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Understanding Substance Abuse and Facilitating Recovery:

A Guide for Child Welfare Workers



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Administration for Children and Families
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**Understanding Substance Abuse
and Facilitating Recovery:
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Contents

Introduction	1
Understanding Addiction	2
Alcohol abuse and dependence.....	2
Women and substance abuse.....	4
Co-occurring substance abuse and dependence and mental illness	5
Determining an alcohol or drug connection to child welfare	5
Impact of parents’ substance abuse on children	8
How to talk to children about parental substance use	8
Cultural and ethnic sensitivity	9
Co-dependence.....	9
Substance Abuse Treatment: Developing and Implementing a Plan for Management of a Lifelong Disease	11
What is treatment?.....	11
What is recovery?	13
Treatment and recovery issues specific to women.....	13
How effective is treatment and recovery?	14
Self-help or 12-step groups	15
Interventions for substance-using, but non-addicted parents.....	15
How to Motivate Parents into Treatment and Enhance Treatment Readiness	16
Readiness for change	16
Motivation to change	17
How to Support and Facilitate Recovery and Enhance Treatment Effectiveness	19
Relapse and relapse prevention	19
Self-help groups and recovery	20
Culture as a factor in recovery.....	20
Supporting recovery for women.....	20
Ways to Facilitate Cross-System Communication and Collaboration	22
Why should I partner with local treatment programs?.....	22
Why should the substance abuse agency partner with me?	22
How do I partner with my substance abuse colleagues?	23
What issues and services should be included in the collaboration?.....	24
How to increase the chance of a successful collaboration.....	26
Resources	27
Federal resources:	27
Other resources:	28
Endnotes	30

Introduction

The abuse and neglect of children are a serious social issue in the United States. During 2002, each day, an average of 2,454 children were found to be victims of abuse or neglect.¹ During that same year, 532,000 children lived in foster homes because they could not safely remain in their own homes.² One of the major reasons children enter foster care is abuse or neglect associated with parental alcohol or drug abuse.^{3,4}

Most states identify substance abuse as one of the top two factors in child abuse and neglect.⁶

The abuse of alcohol and drugs is considered a serious risk factor for child safety.⁵ Whether the substance abuse is by a parent or by another adult caregiver in the home, the behaviors of adults while under the influence of alcohol or drugs can have life-long effects on children.

As a consequence, it is important for child welfare workers to recognize when alcohol or drug abuse is a factor in the case of child abuse or neglect; to help parents obtain appropriate treatment; and to understand the concept of recovery in the context of child safety. A working knowledge of alcohol and drug services can help child welfare workers meet the Adoption and Safe Families Act timelines and fulfill the child welfare commitment to child safety, permanency, and well-being.

The Adoption and Safe Families Act requires a permanency plan within 12 months after a child enters foster care and requires states to initiate proceedings to terminate parental rights if a child has been in foster care for 15 of the most recent 22 months. While 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 with years, or even decades, of alcohol and/or drug abuse. It is critical that the 15-month time period be well spent, and that when substance abuse is an issue, the parent's treatment needs be assessed and appropriate alcohol and drug services accessed without delay. To be effective, child welfare workers must understand substance use disorders. Workers should always screen for substance abuse and feel comfortable asking questions on a routine basis about substance use, abuse, treatment, and recovery while the case is open.

To help accomplish permanency for children, child welfare workers need to partner with local alcohol and drug abuse professionals and programs. An effective partnership between the child welfare and the alcohol and drug treatment systems can help parents with substance use disorders retain or regain a parental role with their child, while not putting the child at risk of harm. Thus, the child welfare-alcohol and drug services partnership becomes a cornerstone for long-term child protection, a key issue for child welfare workers.

The purpose of this guide is to help child welfare workers:

- Understand the relationship of alcohol and drugs to child welfare, and recognize when substance use is a factor in cases;
- Understand addiction and how to support and facilitate treatment and recovery;
- Enhance collaboration with substance abuse treatment partners; and,
- Improve outcomes for children of parents with substance use disorders.

The National Center on Substance Abuse and Child Welfare offers online training courses for child welfare workers available at <http://www.ncsacw.samhsa.gov/tutorials/index.asp>.

Understanding Addiction

Alcohol and drug use occur along a continuum. Not everyone who uses substances is addicted. Levels of use generally are identified as **use**, **abuse**, and **dependence**. Child welfare workers will want to determine whether or not alcohol or drugs may be a factor in the reported abuse or neglect. If substance use is a factor in the abuse or neglect, an assessment should be conducted to determine a parent's status on the use, abuse, dependence continuum.

What is physical dependence?

Physical dependence refers to physical changes in the body, such as tolerance or withdrawal. The symptoms of physical dependence vary by type of drug used.

What is psychological dependence?

Psychological dependence refers to the perceived need for the alcohol and drugs to feel good, function, or to keep from feeling bad.

What is addiction?

Alcohol and drug addiction are diseases that, while treatable, are chronic and relapsing.⁷

What does this mean?

This means that over time, the disease of addiction causes changes in the person's body, mind, and behavior, and that a person is unable to control his or her substance use, despite the harm that results.⁸

Chronic and relapsing mean that the addiction is never "cured," and that substance use may persist or reappear over the course of an individual's life.

Addiction to alcohol and drugs may be physical or psychological. Physical dependence refers to physical changes in the body, such as tolerance or withdrawal. The symptoms of physical dependence vary by type of drug used. Psychological dependence refers to the perceived need for the alcohol and drugs to feel good, function, or to keep from feeling bad. Parents who use substances may use alcohol only, one drug only, a combination of drugs, or a combination of alcohol and drugs. Poly-drug use (more than one drug, or alcohol and drugs combined) is a common pattern of use among substance abusers.

Alcohol abuse and dependence

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 should be considered in child safety and risk assessments. It is important to stress that, even when alcohol use is below the level that suggests "dependence," the child welfare worker should assess parental alcohol use or abuse as an indicator of risk to children.

How much is too much?

A child welfare worker should be concerned about the risk of alcohol addiction if a woman drinks more than seven drinks a week or three drinks at a time. For men, the level is 14 drinks per week, or four per occasion.⁹ The American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV/DSM-IV-TR) gives the definitions of substance abuse and dependence found on the following page.

Alcohol and Drug Use Continuum	Implications for Child Welfare/ Examples of Risk to Children
<p>Use of alcohol or drugs to socialize and feel 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"> • Use during pregnancy can harm the fetus • Use of prescription pain medication per the instructions from a prescribing physician can sometimes have unintended or unexpected effects— a parent caring for children may find that he or she is more drowsy than expected and cannot respond to the needs of children in his or her care
<p>Abuse of alcohol or drugs includes at least one of these factors in the last 12 months:</p> <ul style="list-style-type: none"> • Recurrent substance use resulting in failure to fulfill obligations at work, home or school • Recurrent substance use in situations that are physically hazardous • Recurrent substance-related legal problems • Continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the substance 	<ul style="list-style-type: none"> • Driving with children in the car while under the influence • Children may be left in unsafe care—with an inappropriate caretaker or unattended—while parent is partying • Parent may neglect or sporadically address the children’s needs for regular meals, clothing, and cleanliness • Even when the parent is in the home, the parent’s use may leave children unsupervised • Behavior toward children may be inconsistent, such as a pattern of violence then remorse
<p>Dependence, also referred to as addiction, is 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"> • Tolerance—needing more of the drug or alcohol to get “high” • Withdrawal—physical symptoms when alcohol or other drugs are not used, such as tremors, nausea, sweating, and shakiness • Substance is taken in larger amounts and over a longer period than intended • Persistent desire or unsuccessful efforts to cut down or control substance use • A great deal of time is spent in activities related to obtaining the substance, use of the substance or recovering from its effects • Important social, occupational, or recreational activities are given up or reduced because of substance use • Substance use is continued despite knowledge of persistent or recurrent physical or psychological problems caused or exacerbated by the substance <p>The American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV/DSM-IV-TR)</p>	<p>Despite a clear danger to children, the parent may engage in addiction-related behaviors, such as leaving children unattended while seeking drugs</p> <p>Funds are used to buy alcohol or other drugs, while other necessities, such as buying food, are neglected</p> <ul style="list-style-type: none"> • A parent may not be able to think logically or make rational decisions regarding children’s needs or care • A parent may not be able to prioritize children’s needs over his or her own need for the substance

- Substance abuse—is 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/social problems.
- Substance dependence—is a pattern of use that results in at least three of seven dependence criteria: 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.

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.

Research has shown that chronic alcohol use makes changes in the brain's chemistry, affecting fundamental brain functions.¹⁰ Functions involved in initiation of motor activity and integration of behavior, intellect, and emotion are particularly susceptible to alcohol-induced changes.¹¹ Alcohol may impair attention, information processing, learning, and memory. Alcohol influences two of the brain's neurotransmitters, dopamine and serotonin, affecting stress levels, mood, and feelings of pleasure or pain. Serotonin depletion through alcohol or drug use also can lead to depression. Alcohol-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.

Women and substance abuse

Substance use and abuse issues must be addressed for both parents, as well as other members of the household. However, this section emphasizes treatment needs for women because so many mothers are the primary family caretakers. Generally, it takes less alcohol for a woman to get intoxicated.¹²

In addition, some studies have indicated that women progress to addiction in less time than men. Further, the life experiences that can lead to substance abuse often are different for women than for men.¹³ A range of issues that are unique to women have been found to be important when designing and delivering treatment for women.

A high percentage of women who access substance abuse treatment have experienced physical or sexual abuse in childhood. Many have a history of family dysfunction or addiction. In addition, women who abuse substances may have experienced physical or sexual victimization as adults (e.g., domestic violence). Some women use alcohol or drugs to self-medicate for depression or another mental health disorder, or to help cope with emotions or memories of trauma. As a result of their childhood or adult experiences, they may suffer from post traumatic stress disorder (PTSD).

