol, tobacco, or other drugs go home with their birth parents with these effects totally undetected. One analysis suggests that as many as 95% of all prenatally exposed children—children whose mother used alcohol, tobacco, or other drugs at some point during her pregnancy—are not detected by screening methods at birth (Gardner & Otero, 2004). The screening methods discussed below include tools that can be used prenatally or at the time of birth or shortly thereafter.

Commonly Used Screening Tools

As discussed in Section III of this guidebook, “Collaborative Practice at the Frontline,” the issues specific to screening for substance use during pregnancy are most often germane to prenatal care staff and physicians. However, child welfare agencies may be involved if there are older children in the family, and substance abuse treatment agencies may be involved with the family if the mother has entered treatment.

Prenatal substance exposure can be screened for in a variety of ways. Most commonly, the methods used, either alone or in combination, include:

- Verbal screen with mother;
- Review of mother's history and medical records;
- Observation of mother and/or newborn; and
- Drug testing (urine, blood, hair, or meconium).

Verbal Screens

Screening techniques that include questions about quantity, frequency, and heavy episodic drinking, as well as behavioral consequences of drinking, have proven to be most beneficial; simple questionnaires have been developed to screen for problematic alcohol use among adults in multiple populations and settings (see Section III for additional information on specific screening tools for prenatal care settings) (Cherpitel, 2002). It is suggested that primary care physicians and obstetricians incorporate basic

questions about substance use into the larger context of prenatal health evaluations and refer women for complete alcohol and drug assessments if yes is the answer to any of the questions (Morse, Gehshan, & Hutchins, 1997; Chasnoff et al., 2001). The summary of these and other tools, including information on the tools' features, strengths, and concerns, can be accessed at <http://www.nofas.org/healthcare/screen.aspx>.

Review of History/Medical Records and Observation

A review of the mother's history and medical records may reveal a previous substance-exposed birth or other potential risk factors including a history of substance abuse or dependence. The observation of the mother and infant by a trained professional may reveal signs of substance exposure such as indications of substance use disorder in the mother (e.g., the smell of alcohol, withdrawal symptoms, and needle punctures), or tremors or irritability in the newborn (more signs of exposure in infants are detailed below).

Drug Testing

Urinalysis testing at birth has traditionally been the most common technique for identifying prenatal substance exposure (Lester et al., 2004; Ondersma et al., 2000). However, this method of testing is limited, since the detection of substances in urine is only possible for a few days after use. Such a test does not provide information about use throughout pregnancy if a mother has stopped use as the birth of her child draws closer.

Because of the limitations of urinalysis, scientists have been working to find more effective testing methods. Both meconium (the first stool eliminated by the newborn) and hair analysis have shown promising results for detecting substance use over a broader window of time (Lester et al., 2004; Chan, Caprara, Blanchette, Klein, & Koren, 2004; Ondersma et al., 2000). Meconium analysis is seen as superior to traditionally used biological matrixes such as blood and urine because it is a discarded material for which collection is easy and noninvasive. In addition, meconium is a cumulative matrix in which substances accumulate from the 13th week of gestation through birth, allowing for a much greater window of opportunity for detection (Chan et al., 2004). Hair begins to develop in a newborn at approximately 6 months' gestation, with substances accumulating in the hair shaft and remaining there until the hair is cut, thus allowing for the possible detection of substances used during the last 3 months of pregnancy (Chan et al.).

Postnatal Alcohol/Drug Environment

Children from families with substance use disorders not only face the risk of prenatal substance exposure, but can also be exposed to a harmful postnatal environment. Approximately 11% of children in the United States (8.3 million) live with at least one parent who is an alcoholic or in need of treatment for the abuse of illicit drugs. An estimated 2.3 million of these children live with a parent who abuses both alcohol and illicit drugs (DHHS, 1999). Postnatal risk factors associated with parental substance use disorders include a parent who may still be involved in a chaotic lifestyle of drug- and/or alcohol-seeking behavior, such as illicit drug sales or drug manufacturing, and a lack of adult interpersonal support systems. Postnatal drug use by parents may expose children to violent or traumatic events, the effects of living in poverty, lack of parental education, lack of proper health care, and inconsistent caregivers.

The growing body of literature on the effects of childhood trauma underscores the continuing effects of this overlapping problem as it is affected by parents' substance abuse. Recent work conducted by treatment centers that are part of the National Child Traumatic Stress Network has documented how child development can be affected by childhood trauma (Schnoll & Wilford, 1997). Parental mental illness is another important postnatal risk factor, because maternal depression is associated with serious cognitive and social-emotional outcomes for children (Karr-Morse, Brazelton, & Wiley, 1997).

When a postnatal environment becomes so severe that a child must be removed from the family for abuse or neglect, the child may also be subjected to various risk factors associated with multiple out-of-home placements and inconsistent caregiving environments. Children placed in foster care who have been prenatally exposed to alcohol and/or drugs often place higher demands on caregivers, resulting in foster parent burnout and a higher rate of returning those children to the child welfare system (Burry, 1999). These children face difficulty in forming meaningful attachments with a primary caregiver. The lack of development of secure attachment early on is shown to result in subsequent behavioral problems for children (Kronstadt, 1991). It should also be noted that a substantial number of children who are removed from parents with substance use disorders remain within their own family environments, with some of these children placed with relatives who are part of the overall family system affected by alcohol, drugs, and co-occurring problems.

