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The User Manual Series

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Protecting Children in Substance-Abusing Families

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PREFACE

The Child Abuse Prevention and Treatment Act was signed into law in 1974. Since that time, the Federal Government has served as a catalyst to mobilize society's social service, mental health, medical, educational, legal, and law enforcement resources to address the challenges in the prevention and treatment of child abuse and neglect. In 1977, in one of its early efforts to achieve this goal, the National Center on Child Abuse and Neglect (NCCAN) developed 21 manuals (the *User Manual Series*) to provide guidance to professionals involved in the child protection system and to enhance community collaboration and the quality of services provided to children and families. The manuals described each professional's roles and responsibilities in the prevention, identification, and treatment of child maltreatment. Other manuals in the series addressed special topics, for example, adolescent abuse and neglect.

Our understanding of the complex problems of child abuse and neglect has increased dramatically since the user manuals were developed. This increased knowledge has improved our ability to intervene effectively in the lives of troubled families. Likewise, we have a better grasp of what we can do to prevent child abuse and neglect from occurring. Further, our knowledge of the unique roles key professionals can play in child protection has been more clearly defined, and a great deal has been learned about how to enhance coordination and collaboration of community agencies and professionals. Finally, we are facing today new and more serious problems in families who maltreat their children. For example, there is a significant percentage of families known to Child Protective Services (CPS) who are experiencing substance abuse problems.

Because our knowledge base has increased significantly and the state of the art of practice has improved considerably, NCCAN has updated the *User Manual Series* by revising many of the existing manuals and creating new manuals that address current innovations, concerns, and issues in the prevention and treatment of child maltreatment.

This manual, *Protecting Children in Substance-Abusing Families*, is designed for professionals in the fields of child welfare, mental health, health care, education, law, the faith community, and substance abuse prevention and treatment. The manual is intended to help professionals identify the various forms of parental substance abuse, assess the strengths and needs of families affected by alcohol and/or other drug abuse, develop service plans, and provide intervention. The manual includes a section addressing the identification of substance-abusing clients, a review of the characteristics of substance-abusing parents and the risks to children growing up in households in which alcohol and/or other drugs are abused, a discussion of the legal issues related to child maltreatment and parental substance abuse, a description of approaches to family assessment, and a summary of innovative intervention programs and service delivery strategies.

Protecting Children in Substance-Abusing Families is one in a series of User Manuals developed by the National Center on Child Abuse and Neglect. Initiated in 1977, and now being updated, the User Manual Series provide guidance to professionals involved in the child protection system. Some manuals focus specifically on professional roles and responsibilities in the prevention, identification, and treatment of child abuse and neglect, such as *The Role of Educators in the Prevention of Child Abuse and Neglect*. Other manuals focus on special topics, such as *Treatment for Abused and Neglected Children: Infancy to Age 18*. Readers are encouraged to review the entire *User Manual Series* for additional information relevant to their specific profession and/or topics of particular interest.

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All of the contributors to this manual have collaborated extensively on clinical, training, and research projects under the direction of Judy Howard, M.D. Dr. Howard, Professor of Pediatrics at the UCLA School of Medicine, is currently head of the Developmental Studies Program at the UCLA Department of Pediatrics. Since 1982 she has chaired the Child Abuse Policy Committee at UCLA Medical Center, and from 1982 to 1989 she was Medical Director of the UCLA Suspected Child Abuse and Neglect (SCAN) Team. She has directed the UCLA Intervention Program for Handicapped Children since 1974 and currently leads a pediatric clinic providing medical evaluations and developmental assessments for medically fragile infants. She has been Principal Investigator on a variety of service, training, and research projects related to prenatally substance-exposed infants and currently leads an ongoing training grant program promoting interdisciplinary, community-based teams to serve this population within Los Angeles County; a 5-year comprehensive child development program serving families affected by alcohol and/or other drug abuse; and a comprehensive treatment program for pregnant and parenting women who are exposed to drugs.