Post Traumatic Stress Disorder (PTSD) is an anxiety disorder resulting from exposure to a traumatic event in which both of the following were present:

- The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- The person's response involved intense fear, helplessness, or horror

The American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision.

Historically, substance abuse treatment has been geared toward men, and fewer women had access to substance abuse treatment services. However, in recent years additional emphasis and funding have begun to address women's treatment needs. Gender-specific treatment is becoming more available to women with substance abuse or substance dependence.

Co-occurring substance abuse and dependence and mental illness

The co-occurrence of substance abuse and substance dependence with mental illness is estimated to affect between seven and 10 million adults each year.¹⁴ In individuals with these co-occurring disorders it is not uncommon for one disorder to go unrecognized. These individuals often do not realize they need services or minimize the existence of their disorders. When they do come to the attention of service providers, symptoms of one disorder may mask the symptoms of the other. Service providers may not realize that what appears to be a mental health disorder may be the product of substance abuse and visa versa.¹⁵ Child welfare workers should be aware of the prevalence and complexity of co-occurring substance abuse and dependence and mental illness.

Determining an alcohol or drug connection to child welfare

How can a child welfare worker tell whether or not substance abuse is a factor in abuse or neglect? Every emergency response by a protective services or child welfare worker should consider alcohol or drug involvement as part of the child protective services investigation. If alcohol or drug abuse is indicated, addressing the substance abuse issues should be part of the child welfare case plan. Child welfare workers should use two processes to gather information regarding child safety and future potential risk of harm.

These activities should occur during the investigation phase and when working with the family:

- In-home examination for alcohol or drug involvement, and
- Screening the parent or caretaker for alcohol and drug use or abuse.

In-home examination

By observing the environment and persons in the home, important indicators of alcohol or drug use may become apparent. Check for the following indicators of alcohol and drug involvement as part of every child welfare worker's on-site investigation.¹⁶

- A report of substance use is 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 alcohol and or other drug use by parent(s) or other adults in the home
- A parent appears to be actively under the influence of alcohol or drugs (slurred speech, inability to mentally focus, physical balance is 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)

In addition, workers should observe persons who frequent the home since actions of a parent's friends or associates can be indicators of behaviors and practices.

The most important questions to ask are, "How does drinking affect the person'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?"

Screening the parent for alcohol and drug involvement

Alcohol and drug use often are under-recognized as a factor in child welfare cases. Most studies indicate that between one-third and two-thirds of substantiated child abuse and neglect reports involve substance abuse, and that nationally, at least 50% of substantiated cases of child abuse and neglect involve parental substance abuse.¹⁷

Best practices dictate that child welfare workers should always ask parents and adult caretakers about their substance use to screen for alcohol and drug abuse. Substance abuse screening alone is never diagnostic, but screening can indicate whether a comprehensive assessment or evaluation is needed.

Screens should be brief and should include questions about unintended use and/or desire to end use, as well as some question regarding consequences of use or concerns about such consequences.

One well-known screening tool available for child welfare worker use is the four-question CAGE.

These are quick screens that should be used in conjunction with other information and observations. Answering "no" to all questions on either the CAGE or the UNCOPE does not rule out the possibility of an alcohol or drug-related problem.

Ask the CAGE questions (amended for drug use).

- C** – Have you ever felt the need to **cut** down on your drinking or drug use?
- A** – Have you ever felt **annoyed** by people criticizing your drinking or drug use?
- G** – Have you ever felt bad or **guilty** about your drinking or drug use?
- E** – Have you ever had a drink or used a drug first thing in the morning to steady your nerves or get rid of a hangover (**eye-opener**)?

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

The CAGE can be obtained through a number of Internet sites or by accessing the original American Journal of Psychiatry article—Mayfield, D., McLeod, G., Hall P. The CAGE questionnaire: validations of a new alcoholism screening instrument. *Am J Psychiatry* 1974; 131: 1121-1123.

Another screen that may be used is the UNCOPE.

Ask the UNCOPE questions

- U** – Have you continued to **use** alcohol or drugs longer than you intended? Or, Have you spent more time drinking or using 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 stop using alcohol or drugs but couldn't? (**cut down**)
- 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? Or, Have you frequently found yourself thinking about a drink or getting high?
- 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. The UNCOPE can be obtained from Evince Clinical Assessments at http://www.evinceassessment.com/UNCOPE_for_web.pdf.

Who should be screened?

It may be obvious to a child welfare worker that all adults in the household should be screened. In addition, other individuals connected to the case also should be screened. Substance abuse is an intergenerational disease; other family members may have alcohol or drug involvement. For example, if a child is placed with relatives, the kinship care provider(s) should be screened for the child's safety. The child welfare worker should look for and screen a child's other non-parent caregivers and any nontraditional or extended "family" caregivers, including caregivers not formally identified as family members.

Older children in the home, including pre-teens, should be asked about their own alcohol or drug use. If the answer indicates use, the child or teen should receive a comprehensive assessment by a qualified professional. Youths who have been abused or neglected are at greater risk of developing an alcohol or drug problem. For families involved with the child welfare system, alcohol and drug experimentation by family members (including children) or others in the household calls for early screening and intervention.

What to do when alcohol or drug abuse may be present

If either the home inspection or screening indicates that alcohol or drug use may be a factor in child abuse or neglect, three important next steps are available to the child welfare worker:

1. The parents should receive alcohol and drug assessments from a qualified substance abuse counselor.
2. If alcohol or drug abuse is present, the substance use should be addressed in the case plan. The child welfare and drug treatment plans should be coordinated.

Methamphetamine use, production and impact on children

Methamphetamine use is on the rise in the U.S. Once concentrated on the West Coast, it has now spread throughout most of the country's metropolitan areas and into rural communities as well.^{18,19} The National Household Survey on Drug Abuse shows an increase in methamphetamine use over the last 10 years with 2.3% of the population having reported using methamphetamine at least once in their lifetime in 1996, 4% in 2000, 5.3% in 2002, 4.9% in 2004 and 5.8% in 2006.^{20,21,22}

Increased use of methamphetamine across the U.S. resulted in an escalation in the severity of child abuse crimes and an increase in child abuse homicides, according to law enforcement reports and research.²³ Methamphetamine use is known to trigger violence in a way that many other drugs do not due to the body's increased production of dopamine and adrenaline. Children of methamphetamine users become victims of their parents' drug-focused lifestyles, which are often characterized by neglect, physical or sexual abuse, domestic violence, and other criminal activities.^{24,25,26,27}

Because methamphetamine is relatively inexpensive and fairly easy to make, many children are exposed to dangers of home-based labs. According to one source, 30-35% of seized methamphetamine labs are in homes where children reside.²⁸ Children who live in home-based methamphetamine labs are exposed to the toxic chemicals, waste, and filth associated with methamphetamine production, as well as to the highly psychoactive stimulant itself. Exposure to the chemicals involved in the production of methamphetamine can include poisoning, burns, lung irritation, damage to the liver, kidneys, heart, brain, and immune system, cancers such as lymphoma and leukemia, bone marrow suppression resulting in anemia and increased risk of infections, as well as developmental and growth problems.^{29,30,31} Lack of parental supervision often contributes to children ingesting spoiled, rotten, or chemically contaminated food, as methamphetamine solutions may be stored in real food containers.^{32,33}

For more information on methamphetamine use, production and impact on children see:

Substance Abuse and Mental Health Services Administration
<http://www.samhsa.gov>

Methamphetamine Treatment Project
<http://www.methamphetamine.org>

Drug Endangered Children Resource Center
<http://www.nationaldec.org/resourcecenter/resourcecenterhome.html>

National Center on Substance Abuse and Child Welfare
<http://www.ncsacw.samhsa.gov/resources-methamphetamine.asp>

3. The child should be assessed by a qualified professional for the impact of parental use and for the possibility of his or her own use of alcohol or drugs. Treatment or counseling needs also should be addressed in the case plan.

Impact of parents' substance abuse on children

In some families involved with the child welfare system, children themselves have alcohol and drug issues. In cases in which a child has begun to experiment with alcohol or drugs, the child welfare worker should ensure that the child is assessed and if indicated, receives treatment.

However, whether or not children in the family use substances, parental alcohol or drug use has significant impact. Children from homes characterized by parental substance abuse often experience considerable chaos and an unpredictable home life. They may receive inconsistent, emotional responses and inconsistent care from substance-using adults. Issues of abandonment and emotional unavailability are themes one finds in children of substance-abusing parents. The parental alcohol or drug use may be treated as a family secret; children may feel guilt, shame, and self-blame.

The Children's Program Kit: Supportive Education for Children of Addicted Parents

This helpful resource is a multimedia education kit geared towards substance abuse treatment staff, community groups, and schools. It can be obtained through the National Clearinghouse for Alcohol and Drug Information at (800) 729-6686 or <http://www.ncadi.samhsa.gov>.

Children respond in different ways to their parental substance abuse. Teachers and others may see a child as withdrawn and shy. Conversely, a child may be explosive and express rage.

Some children strive to be perfect. Others become family caretakers by assuming responsibility for other siblings and by "parenting" their parents. Emotionally and developmentally, an abused or neglected child of parents with substance use disorders is likely to develop issues with trust, attachment, self-esteem, and autonomy.

If a mother used substances during pregnancy, the child could be affected in a variety of ways, depending on the type of substance used, the amount used, and the stage of pregnancy during which the substance use occurred.