A Note on Issues Related to Methamphetamine Production

In looking at the postnatal environment, special consideration must be given to the issues related to manufacturing, distribution, and trafficking of methamphetamine. Methamphetamine is relatively inexpensive and easy to make, and children may be exposed to dangers of home-based labs, including the risks of lab-related explosions and fires, exposure or ingestion of the toxic chemicals and waste products associated with methamphetamine production, and exposure to the highly psychoactive stimulant itself. The developing brain and other organ systems of children are more susceptible than adults to the damages caused by the chemicals and drugs resulting in neurological and developmental problems (Drug Endangered Children Resource Center, 2000).

Prenatal Substance Exposure and Postnatal Environment Factors: Consequences for Children

To understand the forces influencing the futures of children exposed to alcohol and drugs, it is necessary to assess many different factors that affect their lives. The consequences of alcohol and drug use are the products of a complex interchange of biological, psychological, and sociological events. The complexity of screening and assessment for these children is compounded by two realities: (1) there is no absolute profile of developmental outcomes based on a child's exposure to parents' substance use, abuse, or dependence (Chasnoff, 1997); and (2) other problems arising in parental behavior, competence, and disorders interact with substance use, abuse, and dependence to cause multiple co-occurring problems in the lives of these children.

Although prenatal substance exposure has been noted to be "...the single largest preventable cause of developmental compromise of American Children today (Malanga & Kosofsky, 2003)," research is both complex and tentative on the short- and long-term effects of prenatal exposure on children. In addition to the lack of consensus of the short- and long-term impacts of parental substance use disorders on children, it is difficult to determine the independent effects of a single substance on brain development, or the effects of prenatal exposure weighed against the child's postnatal environment (Malanga & Kosofsky, 2003; Chiriboga, 2003; Lester et al., 2004; Kronstadt, 1991; Mathis, 1998). These difficulties

arise because substance use during pregnancy is most commonly polydrug use (more than one substance), with illegal substance use being combined with the use of alcohol and/or cigarettes, and is often accompanied by a lack of proper nutrition, other medical complications, and no prenatal care.

At the same time, postnatal environmental risk factors, such as inadequate parenting skills and support, violence, living in poverty, and parental mental illness, have been shown to result in or exacerbate developmental and behavioral problems in children (Carta et al., 2001; Ondersma et al., 2000; Kronstadt, 1991). In the same way that environmental factors can negatively impact the development of a child, longitudinal research on the developmental effects of prenatally exposed children suggests that a stable, nurturing postnatal environment can ameliorate many of the negative effects of prenatal exposure (McGourty & Chasnoff, 2003).

Lester and his colleagues describe three types of consequences of maternal use of alcohol, tobacco, and illegal drugs (MATID) on child development:

- *Immediate drug effects*—the direct teratogenic consequences, or those that can cause birth defects, of MATID exposure occurring during the first year prior to postnatal environmental effects becoming salient;
- *Latent drug effects*—also direct teratogenic effects that affect brain functioning but do not become relevant until later in development; and
- *Postnatal environment effects*—environmental factors such as sociodemographics, caregiving context (such as mother’s stress or neighborhood safety) and style, and caregiver characteristics (both risk and protective factors) (Lester et al., 2004).

Although it may be hard to separate the effects of prenatal substance exposure and a child’s postnatal environment, children whose parents have substance use disorders are at an increased risk for disabilities and have a higher incidence of demonstrable disabilities, as well as involvement with the child welfare service system (Lagasse & Lester, 2000; National Center on Addiction and Substance Abuse, 1999; Byrd, Neistadt, Howard, & Brownstein-Evans, 1999; DHHS, 1999). Below is a discussion of commonly noted consequences of parental substance use disorders on children, designed to inform alcohol and drug, child welfare, and court professionals.

Fetal Alcohol Syndrome (FAS)

In contrast to the mixed results in research on prenatal exposure to illicit drugs, alcohol use during pregnancy has shown to have clear and demonstrable impacts on the child. FAS is one of the most widely recorded problems associated with alcohol use during pregnancy (Lester et al., 2004). Individuals with FAS exhibit a pattern of neurological, behavioral, and cognitive deficits that affect growth, learning, and socialization and consist of the following 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 (SAMHSA Fetal Alcohol Spectrum Disorders Center of Excellence, 2004, February).

The behavioral and cognitive impacts associated with FAS can include the following:

- *Global functioning*—global limitations on learning and problem solving and lower IQ;
- *Executive functioning*—the way information is organized and activities planned, for example, remembering all the steps required for a specific task or the order of those steps;
- *Auditory processing*—inability to effectively understand a sequence of sounds, affecting the understanding of language and remembering instructions and simple problems;
- *Visual/spatial skills*—disabilities in the perception of visual information and understanding spatial relationships, affecting fine and gross motor skills and handwriting;
- *Specific math disability*—difficulty learning arithmetic and other math concepts;
- *Memory*—difficulty learning new information and retrieving stored information; and
- *Attention*—different from the effects of attention deficit hyperactivity disorder, there may be a difficulty learning new information being focused on and in shifting attention to another task, or multitasking (Streissguth, Barr, Kogan, & Bookstein, 1996).