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INTRODUCTION

As the incidence of alcohol and other drug abuse becomes more visible in our Nation, parental substance abuse is increasingly recognized as a significant factor in cases of child maltreatment. Estimates suggest that 50 to 80 percent of all child abuse and neglect cases substantiated by Child Protective Services (CPS) involve some degree of substance abuse by the child's parents.¹ The profound impact of substance abuse on the lives of children is also documented in research on perinatal addiction. A 1990 General Accounting Office study of medical records at 10 hospitals in 5 cities (Boston, New York, Chicago, Los Angeles, and San Antonio) found the incidence of drug-affected newborns ranges from 1.3 to 18.1 percent of all live births.² Other research suggests that over 7,000 children each year are born with Fetal Alcohol Syndrome, a consequence of maternal alcohol use during pregnancy.³

Infants and children who reside in households in which alcohol and other drugs are abused may suffer harm in a variety of ways. A parent's overriding involvement with alcohol and other drugs may leave the parent emotionally and physically unavailable to the child. A parent's mental functioning, judgment, inhibitions, and/or protective capacity may be seriously impaired by alcohol or drug use, placing the child at increased risk of all forms of abuse and neglect. A substance-abusing parent may "disappear" for hours or days, leaving the child alone or with someone unable to meet the child's basic needs. A parent may also spend the household budget on alcohol and/or other drugs, depriving the child of adequate food, clothing, housing, and health care. A child's health and safety may be seriously jeopardized by criminal activity associated with the manufacture and distribution of illicit drugs in the home. Consistent exposure to parental abuse of alcohol and other drugs may contribute to the child's own substance abuse.

As is true in most cases of child maltreatment, parents and caregivers who abuse alcohol and/or other drugs do not intend to harm their children. Most do not stop to consider that even a single incident of substance abuse can result in serious injury to their child. Further, the risks associated with parental substance abuse have no socioeconomic or racial boundaries. Upper- and middle-class parents who abuse alcohol and/or other drugs pose just as much risk of harming their children as parents who abuse drugs and live in poverty. The primary difference lies in the tendency of professionals to overlook or forgive the upper- or middle-class substance abuser, or to offer help more expediently to these families.

Because of the harmful repercussions commonly associated with substance abuse, early identification of the problem and early intervention are essential. All professionals who work with parents and children need to understand the indicators and dynamics of substance abuse, routinely probe for the problem in families, and be prepared to intervene when the problem is suspected or confirmed. This requires examining one's own attitudes about substances of abuse and substance abusers, the origins of these attitudes, and how one's attitudes influence intervention with families. Professionals also need to be sensitive to the cultural context in which the families exist.

Additionally, professionals need to be informed about the various substances of abuse and their effects on adult behavior, child development, and parenting. They need to be knowledgeable about the nature of substance abuse and the chronic, often relapsing nature of this disorder. They need to learn to recognize the warning signs of substance abuse in a family and know how to ask the "right" questions, how to conduct a comprehensive family assessment, and ways to protect a child from maltreatment. Lastly, professionals need

to need to be able to provide culturally sensitive support and guidance to families affected by substance abuse, act as advocates for these families in the service system, and work toward improvements in the prevention and treatment of substance abuse. Unless professionals possess these skills and knowledge, services provided for parents and children may prove inadequate or inappropriate.

IDENTIFYING ALCOHOL AND/OR OTHER DRUG USE

CASE VIGNETTE: Lisa was 19 years old and pregnant with her first child when her mother brought her for her first prenatal visit, which was towards the end of the third trimester. Clinic staff noted that Lisa was tall and quite thin, made poor eye contact, and seemed hostile towards them as well as to her mother. During the clinic appointment, Lisa's mother noted that the baby's father was a substance abuser who was occasionally violent towards Lisa. Just prior to delivery, at a second clinic visit, Lisa revealed to a social worker that she had used phencyclidine (PCP) and cocaine occasionally before her pregnancy. Although Lisa denied that she had a substance abuse problem, staff counseled her about the effects of substance abuse on the unborn child. Two weeks later, Lisa delivered a baby boy who was small for gestational age. Both she and her baby had urine toxicology screens that were positive for PCP and cocaine.