The Child Abuse Prevention and Treatment Act (CAPTA) requires States to refer children under the age of three who are involved in a substantiated case of child abuse and neglect to receive early intervention services. These services are funded under Part C of the Individuals with Disabilities Education Act (IDEA).³⁴

For the reasons stated, it is important for the child welfare worker to ensure that such children are evaluated and treated for the impact of parental alcohol or drug abuse. If a child has been placed in foster care, the child welfare worker can promote better foster-parenting if the foster parents are cognizant of the specific issues and needs of the child, and if the foster parents have received specialized training in working with children from families in which parents abuse alcohol or drugs.

How to talk to children about parental substance use

The child welfare worker's role may include talking with a child about his or her parent's substance use. Equally important, the child welfare worker can help a foster parent or kinship-care provider talk with the children in their care about the parents' substance use or dependence. Case workers and caregivers can provide support and discuss a number of issues with children:

- Addiction is a disease. Your parent is not a bad person; he or she has a disease. Parents may do things that are mean or stupid when they drink too much or use drugs, but this doesn't mean that they don't love you.
- You are not the reason your parent drinks or uses drugs; you did not cause this disease and you cannot stop it.
- There are a lot of kids like you. In fact, there are millions of kids whose parents are addicted to drugs or alcohol; some are in your school. You are not alone.
- You can talk about the problem. You don't have to feel scared or ashamed or embarrassed. Find someone you can trust. Most towns have groups of kids that meet and talk, such as "Alateen." A counselor, teacher, foster parent or other adult you trust may be able to help you find one of these groups.³⁵

One way to help children deal with addiction is to use the 7 Cs of addiction developed by the National Association for Children of Alcoholics. Child welfare workers, foster parents, and relatives can use the 7 Cs to help children understand that addiction is not their fault.

The 7 Cs of addiction

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.

Source: National Association for Children of Alcoholics, on-line at <http://www.nacoa.org>

Cultural and ethnic sensitivity

Only a small percentage of children from homes with serious alcohol and drug problems come in contact with the child welfare system. However, minorities are involved disproportionately with the child welfare system.³⁶ For example, African-American women are more likely to be child welfare involved than white or Hispanic women who abuse substances, despite studies that reflect similar rates of alcohol and drug use.^{37, 38} Child welfare workers must be careful to avoid assumptions about alcohol and drug use (or non-use), type of drugs used, or patterns of use based on racial or ethnic stereotypes. Substance abuse professionals commonly refer to alcohol and drug addiction as an "equal opportunity disease" as it crosses all racial, ethnic, social, and economic groups.

Co-dependence

There are times when one parent abuses alcohol or drugs and the other parent does not. When a child welfare worker finds this dynamic, it is helpful to assess the relationship between the drug-abusing parent and the non-abusing partner or non-abusing child. Co-dependency is a term used to describe an unhealthy relationship or unhealthy interactions that may occur between family members and friends, and alcohol or drug-abusing individuals.

Those in a co-dependent role may assume responsibility for the alcohol and drug use by the other family member. Children may think that if they made better grades, were not naughty, or were better children, their parent would not use. Similarly, spouses may attempt to control the environment to prevent their partner from alcohol or drug abuse, and may believe it is their fault if a spouse or partner drinks or uses drugs. The substance-abusing parent may reinforce this flawed thinking and blame the non-using parent.

A co-dependent parent often has a family history of substance abuse by one or more parent or relative. As a result of the intergenerational nature of the disease of addiction, children in the family are more likely to continue the cycle by becoming co-dependent or alcohol or drug dependent themselves.

It is important for non-using parents to receive support and counseling about ways to make healthy and safe choices for themselves and their children. A goal for a non-substance using parent is to accept that he or she cannot change a spouse or partner's addiction. A non substance-using parent only can effect change in his or her own life and can take action to enhance the safety and well-being of their children. When co-dependency is an issue, it should be addressed in the child welfare case plan. At the end of this document, several self-help resources are presented for family members of individuals who abuse alcohol or drugs.

Substance Abuse Treatment: Developing and Implementing a Plan for Management of a Lifelong Disease

This section provides an overview of substance abuse treatment. It presents treatment principles and special treatment considerations. Most important, the difference between treatment and recovery is discussed.

Detoxification is a process of treating individuals who are physically dependent on alcohol or drugs, and includes the period of time during which the body's physiology is adjusting to the cessation of substance use. In some cases detoxification may be a medical necessity; untreated withdrawal may be medically dangerous or even fatal.

Source: TIP 19: Detoxification From Alcohol and Other Drugs. DHHS Publication No. (SMA) 95-3046 available through the National Clearinghouse for Alcohol and Drug Information at (800) 729-6686 or <http://www.ncadi.samhsa.gov>

What is treatment?

A number of alcohol and drug treatment models are used successfully; treatment can include a variety of services and activities. Levels of treatment can range from outpatient, day treatment, and short- and long-term residential programs, to inpatient hospital-based programs. Prior to beginning treatment, some individuals require detoxification and stabilization.

Other individuals may need outreach services to help overcome barriers to treatment. Treatment may involve a single service or a combination of therapies and services. A partial list of treatment services includes:

- Assessment and treatment planning
- Prescription of certain drugs, such as antabuse for alcohol dependence, or methadone and buprenorphine for heroin addiction
- Crisis intervention
- Case management to coordinate among the treatment provider, child welfare agency, and other services needed
- Individual and group counseling and psychotherapy
- Alcohol and drug abuse recovery education
- Medical assessment and care
- Acupuncture, diet, physical exercise, and other nontraditional services
- Self-help groups or 12-step programs, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)
- Trauma-specific services and mental health services

Other specialized services also may be needed as part of a comprehensive treatment plan, depending on a child's or parent's other medical or psychological needs. Specialized services may address domestic violence, mental illness, childhood trauma, multi-drug use, HIV/AIDS, or other issues linked to the parent's substance abuse.

The duration of treatment can range from weeks or months to years. The type, length, and intensity of treatment are determined by the severity of the addiction, type of drugs used, support systems available, personality, and other behavioral, physical, or social problems of the addicted person. It is important to think about treatment as management of a lifelong disease such as diabetes or high blood pressure, rather than crisis intervention such as emergency treatment for a broken leg.

The treatment plan should be developed based on information gathered in the substance abuse assessment process.

Matching substance-abusing parents to treatment involves matching the severity of substance use to intensity of service.³⁹ Among the issues to consider are the following:

- Acute intoxication and/or withdrawal potential—What risk does the parent’s level of intoxication or withdrawal present?
- Biomedical conditions and complications— Does the parent have illnesses or chronic conditions that affect treatment?
- Emotional/behavioral conditions and complications—Does the parent have psychological or other problems that need specific mental health services?
- Treatment acceptance/resistance—Does the parent object to treatment or disagree with the substance abuse diagnosis? If the parent agrees to treatment, is the compliance to avoid a negative consequence, or is the parent internally motivated to address their alcohol or drug problems?
- Relapse/continued use potential—How aware is the parent of relapse triggers and what skills does he or she have to cope with cravings or life stresses and the impulse to use?
- Recovery environment—Does the parent have family relationships and friendships that support treatment and recovery? Conversely, are there family members, significant others, relationships, or living situations that may sabotage or threaten treatment engagement and success?

National Institute on Drug Abuse (NIDA) Treatment Principles (excerpt)—NIDA has developed 13 research-based treatment principles that are important to the recovery process. An abbreviated list is included here. For a complete listing in English or Spanish, please access <http://www.nida.nih.gov/podat/PODATIndex.html>

- **No single treatment is appropriate for all individuals.** Treatment and services should be matched to the person’s problems and needs.
- **Treatment needs to be readily available.** Parents and children who need treatment need it now.
- **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** Medical, psychological, social, vocational, and legal problems must be addressed, in addition to substance addiction.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness. A child welfare worker can help prevent a parent from leaving treatment prematurely.
- **Treatment does not need to be voluntary to be effective.** Court-ordered treatment, an employment mandate, or family insistence can increase treatment entry, retention, and success.
- **Possible drug use during treatment must be monitored continuously.** Monitoring can help reduce the desire to use and provide early warning of use if a slip or relapse occurs.
- Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk of infection. Counseling can help parents avoid high-risk behavior and help those who are already infected manage their illness.
- **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** Relapses often occur during or after successful treatment episodes. Relapse prevention plans, self-help groups, and other supports can help minimize relapse and support abstinence.

What is recovery?

Treatment does not equal recovery. Treatment is an important part of recovery, but recovery is much more than obtaining sobriety. “Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.”⁴⁰ Recovery is a process of making lifestyle changes to support healing and to regain control of one’s life. Recovery involves being accountable and accepting responsibility for one’s behavior. It is the process of establishing and re-establishing patterns of healthy living. Individuals talk about being “in recovery” as opposed to having “recovered,” because recovery is viewed as an ongoing process. Persons in recovery monitor their feelings, physical changes, and relationships to make healthier choices and to reduce the risk of relapse. Hence the Alcoholics Anonymous adage, “Recovery happens one day at a time ... for the rest of your life.”