While an estimated 0.5 to 3 cases per 1,000 births per year (2,000 to 12,000 births) result in a child with FAS (May & Gossage, 2001), not all individuals exposed to alcohol in utero are later diagnosed with FAS. However, nearly 40,000 babies are born per year within the broader category of Fetal Alcohol Spectrum Disorders (FASD). The term “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 the following conditions: FAS, alcohol-related birth defects, and alcohol-related neurodevelopmental disorder (ARND). Alcohol-related birth defects can include abnormalities of the heart, eyes, ears, kidneys, and skeleton (e.g., holes in the heart, underdeveloped kidneys, and fused bones) (SAMHSA Fetal Alcohol Spectrum Disorders Center of Excellence, 2006, January). Because many of the deficiencies seen in individuals with ARND are similar to those seen as a result of exposure to other substances, they will not be detailed here but are included in the discussion in the following section.

ARND and Other Effects of Parental Substance Use Disorders

Child development occurs along a continuum including prenatal/birth/newborn (0 to 1), toddler/preschool (2 to 5), middle childhood (6 to 12), and adolescent (13 to 18). Each of these developmental phases brings specific tasks and challenges to the developing child. For example, brain development occurs at the fastest rate throughout the prenatal and toddler stages. Critical social-emotional developmental tasks occur in infancy as a child bonds with caregivers and develops secure attachments. The preschool child has unique challenges to acquire language and cognitive skills and to develop autonomy and prosocial behaviors, while physical and motor skills are advancing. Middle childhood brings increased physical challenges and cognitive maturation. A major transition in this phase occurs as children adapt to the educational environment and new peer influences in their widening social circle. In adolescence, youth develop cognitive skills that advance their moral development and ability to reason while seeking independence and identity, but youth lack full executive function control of impulsivity. As a result, this time increasingly becomes one of exploration, risk taking, and sexual experimentation.

When the impacts of parental substance use disorders on children are observed or assessed, it is important to take note of the chronological age of the child and the child’s expected corresponding stage of development. Screening and assessment protocols must be geared to the specific developmental level of the child being screened or assessed. Knowing the developmental skills that are expected will help determine whether or not a child is exhibiting deficits or delays. Attending to the child’s current

developmental phase is important, because behaviors that may be considered appropriate at one stage may be considered maladaptive at a different developmental phase. Further, children from families affected by substance use disorders may not go through the developmental continuum in the normal sequential phases. For example, children in middle childhood may display inappropriate attention-seeking behaviors with strangers because of their lack of attachment to a primary caregiver as infants and toddlers.

When staff have been given basic understanding of child development, observing or screening for the effects of alcohol and drugs on children is possible. The ability to observe or screen for effects of alcohol and drugs on children may not be feasible for people with no training. Research has shown that these effects can manifest themselves 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

It is important to note that 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 consequences detailed below are likely to be noticed in a newborn, whereas cognitive and learning disabilities are more likely to become apparent in school-aged children. Also, there is not consensus on how short-term effects may translate into longer term consequences. Because a child exhibits negative outcomes as a newborn does not predict that the child will suffer 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. It should also be noted that children may have some of these defects for reasons other than prenatal exposure to substances.

Physical Health Consequences

Children who have been prenatally exposed to alcohol, tobacco, and drugs often exhibit a variety of physical health consequences including being born prematurely and having lower birth weights, lengths, and head circumferences (National Institute on Drug Abuse, 2001). Premature birth and low birth weight are important factors in a child's overall health and development, and these children are more likely to have serious medical problems that often require extended periods of hospitalization (National Resource Center for Respite and Crisis Care Services, 1997). Newborns who have been prenatally exposed may appear to be in great distress. They may be jittery, suffer from tremors, and become irritable with mild environmental stimuli. Their muscles may be unusually stiff; they can exhibit prolonged persistence of early reflexes, cry a great deal, and have trouble feeding and falling and staying asleep (Kronstadt, 1991). There is evidence that prenatal exposure to alcohol alters brain development, causing cell loss, gross reductions in brain size, and altered connections between brain regions and the ability for communication among neurons (Sher, 2004; Chen, Maier, Parnell, & West, 2003).

A further set of health problems may result from the parents of these children being unable to keep regular pediatric appointments and to keep track of immunizations and medical records.

Lack of Secure Attachment

As toddlers, these children are often seen to be less securely attached to their caregivers than children who have not been substance exposed. Their inability as infants to achieve a calm state, or to tolerate touch, may impede mutual interaction with their primary caregiver and may affect their capacity to form secure attachments (Ondersma et al., 2000; Kronstadt, 1991). This lack of attachment may be exhibited in the child moving from one adult to another, showing no preference for any one in particular, or in seeking response from all adults. The child may also overreact to separation from a primary caregiver (National Resource Center for Respite and Crisis Care Services, 1997).

Psychopathology

Children who have been prenatally exposed to alcohol and drugs have been shown to display a variety of psychopathologies, including attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) (Lester et al., 2004). They tend to exhibit more internalizing behaviors, including anxiety, depression, and somatic complaints, than nonexposed children (Delaney-Black et al., 2000; Chasnoff et al., 1998; Goldschmidt, Richardson, Cornelius, & Day, 2004). In addition, they may appear passive and apathetic (Kronstadt, 1991). In most cases, it is important to review birth parents' mental health status—which may be difficult for children who have been adopted or in long-term foster care—to ensure that children are not misdiagnosed as ADHD when bipolar, autistic spectrum disorders or other psychopathologies with genetic components may be present.