Because of the nature of chemical dependency and the generally illicit use of many drugs, often self-report is not an adequate screening measure to detect drug or alcohol abuse. Professionals commonly encounter denial and withholding of information when interviewing chemically involved clients. Thus, behavioral and physical indications of intoxication, although sometimes ambiguous, can provide important clues. Further, various tests may be recommended to help in the diagnosis and treatment of substance abuse.

PHYSICAL AND BEHAVIORAL INDICATIONS OF SUBSTANCE ABUSE IN FAMILIES

The negative impact of alcohol and/or other drug abuse on family functioning and health may become apparent through a variety of physical and behavioral indicators. The following indicators can alert professionals to a possible substance abuse problem among family members:

- personality changes and inconsistent behaviors;
- financial problems despite an adequate income;
- sudden, unexplained wealth;
- frequent automobile or other accidents;
- self-defeating behaviors (e.g., missed appointments, absences from work, repeated lateness); repeated changes in friends and associates;
- altered mental status consistent with alcohol or other drug intoxication;
- withdrawal symptoms;
- skin lesions such as abscesses or track marks consistent with injection drug use;
- the presence of drug paraphernalia;

- frequent absences or tardiness of children at school; and
- a family member consistently making excuses for an absent family member.

PHYSICAL AND BEHAVIORAL INDICATIONS OF PERINATAL SUBSTANCE ABUSE

The first step in determining a drug- or alcohol-dependent pregnant woman's need for services is to identify the problem. In addition to the general indicators noted above, the following physical signs and symptoms are suggestive of perinatal alcohol and/or other drug abuse:⁴

- lack of prenatal care,
- previous delivery of a prenatally drug-exposed infant,
- intrauterine growth retardation in the absence of other identifiable causes, and
- placental abruption in the absence of other identifiable causes.

Additional indicators of possible alcohol or other drug abuse may include women who deliver outside the obstetrical unit (in the emergency room, in the ambulance, or at home), or women who have abrupt deliveries.⁵ In order to promote consistency in assessment, the provision of appropriate prenatal services must be ensured. To assure the child's safety after delivery, many hospitals have developed protocols to assist in identification and referral of pregnant and postpartum substance-abusing women and their offspring for treatment and supportive services. Appendix II provides a sample protocol.

PHYSICAL AND BEHAVIORAL INDICATIONS OF RELAPSE FOR INDIVIDUALS IN RECOVERY

Relapse is inherent in alcohol and other drug abuse. The identification of a substance-affected family is only the beginning of a long process toward healing and maintaining a sober lifestyle. For an individual in recovery, the following behavioral signs and symptoms may alert professionals to the imminent risk of relapse:

- increasing self-pity,
- increasing depression,
- setting expectations that are too numerous or unrealistic,
- feelings of being "all-powerful" or not needing support, and
- distancing from friends who are clean and sober.

DIAGNOSTIC TESTS FOR ALCOHOL USE

After drugs or alcohol have been ingested, they pass via the bloodstream to various parts of the body, such as the liver and kidneys, where they are converted into substances called metabolites. Different drugs and their metabolites leave the body at different rates. The rate of drug and alcohol excretion is affected by many

factors, including the amount of alcohol or other drug taken; the frequency of use; the user's daily liquid intake, health status, exercise, age, sex, body weight, and metabolic rate; and the concurrent use of other drugs, including alcohol and/or nicotine.

The most common tests for alcohol use include an evaluation of blood alcohol levels and a breath analyzer, both of which are routinely used to determine whether an individual is driving while under the influence. Because alcohol passes rapidly through the system, these tests must be conducted very quickly in order to ensure any degree of accuracy regarding alcohol consumption. For this same reason, the urine drug toxicology screens described below are generally not helpful in detecting alcohol use.