There are different stages of recovery. A parent who has been drug-free for a week and one who has been drug-free for a year experience different issues. Recovery is complicated. It may be helpful to view recovery as a developmental process. The developmental model of recovery describes stages and tasks as part of recovery:

- Transition—Parent recognizes that her or his attempts to “control” substance use are not working
 - Stabilization—Parent goes through physical withdrawal and begins to regain control of her or his thinking and behavior
 - Early recovery—Parent changes addictive behaviors and develops relationships that support sobriety and recovery
 - Middle recovery stage—Parent builds a more effective lifestyle and repairs lifestyle damage that occurred during substance use
 - Late recovery stage—Parent examines his or her childhood, family patterns, and beliefs that supported a dysfunctional lifestyle; the parent learns how to grow and recover from childhood and adult traumas
- Maintenance stage—Parent learns to cope in a productive and responsible way without reverting to substance use⁴¹

Treatment and recovery issues specific to women

Just as gender-specific issues arise in addiction, gender-specific considerations are important in treatment and recovery. While there is still much to learn about effective treatment for women and how it differs from treatment for men, research studies have begun to identify gender-specific components and issues to address in treatment. Research indicates that women are more likely to complete treatment in women-only programs and that women have different needs than men in treatment (such as dealing with a history of victimization). Women’s treatment success may depend on meeting those needs. For example:

- Often women in treatment have low self-esteem, little self-confidence, and feel powerless. It is important to address these issues to improve treatment effectiveness.
- Since women appear to become addicted more rapidly than men, by the time they enter treatment, their addiction may be more severe, which affects the level and intensity of treatment needed.
- Use of support groups may have greater benefits for women. In a study of pregnant addicted women, support group participation resulted in better outcomes for mothers and their infants.⁴²
- Participation in group counseling appears to influence a lower rate of relapse for women. In addition more intense participation in treatment is related to lower rates of relapse.⁴³
- In the general population, women have twice the rate of depression as men,⁴⁴ and one-third of women who enter substance abuse treatment have experienced clinical depression in the past year.⁴⁵
- Between 50-75% of persons in treatment have a co-occurring mental disorder, including panic attack and other anxiety disorders; it is critical that women’s treatment identify and incorporate mental health services as needed.⁴⁶

- A continuing relationship with the treatment provider, particularly for women, is important in the recovery process.
- Research shows women receive the greatest benefit from alcohol and drug treatment programs that provide comprehensive services.

When child welfare workers seek treatment for a substance-abusing mother, gender-specific components are important considerations. It may be helpful to think in terms of a comprehensive treatment model with the following three levels of services for women with substance abuse:⁴⁷

1. **Clinical treatment services:** Outreach and engagement, screening, detoxification, crisis intervention, assessment, treatment planning, case management, substance abuse counseling and education, trauma specific services, medical care, mental health services, drug monitoring, and continuing care.
2. **Clinical support services:** Primary health care services, life skills, parenting and child development education, family programs, educational remediation and support, employment readiness services, linkages with legal system and child welfare system, housing support, advocacy, and recovery community support services.
3. **Community support services:** The following, when available in the community, support long-term recovery: Recovery management, recovery community support services, housing services, family strengthening, child care, transportation, Temporary Assistance for Needy Families (TANF) linkages, employer support services, vocational and academic education services, and faith-based organization support.

In addition to being gender-specific, treatment should be culturally relevant. Roles, values, and beliefs should be respected, and the treatment milieu should be compatible, whenever possible. For example, some cultures have healing practices and traditions that are important to families. The traditional healing practices may be important tools in treatment and recovery. Effective treatment programs routinely examine and remove potential barriers to treatment and address language needs, when indicated. Treatment also must be geographically accessible.

The child welfare and alcohol and drug services programs may need to collaborate on transportation, visitation with children and other issues related to distance. Last, for individuals involved with the child welfare system, treatment must be family-focused. Issues of intergenerational substance abuse, family relationships and dynamics, and parenting are among concerns to be addressed.

How effective is treatment and recovery?

Decades of research have demonstrated that treatment works. Studies of publicly supported treatment programs show a savings of \$7 or more in other societal costs for each dollar invested in treatment.⁴⁸ Studies indicate drug treatment reduces use by 40-60% and significantly lowers criminal activity. However, treatment must be available, accessible, and individualized. The importance of a holistic approach to treatment effectiveness cannot be overemphasized. The parent must be matched to the appropriate treatment program in terms of intensity, duration, and treatment content. To improve effectiveness, the parent must complete all or most of treatment.

It is not enough to treat only the addiction. For recovery to occur, the child welfare and alcohol and drug services partnership must identify and treat other co-occurring psychological, physical, and social problems. Similarly, it is important to identify other issues to determine their impact on substance use and to address these issues in treatment. For example, alcohol consumption may result in aggression, but it may also result in increased victimization. It is important to identify and work with either or both issues as they affect parents and children involved with the child welfare system.

An important role of the child welfare worker is to support treatment and to help reduce barriers to that treatment. Even if a parent does not achieve complete abstinence, substance abuse treatment

can reduce the number and length of relapses, lessen related problems such as crime and poor physical and mental health, minimize the impact of parental substance use on children, and improve individual and family functioning.⁴⁹

Self-help or 12-step groups

One common addition to treatment is participation in self-help or 12-step groups, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Some areas have Cocaine Anonymous and Crystal Meth Anonymous groups, as well. Most alcohol or drug self-help groups are based on 12-steps originally developed by AA, which begin: "I admit that I am powerless over my addiction and that my life has become unmanageable." The self-help groups can complement treatment and often are recommended during and after treatment. Self-help groups augment treatment but are not in and of themselves treatment.

Interventions for substance-using, but non-addicted parents

Some parents involved with the child welfare system may abuse alcohol or drugs, but are not clinically diagnosed as dependent. Alcohol and drug use without dependence still can lead to serious concerns about parenting and the safety and welfare of children. Because treatment may be indicated, it is important to address effective interactions between the child welfare worker and parent under these circumstances.

Every contact between the child welfare worker and parent is an opportunity for intervention.

Conversation about the reality of substance abuse and the connection to child safety should be initiated regularly and routinely by the child welfare worker. Initiating and continuing the dialogue about alcohol and drug abuse is important. Even if the parent or family is uncomfortable or attempts to minimize the

substance use, the child welfare worker should not shy away from talking about the substance abuse. An open, direct, and "matter-of-fact" approach by the child welfare worker to address the parent's alcohol or drug use can be an important step to facilitate motivation and entry in treatment.

Social workers and other child welfare professionals can improve their skills by using techniques from a substance abuse treatment approach known as "brief interventions." The goal of a brief intervention is to reduce the risk of alcohol and drug use by motivating a person to act to change their substance use.

Substance abuse counselors may choose a brief intervention model to work with persons with mild-to-moderate substance use. Brief interventions also have been used by treatment providers on an interim basis for those on treatment waiting lists or to engage someone needing specialized treatment.

Components of brief interventions—Six components (using the acronym **FRAMES**) offer techniques that may be helpful to child welfare workers when involved with substance abusing parents.

F—Feedback regarding the parent's impairment or risk behavior

R—Responsibility for change is the parent's

A—Advise on possibilities for change

M—Menu of treatment and self-help alternatives is offered to the parent

E—Empathic and non-blaming style is used by the social worker

S—Self-efficacy or positive empowerment is facilitated in the parent

For more information on FRAMES and other brief intervention techniques, see TIP 34 *Brief Interventions and Brief Therapies for Substance Abuse* available through the National Clearinghouse for Alcohol and Drug Information at <http://www.ncadi.samhsa.gov>.

How to Motivate Parents into Treatment and Enhance Treatment Readiness

Parenting and custody of one's children are powerful motivating factors for women to seek treatment and maintain recovery. When a parent has a positive screen or an in-home investigation suggests alcohol and/or drugs are a factor in abuse or neglect, it is important to communicate the gravity of the circumstances.

Parents need to be told about the time requirements for compliance with the Adoption and Safe Families Act, and why it is critical that an alcohol and drug assessment and treatment, if indicated, must occur in a timely manner. The child welfare worker should explain that the child welfare system is built on the belief that each child deserves a safe, stable, and loving home. The parent(s) always should be asked to help accomplish the goals of safety, permanency, and child well-being. If possible, parents should be engaged as partners in working toward reunification or another permanent living arrangement for the child.

The child welfare worker should be direct, without threatening, when communicating with the parent about his or her alcohol and drug abuse and the need for child safety and permanency.

An appropriate goal for a child welfare worker working with an alcohol or drug-involved family is to understand and help create conditions that lead to change. Motivation is not a personality trait, rather it is a dynamic state that can be modified. One way that child welfare workers can enhance their own effectiveness is to operate from the philosophy that "lack of motivation to change is a challenge to therapeutic skills, not a fault for which to blame the parent."⁵⁰

Readiness for change

Child welfare workers can collaborate with their alcohol and drug services colleagues to facilitate a parent's readiness to change his or her substance use and related high-risk behaviors. As part of the change process, it is important to identify the extent to which the parent recognizes problem behaviors and is ready to change. Some parents may feel ambivalent about change. Among the reasons for such ambivalence are: current behaviors seem to work; parents view their behaviors as normal; they are comfortable with a passive role (someone else must fix it for me); or it seems too hard or overwhelming to change. Ambivalence is viewed as positive because it opens the door to examination of other options. Ambivalence should not be confused with rationalizations intended to justify and maintain the *status quo*.

Ambivalence about change allows exploration of costs of status quo, and benefits of change versus costs of change and benefits of status quo.