Behavioral Problems

These children may possess poor internal controls, lack tolerance for frustration and stress, and have difficulty delaying gratification. These issues may result in the expression of their wants, needs, and fears in inappropriate behaviors such as frequent temper tantrums or aggression (National Resource Center for Respite and Crisis Care Services, 1997; Kronstadt, 1991; Mathis, 1998; Chasnoff et al., 1998). They may exhibit aggressive and antisocial behaviors, such as conduct disorder, oppositional defiant disorder, and delinquency (Lester et al., 2004). In addition, they may be easily distracted, behave impulsively, have trouble focusing their attention, and have difficulty organizing their behavior (Kronstadt, 1991; Mathis, 1998). When these deficits are not recognized in early assessment and diagnoses during the preschool period, they may be detected in behavior problems that occur in early or middle elementary school, when schools' rules of acceptable behavior prove difficult for these children to obey consistently.

Poor Social Relations/Skills

Prenatally exposed children may exhibit poor social skills and adjustment (Kronstadt, 1991). Despite a drive to connect with adults, they may often have problems with their peers, showing deficits in their interpersonal relations (Schonfeld, 2003). As children grow older, their deficits in socio-emotional functioning may become more apparent, especially with regard to social judgment, interpersonal skills, aggression, and antisocial behavior (Jacobson & Jacobson, 2003). They may find it difficult to sustain relationships, since their drive to control their environment at times leads to their being overcontrolling in their relations with peers and unable to read signals about peers' responses to them.

Deficits in Motor Skills

These children may exhibit difficulties with gross or fine motor skills (Lester et al., 2004). A difficulty with gross motor skills may be exhibited through problems with swinging, climbing, throwing, catching, jumping, running, and balancing (National Resource Center for Respite and Crisis Care Services, 1997). Below-average handwriting may be an obvious indicator of problems with fine motor skills.

Cognition and Learning Disabilities

Learning problems may be some of the most common and lasting disabilities experienced by children from families with substance use disorders. These children may exhibit delayed receptive and expressive language development, difficulties with expressive language articulation, poor performance on memory and verbal tests, impairments in executive functioning, poor task organization and processing, and poor academic skills (Lester et al., 2004; Kronstadt, 1991; National Resource Center for Respite and Crisis Care Services, 1997). Figurative language and metaphors may be very hard for them to decode, and they may have a very literal approach to language. In school, understanding multiple directions and recording them accurately may be very difficult, due to their difficulty in filtering out different stimuli. They may be easily annoyed by other children, due to sensory overload. It may also be difficult for them to connect actions and consequences logically (Emory School of Medicine Maternal Substance Abuse and Child Development, n.d.).

It is important to remember that while a child who has been prenatally exposed to alcohol, tobacco, or drugs may display some of the characteristics noted above, there is no guarantee that in utero exposure will lead to these negative consequences. And again, the positive and negative impact of the postnatal environment cannot be ignored. Because many postnatal risk factors can contribute to similar developmental problems in a child, the combined influence of biological factors, prenatal substance exposure, and the postnatal environmental risk and protective influences must be examined simultaneously.

Special Concerns for Youth

Prevalence of Substance Use/Abuse Among Youth

The 2005 National Survey on Drug Use and Health (NSDUH) reported that in 2005, of youth ages 12 to 17 years old, 16.5% admitted to current alcohol use or use in the past 30 days. Current binge drinking (5 or more drinks on one occasion) at least once in the past 30 days was reported by 9.9%. Of the youth surveyed, 9.9% admitted to current illicit drug use in the past month. Current (past month) alcohol use was slightly higher among females (17.2%) than among males (15.9%), but males (10.1%) reported illicit drug use at a higher rate than females (9.7%). The NSDUH report also noted that 142,000 youth received treatment in a specialty facility for an illicit drug use problem and that 119,000 youth received treatment at a specialty facility for an alcohol use problem (SAMHSA, 2006).

Special Concerns for Children From Families With Substance Use Disorders

Alcohol and drug, child welfare, and court professionals working with families affected by substance use disorders should be mindful of the potential for a child's own substance use, abuse, or dependence in addition to the impact of the parental substance use disorders on that child. Children who have been prenatally exposed to alcohol, tobacco, and/or drugs, as well as those who have been raised in an

environment in which substance use and/or abuse is present, have an increased likelihood for their own substance use and addiction.

Children of alcoholics have been found to be three to four times likelier to develop alcoholism than children whose parents are not alcoholics (Children of Alcoholics Foundation, n.d.). Studies have also shown a link between mothers who smoked and/or drank during pregnancy and their children being more likely to smoke and drink as adolescents (Lester et al., 2004). In a 14-year followup study, prenatal alcohol exposure was linked more often to adolescent alcohol use and the negative consequences associated with its use than was a family history of alcohol problems (Baer, Barr, Bookstein, & Sampson, 1998). In addition, being the victim of child abuse and neglect is considered a precursor to developing a substance use disorder (DHHS, 1999).