TOXICOLOGY SCREENING FOR DRUG USE

Urine is the body fluid most commonly used for drug screening. For infants, meconium (the first stool passed by a newborn at birth) also can be used for toxicology screening. Compared with urine, the recovery rate and concentration of drug metabolites often is higher in meconium. However, collection of a newborn's first stool is not always possible because some meconium is eliminated during delivery. Hair analysis is another method currently being investigated in research studies to test for drug metabolites. Compared with other methods, hair is reported to provide a longer term of history of drug use.

The urine screening methods used by most laboratories generally can detect drug metabolites no more than 48 to 72 hours following drug use. Drugs such as marijuana and phencyclidine (PCP) are fat soluble and are stored in fat, liver, lung, and brain tissue; these substances or their metabolites often can be found in the urine several days after use. Other drugs such as cocaine and amphetamine are water soluble and are excreted from the body more rapidly.

When requesting and interpreting toxicology results, professionals must remember the following:

- There are two types of testing procedures:
 - screening tests such as thin layer chromatography (TLC) and immune assay tests (EMIT), and
 - confirmatory tests such as gas chromatography.

Screening tests are highly sensitive, whereas confirmatory tests are more specific. Because screening tests may yield false positive results, it is recommended that, when a positive result is obtained with a general screening procedure, it be confirmed by a less sensitive but more specific confirmatory method. Some laboratories may use a blood test to confirm a positive urine screen.

- There may be considerable variation in what drugs are routinely included in the laboratory screening process. Toxicology screening procedures vary from laboratory to laboratory. A negative toxicology result does not apply to a drug that was not included in the screen. For example, many laboratories do not routinely screen for PCP or marijuana. Thus, without a special request for PCP or marijuana screening, these substances, even if present in the urine, would not be identified.
- The quality of control over specimen handling and collection procedures greatly influence toxicology results. Because there are a number of ways to alter toxicology tests (e.g., providing someone else's urine or diluting the urine sample with toilet water), it is important that the person collecting the urine sample monitor the specimen collection process closely. Because test results also can be affected by diet and temporary abstinence, random screening without prior notice may provide a more accurate indication of drug use.

- When screening newborns, it is important to collect the first voided urine. Late collection of urine can yield negative results because metabolites may not be present at a level high enough for detection.
- In cases of prenatal substance abuse, it is helpful to test both mother and newborn to provide a more accurate picture of prenatal exposure.

In interpreting toxicology results, an important point warrants emphasis. False positive and false negative results do, at times, occur. Therefore, it is unwise to rely exclusively on toxicology screening to identify use of illicit substances. Rather, toxicology screening should be used in conjunction with history taking and observation for signs and symptoms to corroborate suspected use.

Toxicology testing during pregnancy and at the time of delivery can provide useful diagnostic information for health care purposes. The results of toxicology screens often are used by hospital personnel as a part of a suspected child abuse report. Although they indicate use of, or exposure to, a substance at some prior time, positive toxicology test results do not substantiate child abuse. In addition, false positive and false negative test results do occur. Thus, results should always be used in conjunction with comprehensive case evaluations of suspected child maltreatment.

The possible dual use of toxicology results for both medical and legal purposes also raises important questions about informed consent. Community standards vary for obtaining consent in cases involving prenatal substance abuse. Some medical facilities conduct toxicology testing under a general "conditions of admission" form that authorizes various medically indicated procedures. Other facilities require a special consent specifically authorizing toxicology testing. Other hospitals require that a patient be specifically informed of potential legal consequences before testing is conducted.

Many hospitals conduct toxicology screening of newborns, either under the general admissions "conditions of admission" form or in accordance with State child abuse and neglect laws that allow for certain testing and evaluation procedures without parental consent for the purpose of diagnosing prenatal drug exposure. Other institutions, however, require specific parental consent for toxicology screening. If parents refuse permission for testing, a court order can then be obtained in some States.