Readiness to change factors:

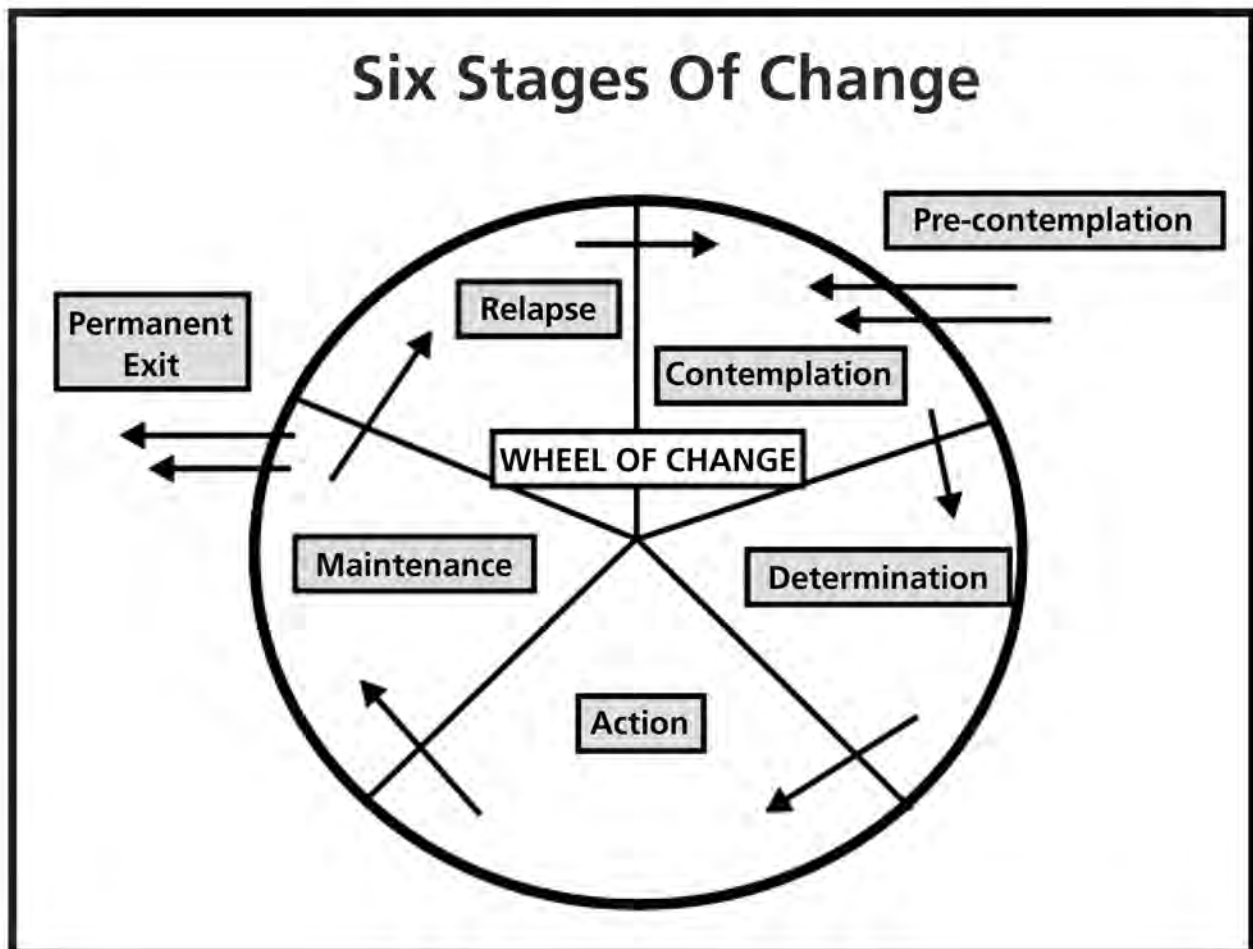
- Perception of need to change
- Belief that change is possible and can be positive
- Sense of self-efficacy to make the change
- Stated intention to change

Several "readiness to change" questionnaires are available,⁵¹ and the alcohol and drug services program may assess readiness to change as part of its evaluation process.

Motivation to change

Motivation to change and motivational interventions go hand-in-hand with readiness to change and the change process. Prochaska & DiClemente described a model of the series of changes a person must go through in order to change or resolve a problem. They suggest that change can be visualized as a circle with segments of the circle representing stages in the change process, as represented in the graphic below.⁵² During the process of change, it is normal to fluctuate between stages. One reason why this model of change is helpful for alcohol- and drug-abusing parents is that relapse is built-in as part of the process and is not viewed as treatment failure.

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. The table on the following 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 collaboration with the substance abuse counselor.



Parent's Stages of Change		Motivational Tasks for Child Welfare Worker
Pre-contemplation	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 doubts 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; tip the balance toward change
Decision to change	Makes a conscious decision 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 change strategy or returns to previous problem behaviors patterns (relapse)	Help parent re-engage in the contemplation, decision, and action stages

Motivational interviewing is a practice technique used by many alcohol and drug services professionals. Motivational interviewing assumes that people are comfortable with their drug-related behaviors and that those behaviors serve some functional purpose in their lives. Part of this technique includes exploring what they see as the positive and negative aspects of their drug-related behaviors. The goal of motivational interviewing is to help parents to develop self-motivational positions to change their use and related behaviors.

Child welfare workers can use motivational interviewing as a strategy to help parents improve their self-esteem and feelings of competence. It is critical that a parent feel he or she has the ability to change.

Motivational interviewing is a technique in which the clinician becomes a helper in the change process and expresses acceptance of the individual he or she is working with. The role of the clinician in Motivational Interviewing is directive, with a goal of eliciting self-motivational statements and behavioral change. The five general principles to be practiced by a clinician using motivational interviewing include:

- Express empathy through reflective listening.
- Develop discrepancy between clients' goals or values and their current behavior.
- Avoid argument and direct confrontation.
- Adjust to client resistance rather than opposing it directly.
- Support self-efficacy and optimism.

Source: U.S. Department of Health and Human Services. (1999). *Enhancing Motivation for Change in Substance Abuse Treatment*. Publication No. SMA 02-3629. Rockville MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

How to Support and Facilitate Recovery and Enhance Treatment Effectiveness

Just as recovery is much more than achieving sobriety, sustaining change is much more than achieving short-term change. Retention in treatment is a critical factor in recovery, and child welfare workers can be sensitive to and help parents address issues that can enhance or hinder their retention in treatment and recovery. Part of recovery is learning to pay attention to stressors and “triggers” that put parents at risk of alcohol and drug use. For example, substance use may have served an anesthetic function as a way to avoid dealing with feelings or trauma. For parents

Child welfare workers, in collaboration with substance abuse counselors, can assist parents to view substance use or a relapse episode as a means for learning to identify what triggers desire or cravings to use.

not in tune with their feelings, learning to pay attention to physiological and emotional states can help them recognize potentially stressful situations and take action to reduce the impact of those situations. Common stressors include returning home to a substance-using environment after treatment, or being with friends or family members who use drugs or alcohol. Supporting recovery may include assisting the parent in finding drug-free housing and encouraging the parent’s efforts to develop new friendships and relationships that support sobriety.

Relapse and relapse prevention

Relapse is not the same as treatment failure. Recurrence of substance use can happen at any point during recovery. When a parent relapses, it is important to help the parent recognize the difference between a lapse (a period of substance use) and relapse (the return to problem behaviors associated with substance use), and to work with the parent to re-engage him or her in treatment as soon as possible. It also important to note that a urine toxicology screen will not tell you whether the individual has had a lapse versus a relapse.

Relapse prevention includes: “What can a parent do differently?” For example, if emotions around holidays spent with family members result in high stress and a desire to use, what can be done differently to minimize stress? Or what can the parent do, to minimize the emotional impact of alcohol and drug use on the child? For example, one mother arranged for her daughter to participate in a weekly support group of teens with addicted parents, as the mother struggled (sometimes unsuccessfully) to maintain sobriety.

Part of effecting long-term change includes working with parents to identify the specific factors that preceded their substance use—What were the emotional, cognitive, environmental, situational, and behavioral precedents to the relapse?

Child welfare workers can help a parent plan for the potential of relapse and for ensuring safety of the child. Parents who learn triggers can become empowered to plan proactively for the safety of their children and to seek healthy ways to neutralize or mitigate the trigger. One element in the process of recovery is to develop a relapse prevention plan and strategies.

Self-help groups and recovery

Support of self-help groups can help maintain a clean and sober lifestyle. Participation in a 12-step program gives a parent a “sponsor”—a group member in recovery who serves as a mentor. It is appropriate for the child welfare worker to support a parent’s participation in self-help groups and for the child welfare worker to ask questions, such as: Does the parent have a sponsor? How can the sponsor have a role in planning for the safety of the child? Self-help groups also exist for family members of addicts, and some groups are specifically for children. Examples include: Al-Anon, Alateen, and Nar-Anon (see resources listed at the end of this document). These groups provide support for family members, help them learn about addiction, and that they are neither responsible for the addiction nor can they cure the addicted family member.

Culture as a factor in recovery

One factor in relapse may be that the treatment plan did not adequately address cultural, ethnic, or language issues. Both child welfare and alcohol and drug services programs should work to recruit staff with backgrounds similar to those of parents receiving services. Staff should be trained in cultural issues, and be able to identify and eliminate discriminatory language and behaviors. Agencies should offer specialized programming and bilingual counselors. The therapeutic environment should provide sensitivity to spiritual beliefs and values. Recovery can often be enhanced and sustained by incorporating healing and support systems from the parent’s culture.

Supporting recovery for women

Just as the etiology and physiology of addiction may differ between men and women, the recovery process also appears to differ. For example, women in treatment relapse less frequently than men do; while in treatment they are more likely to engage than men, particularly in group counseling.⁵³

One study of women cocaine users found that when women relapse, they were more likely than men to report negative emotions or interpersonal problems before the relapse. Women also appeared more impulsive in their return to use.⁵⁴ Additional psychotherapy may help women manage these issues to help reduce the occurrence or duration of relapse. Men were more likely to report positive feelings and a belief they could control their drug use prior to relapse.⁵⁵

As discussed previously, it is important to use a holistic approach with women in treatment and to avoid an assumption that retention problems reflect a lack of cooperation. Women experience a variety of barriers that interfere with treatment participation. Hence, it is critical to examine and address issues that can create barriers to treatment success, among them: transportation, childcare, health, and support or sabotage from a partner or other family member. The child welfare worker can help a mother identify and coordinate the various services she needs to help reduce barriers to recovery and treatment success.