Also of importance is children's experience in out-of-home care and their increased likelihood of developing their own substance use disorder. The National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration has found that youth who had ever been in foster care were more likely to use illicit substances and more likely to need drug treatment than youth who had never been in foster care. Based on analyses of the 2002 and 2003 survey among youth aged 12 to 17, 37.6% of youth who had ever been in foster care used alcohol in the prior year and 33.6% had used illicit drugs. This finding compares to 34.4% of non-foster-care youth using alcohol and 21.7% using illicit drugs (OAS, 2005).

About 10% of youth who had ever been in foster care needed treatment for alcohol problems, 13% needed treatment for illicit drugs, and 17.4% needed treatment for either alcohol or drugs. These findings compare to much lower rates among youth who had not been in foster care; only 5.9% needed treatment for alcohol, 5.3% needed treatment for illicit drugs, and 8.8% needed treatment for either alcohol or drugs (OAS, 2005).

Substance Use/Abuse Screening for Youth

Screening with youth should be used to uncover the potential of a serious substance-related problem. Positive indicators on a screen should be followed by a referral for a full assessment with a professional trained in assessing youth. Screening should be looked at as a process, rather than just the administration of a single tool. It should include the examination of multiple domains related to the youth's self and environment, including family history, social/peer group, mental health, and child abuse/neglect. While many screening tools provide cutoffs in scoring to assist in the decision to make a referral, these results should be used in conjunction with other observations and indications that there may be substance use disorders, including family history of disorders and prenatal substance exposure. For adolescents at high risk for substance use disorders, it is recommended that a negative screening result be followed up with a reevaluation in approximately 6 months (SAMHSA, 1999).

A list of screening tools commonly used with adolescents can be found in Appendix D on substance abuse screening tools. Also included are several diagnostic and assessment tools to provide an understanding of the types of tools used by professionals trained in assessment.

Self-Harm and Suicide

Adolescents affected by substance use disorders are also at risk for harming themselves and for committing suicide. These issues too often manifest themselves among youth who also have mental illness. Studies indicate that more than 90% of suicide victims have a mental or substance use disorder

(McKeon, 2005). In addition, the combination of childhood trauma, particularly childhood sexual abuse, and mental illness have been shown to increase suicide risk (Goldsmith, Pellmar, Kleinmann, & Bunney, 2002).

Suicide rates in the United States among adolescents rose steadily from the 1950s, and then leveled off in the 1990s and began declining. There is some evidence more recently that this trend has ended and that teen suicide rates are now essentially flat. More frequent female attempts at suicide are typically contrasted with more frequent male successes. Teens between the ages of 15 and 19 are the highest risk group (President's New Freedom Commission on Mental Health, 2003).

Children and adolescents who are suicidal report intense emotional distress including depression, anger, anxiety, hopelessness, and worthlessness. They report feeling that they are unable to change frustrating circumstances and to find solutions to their problems (Kienhorst, De Wilde, Diekstra, & Wolters, 1995; Ohring et al., 1996). Another class of risk factors is related to family discord often characterized by poor communication, disagreements, and lack of common values, goals, and activities.

In an extensive study of suicides in Utah, the agencies that victims had most frequently had contact with prior to their suicide were the juvenile justice and child protective services agencies, which led the researchers to the conclusion that suicide prevention efforts should focus on institutions, rather than individuals (Silverman & Felner, 1995). In this group, 63% of the suicide victims had contact with the juvenile justice agency, and of those, 54% were substance related. In 27% of completed suicide cases, the individual or a family member had been referred to child protective services. Of the individuals referred, 83% were victims of abuse. Only 5% to 20% of suicide completers were in psychiatric treatment at the time of their deaths (Gray et al., 2002).

Suicide risk is difficult to assess (Goldsmith et al., 2002). Any assessment instrument should be used in combination with professional and clinical judgment. While suicide risk is difficult to assess, there is evidence that adolescents provide accurate information about their suicidal thoughts and direct questioning using a nonthreatening approach suggested for screening. The questions should include information about (1) previous suicide attempts; (2) recent, serious, suicidal preoccupations; (3) depression; or (4) complications of alcohol and substance use. Youth identified as being at risk should be referred to mental health professionals for further assessment and treatment (Shaffer & Craft, 1999).

The term "self-harm," or "self-injury," is another issue that seems to disproportionately affect adolescents. Included under the term is a broad range of behaviors one inflicts upon oneself, including cutting, burning, hitting the body with an object or fists, biting, bruising, and ingesting toxic substances. While the majority of research on self-harm has been conducted in Europe, it is estimated that in the United States, almost 3 million people, most of whom are adolescents, engage in self-injury (University of Michigan Health System, 2003). An Australian study found that 6.2% of Year 10 and Year 11 students (11.1% of the female respondents) had a lifetime history of self-injury (De Leo & Heller, 2004).

As noted in the Australian study, adolescent females are more likely to engage in self-harm than are males. Self-harming behaviors cut across a wide range of familial, cultural, and economic backgrounds. Some constants that do exist among those who self-harm are depression, anxiety, low self-esteem, feelings of guilt, emptiness, numbness, invalidation, and an inability to cope with emotions (Selekman, 2002; Martinson, 2002). A history of abuse is common among individuals who engage in self-injury; however, not all who self-injure were abused. In nonabuse instances, it appears that feelings of invalidation and a lack of role models for coping may be enough of a precursor (Selekman, 2002).