Because practices vary, it is important that professionals are aware of alcohol and drug abuse confidentiality regulations (e.g., 42 CFR, Part 2), the standards used within their local communities for obtaining consent for toxicology testing and for disclosing test results to child protection agencies. Hospital protocols also provide guidance for staff as well as help ensure consistency in hospital practice.

SUMMARY

The behavioral changes brought on by various substances differ greatly from drug to drug. Alcohol, for instance, is considered to be a sedative/depressant, whereas cocaine and methamphetamine are stimulants. However, because polysubstance abuse is the most prevalent form of addiction, the effects of individual substances often are difficult to determine in any individual. Thus, if a client admits to cocaine use, it is often helpful for the professional to inquire about possible use of alcohol, marijuana, and/or another substance. The identification of alcohol and/or other drug abuse is a complex process that involves history-taking; observation of an individual's lifestyle and behaviors; and, finally, the use of diagnostic tests such as a breath analyzer, urine toxicology screens, and others described above. Once an individual with a substance abuse problem has been identified, professionals need to collaborate in planning a treatment/supportive services program that is sensitive to that individual's needs and family situation.

CHEMICALLY INVOLVED PARENTS: CHARACTERISTICS OF PARENTS AT RISK

CASE VIGNETTE: Lisa had not seen her father since she was around 8 years of age. Her mother was an unemployed recovering alcoholic who lived with her boyfriend. Before her pregnancy Lisa had been a model for 3 years and reported that she was introduced to illicit drugs by friends at work who "partied" in the evenings. Through these friends, Lisa met Johnnie, the father of her child. Johnnie was a photographer who used drugs regularly and encouraged Lisa to join him. Drugs became part of their relationship, and before long Lisa lost her job and moved in with Johnnie. Although he was very jealous and sometimes abusive, Lisa stayed with Johnnie because she cared about him and because he also supplied her with drugs.

Parents who abuse alcohol and/or other drugs come from all walks of life, all ethnic backgrounds, and all socioeconomic levels. Further, alcohol and other drugs are not discriminatory in their effects on individuals who abuse them. This chapter describes the most common behavioral patterns associated with substance abuse that can be observed across the entire societal spectrum.

By the time they are identified by professionals, substance-abusing parents generally have progressed to the final stage of chemical dependency, and their long-term alcohol and/or other drug use is deeply entrenched and seriously disabling. If they do not have substantial financial and family supports to provide for them, these parents/caregivers often have limited ability to meet their own survival needs, let alone those of their dependent or, particularly, medically fragile children. However, even when substance-abusing parents do have financial and family supports, and therefore may be "invisible" to child welfare systems, their alcohol and/or drug abuse problem still has a devastating impact on family functioning and their children's healthy development.

Thus, a basic knowledge of the dynamics and effects of alcohol and other drug abuse is fundamental for professionals working with substance-abusing families. Many chemically involved parents are sincere in their desire to meet their children's needs, but they are limited in their physical, financial, social, and/or emotional abilities to do so. Substance abuse has a profound impact on a parent's capacity to provide the consistent nurturing and hands-on care that children require in order to thrive. Unless professionals are aware of the nature of substance abuse; the chronic, often relapsing nature of this disorder; and the unique characteristics and problems of chemically involved parents; services provided for parents and children may prove inappropriate or inadequate.

Substance abuse is a problem that affects all aspects of an individual's personal and family life. Strategies for intervention, therefore, generally acknowledge the following three basic assumptions:

- A true chemical dependency becomes the central organizing force around which the life of the substance abuser revolves, and that dependency affects every significant aspect of that person's functioning.
- The abuse of alcohol or other drugs on the part of even one family member, particularly if that person happens to be a parent, has a profound impact on the lives of all members of that family.

- The chemically involved parent has a range of serious medical and/or psychiatric problems, some of which may predate his/her alcohol and/or drug use and some of which may be the consequence of the dependency. All of these problems need to be addressed if intervention is to succeed.