While family members can play a key role in supporting the treatment and recovery process, significant others can also sabotage treatment. If a spouse continues to use alcohol or drugs, it is much more difficult to make the lifestyle changes necessary for recovery; the accessibility of a partner’s drugs can exacerbate cravings. A woman may benefit from drug-free safe housing. If family violence is an issue, a woman may be at higher risk of domestic violence when she begins to make treatment progress or if she takes steps to leave an abusive partner. Children in the home at this time also may be at increased risk from the abusive partner. Research findings reveal that between 30-60% of men who batter their female partners also abuse their children.⁵⁶

Important actions by the child welfare worker during treatment and recovery include regular contact with a mother and recognizing risks and potential of danger to the mother and children.

Helping develop aftercare step-down services also is a valuable support that the child welfare worker can facilitate to help sustain recovery.

If children have been removed from the home, a mother's regular and frequent visitation with her children and planning for their return are factors that can motivate continued abstinence. However, some treatment programs prohibit visitations during early stages of treatment. Restricted visitation between a mother and her children by the treatment program creates a conflict with the child welfare expectation of frequent parent-child visits as part of the reunification plan. Child visitation should be addressed by child welfare and substance abuse treatment providers in the development of a collaborative case plan. Rather than a blanket rule regarding visitation between parent and child, it may be more appropriate to look at the factors affecting a specific case to make an individual determination.

The freedom and stability of recovery are benefits that persons in recovery have identified as important. Helping a parent understand how his or her life is better is an important support for recovery. Many recovering individuals also talk about a new appreciation of everyday tasks, such as reading a story with their child, having a family meal together, or going to a park with their children.

Ways to Facilitate Cross-System Communication and Collaboration

Collaboration between child welfare and substance abuse treatment professionals is more than networking or cooperation. It means forming a partnership. Collaboration is a mutually beneficial and well-defined relationship, entered into by two or more entities to achieve common goals. For those concerned about the welfare of children, collaboration provides the opportunity to improve child safety and support the recovery of parents.

When considering the development of a collaborative relationship, child welfare workers may want to ask themselves:

- Why should I partner with local treatment programs?
- Why should the substance abuse agency partner with me (i.e., what do I have to offer)?
- How do I partner with my substance abuse colleagues?
- What issues and services should be included in the collaboration?
- How can I increase the chances for a successful collaboration?

Each question is discussed on the following pages.

Why should I partner with local treatment programs?

Shared planning and service delivery lead to practices that better meet the needs of children and families. Through collaboration, multiple agencies working with the same family can reduce confusion and fragmentation for the family members and improve coordination of services. Collaboration with local treatment programs can provide the expertise that is needed for a family in the child welfare system.

If the protective services on-site investigation and screening of parents suggest that alcohol or drug abuse is a factor in the abuse or neglect, substance abuse treatment providers are needed to:

- Conduct a substance abuse assessment or evaluation;
- Help identify the level and type of treatment program that is needed;
- Provide treatment and aftercare services; and
- Participate in case management and monitoring.

In addition, substance abuse treatment agencies may be able to provide crisis intervention, trauma-related services, or other services needed by the parent.

Provisions of the Child Abuse Prevention and Treatment Act require that substance-exposed births be reported to the child protective services agency. The substance abuse treatment community can provide invaluable assistance to their child welfare partners in the development of appropriate responses and services under the new requirements.

Why should the substance abuse agency partner with me?

The first goal of a substance abuse counselor for clients is generally to “help them stop using substances and maintain abstinence.”⁵⁷ This goal is not easily accomplished. Substance abuse and dependency, treatment, and recovery are complex and multi-faceted. By working collaboratively with the child welfare worker, the substance abuse counselor may be able to provide more effective treatment for persons involved with both systems and incorporate a more holistic approach.

Parenting issues tend to be a significant factor in recovery, particularly in women's treatment. When the substance abuse counselor works in concert with the child welfare worker, the motivation for change and treatment effectiveness may be enhanced. Parenting skills and child safety in the family are areas in which the child welfare worker has expertise that may be useful in development of the treatment plan.

In addition, the child welfare worker can play an important role in educating the substance abuse treatment provider, and reminding parents in treatment, about the Adoption and Safe Families Act timelines and case plan requirements where failure to comply could lead to termination of parental rights.

How do I partner with my substance abuse colleagues?

Research on effective collaborations provides a series of principles that can serve as a guide for developing partnerships to improve services to vulnerable children and families:

- Mutual respect, understanding, and trust;
- Open and frequent communication;
- Partners see collaboration in their interest;
- A mutual sense of ownership;
- Formal and informal communication; and
- Concrete, attainable goals and objectives.^{58, 59}

Steps child welfare workers can take toward collaborating with substance abuse treatment providers include:

- **Understand that different values do not preclude collaboration** or the development of joint goals for systems or for individual cases.
- **Learn about your potential partner.** Locate or create an inventory of treatment programs. You can start with the Substance Abuse and Mental Health Services Administration treatment locator website at <http://www.findtreatment.samhsa.gov>.

- Many areas have local directories available through organizations such as the United Way, a service agency, or county government. Find out: Are women's treatment programs available? What intensity of treatment is offered—day treatment, residential, a therapeutic community? Are children's services also on-site?

- **Establish relationships.** Look for what you have in common, not just the areas that divide you. Learn about the treatment program's philosophy, the goals of treatment, and the services provided. What are the child welfare and alcohol and drug services agencies each trying to accomplish? Where is the common ground between the two systems?

- **Understand and value substance abuse counselors** and the contributions each of you makes to the community. What roles do child welfare and substance abuse professionals play in the community? It is important for child welfare workers to be open and communicative about the child welfare agency, and to respect and try to understand your alcohol and drug services partner's framework. Conversely, it is important for substance abuse counselors to be open and communicative about the substance abuse treatment program, and to respect and try to understand the child welfare framework. Most importantly, how can the child welfare worker and substance abuse counselor work together to do a better job? Openness and communication are building blocks for trust.

- **Acknowledge and learn about each other's boundaries.** Workers in all systems work within boundaries and parameters. Generally, the parameters and current practice are intended to enhance ethical and effective services. Sometimes system and practice requirements are perceived as barriers by those in other agencies. Workers need to look for ways to improve communication.

Both child welfare and alcohol and drug services workers improve their ability to navigate each others systems when they begin to understand and accept the limitations, parameters, issues, and practices of their partner.

- **Ask your supervisor for help.** Your supervisor may know if cross-training is available between child welfare and substance abuse agencies, or if inter-agency agreements exist between the two systems. To be most effective, collaboration should occur at all levels of your organization, not just at the level of direct services. However, even if the child welfare and alcohol and drug services agencies lack a formal memorandum of agreement, partnerships can be created between service units and between workers in the two systems.
- **Identify specific areas for collaboration.** When you are ready to collaborate, define the subset of tasks and responsibilities in each area, and determine who will be responsible for each task. The result is a roadmap of shared responsibility, ownership, and outcomes for a family served by both agencies.

What issues and services should be included in the collaboration?

This section has three parts:

1. ***What information about substance abuse treatment will help a child welfare worker work with families? What do I need to learn from the treatment counselor?***
 - **Confidentiality**—Treatment for alcohol and drug abuse is the only client counseling area governed by Federal confidentiality regulations (as opposed to State laws). Alcohol and drug services programs use consent forms specifically designed to incorporate Federal requirements. The form must address the purpose of disclosure and how much and what types of information are

being disclosed. It must explain that redisclosure is prohibited unless expressly permitted in the signed consent. Child welfare workers and child welfare agencies should use consent forms designed or approved by the alcohol and drug services provider. Different consent forms are used to release alcohol and drug treatment information to courts, with the primary difference being that the criminal justice form does not permit revocation, unlike the consent to release information to the child welfare agency which permits revocation of consent at any time. A court order or consent is required even when a parent is mandated into assessment or treatment. “Confidentiality of Alcohol and Drug Abuse Patient Records” requirements are found in Volume 42 of the Code of Federal Regulations, Part 2 (42 C.F.R. Part 2). The Health Insurance Portability and Accountability Act (HIPAA) also protects use and disclosure of certain health information through national standards available at <http://www.hhs.gov/ocr/hipaa>.

- **Cycle of addiction**—The collaboration should ensure that child welfare workers have an understanding of the nature and progression of the disease of addiction.
- **Relapse is an opportunity for intervention and may be part of enhancing recovery**—When child welfare workers share this understanding of relapse, they can work with their alcohol and drug services partner and parents to create plans to address child safety.
- **Longer time in recovery is positive**—Successful treatment outcomes are related to length of time in treatment. Therefore, it is important to connect a person in need of treatment to a treatment program as soon as possible. This is especially important for individuals involved with the child welfare system due to the timelines of the Adoption and Safe Families Act.

2. What information about child welfare will help substance abuse counselors work with parents in treatment? Or, what does the treatment counselor need to learn from me?

Understanding and navigating through the child welfare system is a challenge even to those who work within it. For those outside the system, it is even more difficult to understand. The rules are neither intuitive nor obvious. Child welfare workers can help demystify the child welfare system.

- Explain the role of a child welfare worker.
- Help the substance abuse counselor understand that child welfare actions are driven by a priority for immediate child safety, the need to prevent future risk, and that safety and risk must be assessed throughout the period that the case is active.
- Help the substance abuse services provider understand your timelines under the Adoption and Safe Families Act. The substance abuse counselor should be aware of the applicable Adoption and Safe Families Act rules and court processes and how they affect the child welfare case plan.
- Share specific child welfare parameters for each case receiving alcohol and drug services. For example, is this an in-home case or has the child been removed from the home? Have one or more children been removed, while one or more children remain in the home? Is it a voluntary case or is the court involved? What are the court dates and case plan requirements? Explaining the child(ren)'s placement and the voluntary or involuntary nature of the case can also be used by the substance abuse counselor to facilitate treatment.
- Explain the development of court reports, including the types of information needed to show progress on the child welfare case plan, hearings schedule and procedures, and importance of including information regarding the parent's treatment and recovery progress.