Self-harm is intentional, impulsive, and repetitive (University of Michigan Health System, 2003). Self-harming behaviors release endorphins into the bloodstream, resulting in a pleasurable or numbing sensation that takes away the unpleasant thoughts or feelings the individual has been feeling. This endorphin effect can become addictive to adolescents trying to cope with the emotions and stresses of their lives (American Association for Marriage and Family Therapists, 2002). Indications that an adolescent might have a problem with self-harm include—

- Cut or burn marks on their arms, legs, and abdomens;
- Finding knives, razor blades, box cutters, and other sharp objects hidden in the teen’s bedroom;
- Regularly locking herself or himself up in the bedroom or bathroom after a bad day at school, negative encounters with peers, and family conflicts for lengthy periods of time;
- The family physician, a teacher, or other adult observes cut or burn marks, or that the teen appears to be regularly removing bodily hairs;
- The teen’s peers cut or burn themselves; and
- Reports from a sibling indicating that he or she found blood encrusted razors or caught the teen in the act of self-injuring (American Association for Marriage and Family Therapists, 2002).

Therapeutic approaches exist, and more are being developed, to help individuals who engage in self-harm to develop new coping mechanisms to replace the self-harming behaviors. It is believed that once the self-harming behaviors can be stabilized, work can be done on the issues that underlie the self-harm. In addition, research into the use of medications that reduce depression, anxiety, and stabilize mood for those who self-harm is being conducted (American Self-Harm Information Clearinghouse, n.d.).

Referral Resources

As children from families with substance use disorders can be affected both by the physiological effects of alcohol and drugs and the psychological and social effects of living in a family in which alcohol and drugs are used and/or abused, a multiservice response from a wide variety of disciplines, including child welfare, alcohol and drug, mental health, primary health, domestic violence, education, and juvenile justice is needed.

Services for children vary across jurisdictions. Some jurisdictions may have services that are designed to specifically work with children from families with substance use disorders, while others may be able to work with these children through services created to serve other vulnerable children. Each State or community will need to assess what resources are available to them for referral of children for further assessment and services. Examples of resources that might be available include:

- Early Intervention Services
- Mental Health Services
- School-Based Resources
- Substance Abuse Treatment

Early Intervention Services

Providers of early intervention services might include child care; Head Start and Early Head Start, and prekindergarten/preschool programs. In the case of children who have received an early diagnosis of special needs, regional developmental disabilities agencies may provide services to both parents and

children; some home visiting programs that are based in maternal and child health agencies may also have links with services for children with special needs.

An additional resource available to young children and their parents is services available under Part C of the Individuals with Disabilities Education Act (IDEA). Congress established this program in 1986 to—

- Enhance the development of infants and toddlers with disabilities;
- Reduce educational costs by minimizing the need for special education through early intervention;
- Minimize the likelihood of institutionalization, and maximize independent living; and
- Enhance the capacity of families to meet their child’s needs (National Early Childhood TA Center, 2006, January).

Part C of IDEA is a Federal grant program that supports States in operating comprehensive statewide programs of early intervention services for children ages birth through 2 years, who have disabilities, and their families. Currently, all States and eligible territories are participating in the program, and receive annual funding based upon census figures of the number of children age birth to 2 years old in their general population. The Federal requirements under Part C specify the minimum components that must be included in a comprehensive statewide early intervention system. However, there is some discretion in setting criteria for eligibility, including whether or not to serve children at risk. As a result, eligibility and services can differ significantly from State to State. Each State and territory must designate a lead agency. Lead agencies also can vary from State to State but typically include departments of health/public health/human services, education, and mental health/mental retardation. The following link provides information about lead agencies in each State and territory:

<http://www.nectac.org/partc/ptclead.asp>.

Mental Health Services

Children from families with substance use disorders may qualify for services under their local children’s mental health department. Many jurisdictions provide a system of care (SOC) to children with serious emotional disorders who are in need of mental health services under the federally funded grant program Comprehensive Community Mental Health Services Program for Children and Their Families. Since 1992, this program has funded 92 sites across the country. The program promotes the development of service delivery systems based upon the following philosophies:

- Mental health service systems should be driven by the needs and preferences of the child and family, and address these needs through a strength-based approach;
- The focus and management of services should occur within a multiagency collaborative environment and be grounded in a strong community base;
- The services offered, the agencies participating, and the programs generated should be responsive to the cultural context and characteristics of the populations served; and
- Families should be partners in the planning, implementing, and evaluating of the system of care (Center for Children’s Mental Health Services, 2004).

A 2001 report on promising practices from the SOCs detailed that services supporting the mental health of young children should include the following components:

- *Family-Centered*—designed around the family’s strengths, needs, and preferences;
- *Individualized*—respecting family’s race, ethnicity, culture, socioeconomic background, values, and beliefs;

- *Comprehensive*—provide a variety of interventions to meet the developmental, physical health, and mental health needs, and address the needs of the whole family;
- *Community-Based*—including informal supports that exist in the community and in settings familiar to the child and family, such as in the home or daycare center;
- *Coordinated*—services provided by multiple agencies or disciplines;
- *Based on Developmental Needs*—awareness of age-appropriate behavior and cognitive and social development; and
- *Built on Strength and Resilience*—designed to promote resiliency in children, to enhance self esteem, to improve coping skills, and to increase positive social supports (Simpson, Jivanjee, Koroloff, Doerfler, & Garcia, 2001).