THE NATURE OF SUBSTANCE ABUSE

The impact of alcohol and other drug abuse varies widely from individual to individual. The following characteristics seem fairly universal, however, regardless of the substance or substances of choice, and can help us to understand the nature of most chemical dependencies. By building upon this understanding, professionals will be better equipped to design realistic service plans that are more likely to be effective.

- **Alcohol and other drug abuse is progressive.** People do not set out to become alcoholics or addicts. First-time users universally resist the notion that they could ever become dependent on any chemical. It is with an accumulation of time and experience that the casual user becomes a substance abuser and that life can no longer be endured "clean and sober."
 - **Experimental use.** Early use is described as experimental. The user generally is motivated by curiosity or social pressure to try substances reputed to alter ways of thinking and feeling. Use during this phase is occasional, frequently unplanned, and involves little, if any, reorganization of lifestyle to accommodate it. Similarly, there may be no detectable deterioration in health, relationships, or ability to function as expected.
 - **Intensified use.** Progressively more regular use begins to impact the user's life in more significant ways. Because it is both planned and more frequent than experimental use, increased amounts of time, thought, energy, and money go into the acts of "scoring" and using. At this stage, one's social life may revolve around getting high, and peer relationships often change accordingly. The economic and personal costs escalate as the ability to function at school or work declines, and mood swings become more prominent.
 - **Habitual use.** Habitual use marks the onset of chemical dependency. Tolerance to the original drug of choice has developed, a problem remedied either by using larger amounts of the same drug or recourse to drugs that will produce a more intense experience. Solitary use increases; now the emphasis is on simply getting high, rather than on the social experience of "partying" with one's peers. The user is increasingly preoccupied with drug use and may turn to dealing or other criminal activity to support a growing dependency on more potent and more expensive drugs. Deterioration in all significant areas of functioning is present.
 - **Dependency.** Dependency, or addiction, is said to exist when the user can no longer manage life without getting high. Use may occur continuously or in binges, but now the substance plays such a central role in the individual's life that everything else tends to revolve around it. The effects of the alcohol and/or other drug use on health, finances, relationships, and emotional stability are profound as the user finds it increasingly difficult to perform even ordinary tasks. Judgment at this stage can be severely impaired.
- **The onset of chemical dependency is insidious.** Chemical dependency sneaks up on the individual who is, in any case, often not the best judge of his/her own addiction. In actuality, the lines drawn by professionals to note phases of drug and alcohol use (experimental, regular, habitual, and so on) are blurred, and precisely when the user moves from one phase to the next depends on many factors, including:

- physiological and psychological makeup,
- drug of choice,
- means of ingestion, and
- prior history.

A dependency can evolve over a long period of time (months or even years) or, as many crack addicts report, it can occur over the course of a weekend.

- **The earlier the person starts to use, the more likely that person is to become chemically dependent.** Although there are exceptions to this rule, generally, children who are introduced to drugs while still very young are more susceptible to heavier use and abuse than individuals whose experimentation occurs at a later age.
- **Anyone can become an addict.** Chemical dependency cuts across all racial, social, and economic lines. No one is immune. Although some individuals seem to have a higher threshold of addiction than others, exposure to the right substance of abuse under the right circumstances (times of stress, loss, pain, or boredom) has the potential to seduce anyone into a true chemical dependency.
- **Substance abuse is a family problem.** Substance abuse is a family problem in both a biological and a psychological sense. There is a growing body of evidence that certain people (some children of alcoholics, for instance) are biologically at highest risk of becoming chemically dependent. It is a family problem, also, insofar as coping behaviors are learned within the context of the family. Children of substance-abusing parents may learn to cope with unpleasantness in their lives as their parents have done before them, by taking substances into the body to effect a change in mental status. Finally, it is a family problem because everyone in the family is profoundly affected by the alcohol and/or drug abuse of even one of its members.
- **Denial is intrinsic to the problem of alcohol and other drug abuse.** It is well known that the substance abuser generally denies that there is a problem or minimizes its extent. It is less well known that the entire family, to protect its integrity and tenuous ability to function, also often denies the existence and impact of the problem.
- **Alcohol and other drug abuse is a systemic problem.** Substance abuse impacts every aspect of the user's physical, emotional, work, and social life. Health, jobs, school, and relationships are affected. With chronic abuse, no significant area of functioning remains untouched.
- **Substance abuse often afflicts those individuals who are already the most vulnerable, the least equipped to cope.** Frequently, persons most severely impacted by substance abuse come from families with multiple stresses, including alcohol and/or other drug abuse problems, mental health disorders, failures in school and/or employment, and/or a history of physical and/or sexual abuse. These individuals, already struggling to cope, are then further impaired by their drug use. Thus, they tend to come to treatment in very serious condition and typically need a wide range of services.