- Share permanency plans. What is the permanency goal for the child? Is there a goal of reunification? What is the optimum parent-child visitation schedule? Is there a concurrent plan? Discussing permanency, concurrent planning (if applicable) and how the parent's progress will be determined in the case plan is important to the child welfare-alcohol and drug services partnership; it impacts the child welfare case plan and the alcohol and drug services treatment plan.

3. What specific areas should be included in the collaboration?

The partnership between a child welfare worker and substance abuse counselor works best when both parties share mutual ownership. Both professionals have resources they can bring to bear on a family's needs. Areas to consider for child welfare-substance abuse treatment collaboration include:

- In-depth **assessment** of parents' and children's needs, including a substance abuse assessment.
- Services to be provided if there is a **waiting list** for treatment. For example, regular and frequent contact with the parent, brief interventions with the parent, or other strategies while the parent waits for the desired level of treatment to become available should be designed and arranged.
- **Case planning.**
- **Integration** of case plans or a joint treatment/child welfare case plan.
- **Engagement** of parent and **retention** in treatment.
- Identification and inclusion of other potential **partners** and needed services, such as: income support, mental health, domestic violence services, childcare, employment training, health care, and housing programs.
- **Child visitation.**

- Supportive or counseling **services for the child**, including services for the child’s alcohol or drug experimentation or use.
- Coordinate **case management**.
- **Treatment monitoring** and recovery progress.
- Joint system of **follow-up** with parents who miss treatment appointments or drop out of treatment.
- Deciding how to handle **slips and relapses**.
- Collaborative intervention by the child welfare and alcohol and drug services agencies to **re-engage a parent in treatment** and reassess child safety.
- Ongoing **assessment of child safety and risk of harm**.

How to increase the chance of a successful collaboration

Collaborations can be like families—there are times when everyone gets along and everything works smoothly; there are other times when there are disagreements and unclear communications. Child welfare and alcohol and drug services professionals generally are passionate and committed; emotions may be strong and feelings may run high. You will disagree about some things. Collaborations and partnerships can weather these times. A key ingredient for continued collaboration is communication.

You can foster a culture of collaboration. One expert has identified seven rules of successful collaboration that can be tailored to a child welfare-substance abuse partnership.⁶⁰ These rules are simple, but not always easy to carry out.

An important rule of collaboration—Make the commitment to stay at the table, and continue to talk.

- Believe in the value of the work you do every day.
- See your community as a place of abundance rather than scarcity.
- Recognize that the needs of children and families in your community are greater than one organization can meet.
- Focus on child and family needs rather than on organizational needs.
- Understand the strength of what you have in common with collaborators.
- Value diversity and synergy; there is often another way that is more effective than my way or your way.
- Reject the notions of turf and territory. Remember, you are standing on common ground.

In collaborations personalities matter. Important qualities include: flexibility, openness, patience, interpersonal sensitivity, the willingness to extend trust, and the willingness to do things in a new way.⁶¹ Our most vulnerable children and families will benefit when you bring these traits to your child welfare-substance abuse partnership.

Resources

Federal resources:

Administration for Children and Families

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. <http://www.acf.hhs.gov/index.html>

ACF's **Child Welfare Information Gateway** promotes the safety, permanency, and well-being of children and families by connecting child welfare, adoption and related professionals as well as concerned citizens to timely, essential information. <http://www.childwelfare.gov>

National Institute of Health

The **National Institute on Alcohol Abuse and Alcoholism** (NIAAA) provides leadership in the national effort to reduce alcohol-related problems. Its research programs include genetics, neuroscience, epidemiology, health risks and benefits of alcohol use, prevention and treatment. <http://www.niaaa.nih.gov>

The **National Institute on Drug Abuse** (NIDA) leads the national scientific effort to address drug abuse and addiction. The website provides information for students and young adults, parents and teachers, and researchers and health professionals. <http://www.nida.nih.gov>

This NIDA website provides a list of commonly abused drugs, how they are ingested or used, and intoxicating effects of types of drugs. <http://www.drugabuse.gov/DrugofAbuse.html>

Substance Abuse and Mental Health Services Administration

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. <http://www.samhsa.gov/index.aspx>

SAMHSA's/ACF's **National Center on Substance Abuse and Child Welfare** (NCSACW) provides assistance to local, State, and tribal agencies to improve systems and practice for families with substance use disorders who are involved in the child welfare and family judicial systems. NCSACW provides on-line courses for child welfare, substance abuse treatment and court professionals. <http://www.ncsacw.samhsa.gov> (714) 505-3525

SAMHSA's **National Clearinghouse for Alcohol and Drug Information** (NCADI) is the Nation's one-stop resource for information about substance abuse prevention and addiction treatment. NCADI distributes a wide range of free or low-cost materials, including fact sheets, brochures, pamphlets, monographs, posters, and video tapes. Information specialists are available to answer questions about alcohol and drug abuse 24 hours a day, 7 days a week. <http://www.ncadi.samhsa.gov> (800) 729-6686

SAMHSA's **treatment program locator** Web site includes more than 11,000 addiction treatment programs, including residential treatment centers, outpatient treatment programs, and hospital inpatient programs for drug addiction and alcoholism. Listings include treatment programs for marijuana, cocaine, and heroin addiction, as well as drug and alcohol treatment programs for adolescents, and adults. <http://www.findtreatment.samhsa.gov>

Other resources:

The following is a sampling, not a complete list, of available resources for family members. Inclusion on this list does not imply endorsement by SAMHSA. All States and most local governments have an office on substance abuse issues that can be an excellent resource; consult your local telephone book.

Alcoholic Anonymous

Alcoholics Anonymous (AA) is a fellowship of men and women who share their experience, strength and hope to help each other to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees, AA is self-supporting through member contributions. AA's primary purpose is to stay sober and help other alcoholics to achieve sobriety. <http://www.alcoholics-anonymous.org> (212) 870-3400

Al-Anon and Alateen

Al-Anon and Alateen are organizations to help families and friends of alcoholics recover from the effects of living with the problem drinking of a relative or friend. Whether the alcoholic is still drinking or not, Al-Anon offers hope and recovery to all people affected by the alcoholism of a loved one. Alateen is the recovery program for young people. Alateen groups are sponsored by Al-Anon members.

<http://www.al-anon.alateen.org> (888) 4AL-ANON

Adult Children of Alcoholics

Adult Children of Alcoholics is a twelve step, twelve tradition program of women and men who grew up in alcoholic or otherwise dysfunctional homes. Members meet with each other in a mutually respectful, safe environment and acknowledge common experiences.

<http://www.adultchildren.org> (310) 534-1815

Cocaine Anonymous

Cocaine Anonymous (CA) is open to all persons who state a desire to stop using cocaine, including "crack" cocaine, as well as all other mind-altering substances. There are no dues or fees for membership. Expenses are supported by voluntary contributions of members. CA uses the 12-step recovery method, which involves service to others as a path towards recovery from addiction. CA believes that one addict talking to another can provide a level of mutual understanding and fellowship that is hard to obtain through other methods. <http://www.ca.org> (310) 559-5833

Co-Dependents Anonymous

Co-Dependents Anonymous, a program of recovery from codependence, is a fellowship of men and women whose common purpose is to develop healthy relationships. The only requirement for membership is a desire for healthy and fulfilling relationships. The twelve steps and twelve traditions are used for knowledge and wisdom.

<http://www.codependents.org> (602) 277-7991

Families Anonymous

The Families Anonymous (FA) purpose is to provide mutual support, and to offer a safe place to share experiences and concerns for relatives and friends of those who have alcohol, drug or behavioral problems. FA is a 12-step fellowship of support groups.

<http://www.familiesanonymous.org> (800) 736-9805

Narcotics Anonymous

Narcotics Anonymous (NA) is an international, community-based association of recovering drug addicts with more than 31,000 weekly meetings in over 100 countries worldwide. Meeting sites are online, as well as, recovery literature in English and Spanish. <http://www.na.org> (818) 773-9999

National Association for Children of Alcoholics

The National Association for Children of Alcoholics (NACOA) is a national nonprofit membership organization whose mission is to advocate for all children and families affected by alcoholism and other drug dependencies. NACOA's website provides access to research, books, videos and other resources to help families, raise public awareness and advance professional knowledge.
<http://www.nacoa.org> (888) 554-COAS