School-Based Resources

Schools have multiple roles in responding to substance use, abuse, and dependence by their students and as these problems affect their students. Schools are critical venues for identifying and responding to conditions related to the effects of substance use disorders on children’s lives. Child welfare professionals, as well as all other professionals who work with children outside a school setting, need to understand how schools can respond to the needs of children and youth affected by substance disorders.

In general, schools are far more focused on adolescent patterns of use, abuse, and dependence than the academic and behavioral effects of parents’ and caretakers’ substance use disorders on their children. Schools are sometimes focused on substance abuse and violence prevention programs aimed at preteen or adolescent groups while underestimating the importance of intervention and treatment programs for younger students whose parents and caretakers are involved with alcohol and drugs in ways that affect students’ learning and behavior.

For the youngest, pre-school-aged children, the effects of parental substance use disorders may begin to show up as a result of developmental screening. The effects may occur when parents take a child to be assessed. Under Federal special education legislation, every school district is obligated to identify, locate, and evaluate all children between the ages of birth and 21 who may need special education and related services. Anyone (a parent, teacher, service provider, and others) may request that a child be considered for special education, and most professionals, including doctors, mental health workers, and counselors must notify the State Superintendent of Public Instruction of any child who appears to be disabled but is not receiving special education services. If a child is younger than 5 years old, the school district will likely refer the family to a local referral and evaluation agency (After the evaluation, a disabled child may be provided with specific programs and services to address his or her special needs. The Individuals with Disabilities Education Act (IDEA) defines “children with disabilities” as individuals between the ages of birth and 21 with one or more of 10 specific categories of disabilities (Council for Exceptional Children, 1998).

Assessments may also happen when a child is taken into the child welfare or mental health systems as a result of a referral for abuse or neglect. The Early Head Start program mentioned above has worked on making a “good handoff” to school districts that their “graduates” will be attending, and emphasizes continuity of care for children identified in preschool settings.

Those school districts that operate or work closely with school-based or school-linked health centers have an additional resource to assist with the task of identifying children affected by their own or their parents’ substance use disorders, but staff in such centers need the training to identify these disorders.

In studies of adolescents receiving mental health services, about half had a co-occurring substance use disorder (Greenbaum, Foster-Johnson, & Petril, 1996). The study found that depression and conduct disorders were the most frequent mental disorders diagnosed in the presence of a substance use disorder. School personnel and their collaborating partners must be able to differentiate between mental illness and substance use disorders, while recognizing the substantial overlap.

For children in adolescence who are 14 or older, the Individuals with Disabilities Education Act (IDEA) requires that the Individual Education Plan (IEP) team consider vocational and advanced-placement needs and courses, and any needed involvement with noneducational agencies that provide vocational and other support services for individuals with disabilities. For some children, Section 504 plans may provide a less rigorous approach to accommodations required by children with special needs, such as more time for homework and changes in the ways tests are given.

While the discussion above highlights some of the common referral sources available throughout the country, every jurisdiction will have its own set of services. It is important for alcohol and drug, child welfare, and court professionals to become familiar with the resources available to vulnerable children and their families in their area. The following are a number of national resources providing further information on children and families affected by substance use disorders.

Substance Abuse Treatment Services

The advancement of specialized substance abuse treatment for adolescents—treatment different from that offered to adults—has emerged in the field over the past 20 years. Since then, many programs for treating adolescents have been established. Until recently, however, little was known regarding which of the programs or treatment strategies were effective.

To address this lack of information, in 1997 the Center for Substance Abuse Treatment (CSAT) began by sponsoring the Cannabis Youth Treatment (CYT) study. Under CYT, CSAT supported the operation and evaluation of several programs that used one of five theory-based models to treat adolescent marijuana use. The research found that these models substantially reduced adolescent substance abuse.

In 1998, CSAT launched the Adolescent Treatment Models (ATM) project. The ATM project evaluated a range of promising existing programs for adolescents. Models evaluated included inpatient, residential, and outpatient programs. The ATM study was not restricted to marijuana. Overall, the ATM programs produced fairly substantial reductions in substance use, emotional problems, and illegal activities in the year after admission. For example, there was a 56% to 60% reduction in the number of days adolescents used drugs.

An e-mail discussion group called the Society for Adolescent Substance Abuse Treatment Effectiveness listserv—an outgrowth of the ATM project—facilitates ongoing conversation and sharing of information. The listserv is open to anyone in the field. To learn more about the listserv for the Society for Adolescent Substance Abuse Treatment Effectiveness, e-mail Donna Williams at dwilliam@samhsa.hhs.gov.

For additional information about the CYT and ATM studies, please visit http://www.samhsa.gov/samhsa_news/VolumeXI_2/article8.htm.

There are some other steps that States and counties can take to facilitate access to substance abuse treatment. For example, adolescent substance abuse treatment is an optional service under the State

Children’s Health Insurance Program (SCHIP). Covering these services under SCHIP removes a financial barrier to entering treatment.