THE CHEMICALLY INVOLVED PARENT

The preceding description of the nature of substance abuse provides a background against which to better understand the characteristics and needs of substance-abusing parents. Because chemical dependencies have certain characteristics in common, it follows that victims also have much in common with one another. There is no "typical" substance abuser; however, the following summary of characteristics is intended to sensitize professionals to the issues with which many chemically involved parents struggle.

Childhood Deprivation

Many substance-abusing parents report histories of significant childhood deprivation. Often, this history includes an early home life marked by family violence, parental substance abuse, or parental psychiatric disorders. Parents who grew up in such environments often report deprivation in many areas of their lives—economic, physical, social, and emotional.

In families with inadequate early caregiving, oftentimes parents were poorly nourished, they may not have been provided with necessary health care, and their educational needs may have been neglected. Thus, as adults and parents, such individuals have numerous and chronic medical, dental, and educational problems that require attention. Developmental assessments, educational testing, and speech and other therapies that were overlooked during childhood can result in serious deficits that last a lifetime.

Many substance-abusing parents also recount histories of growing up in households in which there was a blurring of boundaries between parental and child roles. As young children, such parents often assumed primary responsibility for taking care of household and family needs. Although it may have filled a void or a need within the family, this role reversal may have also seriously interfered with the parent's timely acquisition of age-appropriate life skills and experiences. Thus, as adults, such individuals often have an impaired ability to form truly mutual adult relationships and a healthy self-concept that are prerequisites to successful parenting.

Frequently, the emotional and protective needs of parents who experienced early deprivation also were neglected. Adults who grew up in such homes may have difficulty remembering occasions when warmth and affection were freely and consistently expressed. Parents often report feeling that their needs for protection, comfort, reassurance, and support were met infrequently, if at all. During early childhood, their fears were often disregarded. When they were teenagers, their parents were often inattentive or incapable of maintaining the delicate balance between structure and freedom that adolescents need as they negotiate their way from childhood to responsible adulthood.

Finally, significant numbers of substance-abusing parents report histories of severe neglect, physical abuse, and/or sexual abuse during their childhood and teenage years. As adults, such parents are more likely to become involved in unhealthy and abusive relationships. As one might predict, spousal abuse and domestic violence are, in fact, common occurrences in the lives of adults who seek treatment for alcohol and other drug abuse. Moreover, having grown up in homes in which parenting was unpredictable and discipline often abusive, chemically involved parents frequently are ill equipped to provide effective parenting for their own children. The risk that they will perpetuate the cycle of abuse or neglect with their offspring is considerable.

Survival Needs

Regardless of socioeconomic status, substance-abusing parents commonly have a range of basic unmet survival needs. Substance abuse among low-income parents often quickly leads to impoverishment, but even successfully employed individuals may eventually find themselves homeless or facing homelessness. As a

result of their alcohol and/or other drug use, many substance-abusing parents lack stable housing, food, clothing, and basic personal necessities for themselves and their children. They may live on the street, in temporary shelters, in substandard housing, or be on the brink of eviction. Furthermore, as noted above, chemically involved parents may have extensive and chronic medical and/or psychiatric problems that require immediate care and often long-term intervention. Often, such parents have little knowledge of how to locate and mobilize needed resources on their own behalf.