Endnotes

- 1 U.S. Department of Health and Human Services (2004). *Child Maltreatment 2002*. Washington, DC: U.S. Government Printing Office.
- 2 U.S. Department of Health and Human Services (March, 2003). *The AFCARS Report* [Electronic version]. <http://www.acf.dhhs.gov/programs/cb/publications/afcars/report8.htm>.
- 3 U.S. General Accounting Office (1994). *Foster Care: Parental Drug Abuse Has Alarming Impact on Young Children*. GAO/HEHS-94-89.
- 4 U.S. Department of Health and Human Services (1999). *Blending Perspectives and Building Common Ground. A Report to Congress on Substance Abuse and Child Protection*. Washington, DC: U.S. Government Printing Office.
- 5 U.S. Department of Health and Human Services (1999). Ibid.
- 6 Child Welfare League of America (1998). *Alcohol and Other Drug Survey of State Child Welfare Agencies*. Washington, DC: Author.
- 7 U.S. Department of Health and Human Services (1999). Ibid, p. 14.
- 8 U.S. Department of Health and Human Services (1999). Ibid., p. 12.
- 9 U.S. Department of Health and Human Services (1999). *Brief Interventions and Brief Therapies for Substance Abuse*. DHHS Publication No. SMA 99-3353. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.
- 10 National Institute on Alcohol Abuse and Alcoholism (July, 2003). *Alcohol Alert*, 60 [Electronic version]. <http://www.niaaa.nih.gov/publications/aa60.htm>.
- 11 U.S. Department of Health and Human Services (2000). *10th Special Report to the U.S. Congress on Alcohol and Health* [Electronic version]. <http://www.niaaa.nih.gov/publications/10report/chap02.pdf>, p. 136-137.
- 12 National Institute on Drug Abuse (2000). *Gender Differences in Drug Abuse Risks and Treatment. Research Findings (15) 4*. Rockville, MD: Author.
- 13 The National Center on Addiction and Substance Abuse (CASA) at Columbia University (2003). *The Formative Years: Pathways to Substance Abuse Among Girls and Young Women Ages 8-22* [Electronic version]. Retrieved April 1, 2003, from <http://www.casacolumbia.org>
- 14 U. S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
- 15 U.S. Department of Health and Human Services (2002). *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorder and Mental Disorders. Substance Abuse and Mental Health Services Administration*.
- 16 Young, N.K. and Gardner, S.L. (2002). *Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services With Child Welfare*. SAMHSA Publication No. SMA-02-3639. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, p. 132.
- 17 Young, N.K., Boles, S.M., & Otero, C. (2007). Parental substance use disorders and child maltreatment: Overlaps, gaps, and opportunities. *Child Maltreatment*, 12(2), 137-149.
- 18 Office of National Drug Control Policy (2003). *Drug Facts: Methamphetamine*, <http://www.whitehousedrugpolicy.gov/drugfact/methamphetamine/index.html>

-
- 19 National Institute on Drug Abuse (2002). Research Report Series: Methamphetamine Abuse and Addiction, <http://www.drugabuse.gov/Research Reports/Methamph/methamph2.html>
- 20 National Institute on Drug Abuse Info Facts (June, 2004). <http://www.drugabuse.gov/Infobox/methamphetamine.html>
- 21 National Institute on Drug Abuse (2002). Research Report Series: Methamphetamine Abuse and Addiction, <http://www.drugabuse.gov/Research Reports/Methamph/methamph2.html>
- 22 Office of National Drug Control Policy (2003). Drug Facts: Methamphetamine, <http://www.whitehousedrugpolicy.gov/drugfact/methamphetamine/index.html>
- 23 The social and economic effects of the methamphetamine epidemic on America's child welfare system. US Senate Committee on Finance, 109th Cong. (2006) (testimony of Nancy K. Young)..
- 24 Hampton, R.L., Senatore, V., & Gullota, T.P. (1998). *Substance Abuse, Family Violence, and Child Welfare: Bridging Perspectives*. Sage Publications: Thousand Oaks, CA.
- 25 Shillington, A., Hohman, M. & Jones, L. (2001). Women in Substance Use Treatment: Are Those Involved in the Child Welfare System Different? *Journal of Social Work Practice in the Addictions*, 1(4), 25-46..
- 26 Rosas, A. (2003a). Child Sexual Abuse. In *Child Abuse and Neglect: Guidelines for the Identification, Assessment, and Case Management*, Durfee, M. and Peterson, M. (Eds.). Volcano Press: Volcano, CA.
- 27 Rosas, A. (2003b). Sexually transmitted diseases. In *Child Abuse and Neglect: Guidelines for the Identification, Assessment, and Case Management*, Durfee, M. and Peterson, M. (Eds.). Volcano Press: Volcano, CA.
- 28 Colorado Drug Endangered Children, Inc., <http://www.colodec.org>.
- 29 Drug Endangered Children (2000). *Drug Endangered Children Health and Safety Manual*. (Previously available from the Drug Endangered Children Resource Center, 14622 Victory Blvd., Van Nuys, CA 91411).
- 30 Irvine, G.D. & Chin, L. (1997). The Environmental Impact and Adverse Health Effects of the Clandestine Manufacture of Methamphetamine. *Substance Use and Misuse*, 32 (12 & 13), 1811-1812.
- 31 National Institute on Drug Abuse, Research Report Series (1998). Methamphetamine, Abuse and Addiction (NIH 98-4210).
- 32 Department of Justice Information Bulletin (2002). *Children at Risk* (No. 2002-L0424-001).
- 33 Manning, T. (1999). Drug Labs and Endangered Children. *FBI Law Enforcement Bulletin*, 10-14.
- 34 U.S. Department of Health and Human Services (2008). *Child Welfare Policy Manual*. Retrieved October 30, 2008 from http://www.acf.hhs.gov/j2ee/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=354
- 35 National Association for Children of Alcoholics (n.d.). *Facts 4 You*. Retrieved September 28, 2003 from <http://www.nacoa.org>
- 36 The 1999 Report to Congress, *Blending Perspectives and Building Common Ground*, noted that 11% (8.3 million) of U.S. children live with at least one parent who is an alcoholic or in need of treatment for the abuse of illegal drugs.
- 37 Green, M. Y. (2002, November/December). Minorities as Majority: Disproportionality in Child Welfare and Juvenile Justice [Electronic version]. *Children's Voice*. <http://www.cwla.org/articles/cv0211minorities.htm>
- 38 Goldstein, A. (2001). *Addiction: From Biology to Drug Policy* (2nd ed.). New York: Oxford University Press, p. 263.

-
- 39 Mee-Lee, D. (n.d.). Placement Criteria and Patient-Treatment Matching. Retrieved September 24, 2003, <http://www.adoctorm.com/docs/match.htm>
- 40 Center for Substance Abuse Treatment. (2006). *National Summit on Recovery Conference Report*. DHHS Publication No. (SMA) 06-xxxx. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- 41 Gorski, T.T. and Kelley, J.M. (1996) *Counselor's Manual for Relapse Prevention with Chemically Dependent Criminal Offenders*. Technical Assistance Publication Series 19. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration.
- 42 U.S. Department of Health and Human Services, National Institute on Drug Abuse (2003). A Collection of Articles that Address Women and Gender Differences research [Electronic version]. *NIDA Notes*. http://www.drugabuse.gov/NIDA_Notes/NN0013.html
- 43 U.S. Department of Health and Human Services, National Institute on Drug Abuse (n.d.). Ibid., p. 56.
- 44 National Institute of Mental Health (2005). *Men and Depression*. Retrieved July 21, 2009 from <http://www.nimh.nih.gov/health/publications/men-and-depression/men-and-depression.pdf>
- 45 National Institute of Mental Health. *Co-Occurrence of Depression with Medical, Psychiatric, and Substance Abuse Disorders*. Retrieved July 21, 2009 from [http://www.mhacolorado.org/file_depot/0-10000000/30000-40000/31946/folder/76324/Depression\\$2C+Co-Occurring+with+other+illnesses.pdf](http://www.mhacolorado.org/file_depot/0-10000000/30000-40000/31946/folder/76324/Depression$2C+Co-Occurring+with+other+illnesses.pdf)
- 46 Center for Substance Abuse Treatment. (2005). *Substance Abuse Treatment for Persons With Co-Occurring Disorders*. Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3922. Rockville, MD: Substance Abuse Mental Health Services Administration.
- 47 Center for Substance Abuse Treatment (2003). CSAT's Comprehensive Substance Abuse Treatment Model for Women and their Children. Unpublished manuscript.
- 48 The National Center on Addiction and Substance Abuse (CASA) at Columbia University (2001). *Shoveling Up: The Impact of Substance Abuse on State Budgets* <http://www.casacolumbia.org>
- 49 U.S. Department of Health and Human Services (1999). Ibid., p. 13.
- 50 Miller, W. R., and Rollnick, S. (1991). *Motivational Interviewing: Preparing People to Change Addictive Behavior*. New York: Guilford Press.
- 51 U.S. Department of Health and Human Services (1999). *Enhancing Motivation for Change in Substance Abuse Treatment*. Publication No. SMA 02-3629. Rockville MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Appendices B and C, 185-237.
- 52 Prochaska, J.O., & DiClemente, C.C. (1982). *Transtheoretical Therapy: Toward a More Integrative Model of Change*. *Psychotherapy: Theory, Research, and Practice*, 19, 275-288.
- 53 Stocker, S. (1998, November). Men and women in drug abuse treatment relapse at different rates and for different reasons. *National Institute on Drug Abuse Research Findings (13)*, 4, p. 56.
- 54 Stocker, S. (1998, November). Ibid p. 57.
- 55 Stocker, S. (1998, November). Ibid p. 56.
- 56 Findlater, J. E. and Kelly, S. (1999). Child Protective Services and Domestic Violence. *The Future of Children Domestic Violence and Children (9)*, 3. (pp. 84-96). Los Altos, CA: The David and Lucile Packard Foundation.

-
- 57 U.S. Department of Health and Human Services (2000). *Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues*. DHHS Publication No. SMA 00-3357. Rockville MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, p. 57.
- 58 Sussman, T. (2000, January). Interagency Collaboration and Welfare Reform. *Welfare Information Network Issue Notes (4)*, 1.
- 59 Hogue, T. (n.d.). Community Based Collaboration: Community Wellness Multiplied. Retrieved December 5, 2003, from <http://crs.uvm.edu/ncco/collab/wellness.html>.
- 60 Sturm, P. (2000). The Seven Rules of Successful Collaboration. *Nonprofit World*, 18, (2), p. 33-36.
- 61 Hoel, J.L. (1998). *Cross-System Collaboration: Tools that Work*. Washington, D.C.: Child Welfare League of America.

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