Federal Medicaid regulations require States to offer “Early, Periodic, Screening, Diagnosis, and Treatment” (EPSDT) services to all Medicaid recipients younger than age 21. EPSDT was established to ensure that young Medicaid recipients receive routine health checks, screenings for possible illnesses, and a range of preventive and treatment services. Many States and communities have used EPSDT services to enhance their adolescent programs and to ensure that youth in the child welfare system have access to substance abuse treatment.

Resources

The **Administration on Children and Families (ACF)** supports 61 University Centers for Excellence in Developmental Disabilities, Education, Research, and Service (UCEDDs), which can be accessed through http://www.aucd.org/aucd_aboutuce.htm.

ACF’s **Head Start Bureau** has information about the program including grants and services, resources for families and communities, and research. This information can be accessed at <http://www.acf.hhs.gov/programs/hsb/>.

The **Center on the Social and Emotional Foundations for Early Learning** is a national center dedicated to strengthening the capacity of child care and Head Start programs to improve the social and emotional outcomes of young children. The Web site for the center is <http://csefel.uiuc.edu>.

The **Substance Abuse and Mental Health Services Administration** supports a variety of services and technical assistance centers related to children and adolescents. They include the following:

- The **Center for Mental Health Services (CMHS)** operates the National Mental Health Information Center at 1-800-789-2647. The Center has a variety of fact sheets and information available. The Center’s Web site is at <http://www.mentalhealth.samhsa.gov>.
- The **National Technical Assistance Center for Children’s Mental Health** at Georgetown University at http://gucchd.georgetown.edu/programs/ta_center/index.html is an excellent resource for children with special mental health needs.
- The **Substance Fetal Alcohol Spectrum Disorders (FASD) Center of Excellence** for technical assistance, information, and training on FASD <http://fascenter.samhsa.gov/>.
- The **Center for Substance Abuse Prevention** has developed the Children’s Program Kit: Supportive Education for Children of Addicted Parents. This multimedia education kit is geared toward substance abuse treatment staff, community groups, and schools. The kit can be obtained through the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686 or <http://www.ncadi.samhsa.gov>.
- SAMHSA’s **National Registry of Evidence-based Programs and Practices (NREPP)**. The NREPP Web site serves as a comprehensive resource for learning about and/or implementing model programs. The programs featured on the Web site have been tested in communities, schools, social service organizations, and workplaces across the country, and have provided evidence that they have prevented or reduced substance abuse and other related high-risk behaviors. The NREPP Web site can be accessed at <http://modelprograms.samhsa.gov/template.cfm?page=default>.

- The **National Child Traumatic Stress Network (NCTSN)**. Its purpose is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events http://www.nctsn.org/nccts/nav.do?pid=abt_main.
- The **Center for Substance Abuse Treatment** operates a Web-based facility locator for substance abuse services. The locator can be accessed at <http://www.findtreatment.samhsa.gov/>.
 - CSAT has approved **Treatment and Assessment Protocols for Adolescent Treatment**. They can be accessed at <http://www.chestnut.org/LI/apss/CSAT/protocols/>.
 - In partnership with the ACF, the Substance Abuse and Mental Health Services Administration supports the **National Center on Substance Abuse and Child Welfare (NCSACW)**. The Center provides technical assistance to States and communities to improve outcomes for families affected by substance use disorders in the child welfare and dependency court systems <http://ncsacw.samhsa.gov>.

The Department of Education has a number of offices that may provide useful information about services to children who are vulnerable. These include:

- The **Office of Special Education and Rehabilitative Services (OSERS)**. OSERS assists in educating children with disabilities and rehabilitating adults with disabilities and conducts research to improve the lives of individuals with disabilities regardless of age. OSERS can be accessed at <http://www.ed.gov/about/offices/list/osers/index.html?src=oc>.
 - The **Office of Special Education Programs (OSEP)** under OSERS is dedicated to improving results for infants, toddlers, children, and youth with disabilities ages birth through 21 by providing leadership and financial support to assist States and local districts. OSEP supports a variety of technical assistance resources, and can be accessed at <http://www.ed.gov/about/offices/list/osers/osep/index.html?src=mr>.
 - The **Center for Evidence-Based Practice: Young Children with Challenging Behavior** is funded by OSEP. The center is dedicated to promoting the use of evidence-based practice to meet the needs of young children who have, or are at risk for, problem behavior, and can be accessed at <http://challengingbehavior.fmhi.usf.edu/index.html>.
 - The **National Early Childhood Technical Assistance Center** provides information on the early childhood provisions of the Individuals with Disabilities Act (IDEA) and can be accessed at <http://www.ectac.org/>.
 - The **National Center on Educational Outcomes** provides national leadership in the participation of students with disabilities in national and State assessments, standards-setting efforts, and graduation requirements, and can be accessed at <http://education.umn.edu/nceo/>.
 - The **Center for Effective Collaboration and Practice** is designed to improve services to children and youth with emotional and behavioral problems by helping communities create schools that promote emotional well-being, effective instruction, and safe learning, and supporting effective collaboration at the local, State, and national levels. More information is available at <http://www.air.org/cecp/about.htm>.

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