Psychiatric Disorders

A significant percentage of chemically dependent adults suffer from a psychiatric disorder of sufficient severity to require intervention. Post-traumatic stress disorder is not uncommon, particularly in substance abusers with histories of child sexual abuse or alcoholic parents. Alcohol and other drugs may be used to medicate the intrusive symptoms associated with the disorder (panic attacks, obsessive ruminations, flashbacks, nightmares). For some individuals, another underlying condition such as a depression, personality disorder, or psychotic illness preexisted the chemical dependency, and the drug and/or alcohol use was essentially an ill-advised attempt to self-medicate. For other chemically involved adults, the psychiatric disorder may be the consequence of long-term addiction or alcoholism. In any case, a psychiatric disorder may profoundly impact the sufferer's ability to function as well as to benefit from services offered to the family.

As children, many chemically involved parents experienced periods of parental absenteeism or even parental death. Many of these parents recall having been moved frequently from caregiver to caregiver. Such experiences of loss, inconsistency, and perceived abandonment can create feelings of anger, mistrust, low self-esteem, and confusion that complicate relationships well into adulthood.

Denial

It is virtually a given in the field of substance abuse treatment that most clients, particularly those who are involuntary, will deny the extent of their abuse of alcohol and/or other drugs. Thus, the chemically involved parent more often than not minimizes the problem, denies its impact on the family, and is resistant to treatment.

Often, parents will emphatically deny any drug or alcohol use whatsoever. In cases of prenatal substance abuse, parents may explain that positive toxicology reports are lab errors or reflect a one-time lapse that occurred, unfortunately, just prior to delivery. At the time of assessment and sometimes well into the course of treatment, it is commonplace for both clients and families to deny the reality of a parent's devastating, long-term, polydrug abuse.

Frequently, this denial is tenaciously held and will not readily be relinquished, particularly in a setting that is felt to be adversarial. For example, substance-abusing parents who have reasonable fears about losing custody of their children may not admit to any alcohol and/or drug abuse. Given the stressful circumstances that surround allegations of child abuse and the power agencies have to disrupt parents' and children's lives in profound and painful ways, professionals should neither be surprised nor take it personally when they are met with a wall of denial and resistance.

Denial and resistance, however, are not necessarily insurmountable obstacles to treatment. Professionals need to understand the function and importance that these defenses have played in the lives of parents. By building meaningful relationships with parents and taking the time necessary to work through denial and resistance, it is often possible for professionals to form a supportive and mutually respectful treatment alliance with the parent and the family.

In summary, chemical dependency has a profound impact on virtually every area of individual and family functioning. Personal drug and alcohol use can seriously impair judgment and limit the users' abilities to take care of themselves and their children. The history of deprivation, inconsistency, loss, and abuse that many chemically dependent parents experienced during their childhood years bodes poorly for their own ability to parent and, without intervention, predisposes these individuals to repeat similar patterns with their own children.

THE NEEDS OF CHILDREN AND PARENTING TASKS

Different types of families (e.g., two-parent families, grandparent/grandchild families, single-parent families, stepfamilies, adoptive families, and foster care families) are capable of assisting children to become competent and self-assured adults, as long as the caregivers assume primary responsibility for both the life support and socialization needs of family members. This goal can be accomplished in a variety of ways, depending on family configuration, resources, and cultural background. However, when one or both caregivers abuse alcohol and/or other drugs, basic parental responsibilities can be profoundly affected.

- **Children need to live in a home with sufficient and well-managed income so that the family's basic economic needs are met.** Chemically involved parents may spend money on alcohol and/or other drugs and fail to provide for their children's basic needs. Thus, these parents may not meet their children's nutritional, housing, and medical requirements. Chemically involved parents may care deeply about their children, but the special relationship they have with their drug(s) of choice can dominate family finances in a way that is detrimental to all family members.
- **Children must receive appropriate and consistent discipline so that they understand and internalize the rules of the family and of the culture.** Again, this objective can be accomplished in various ways, but it must be done in a manner that builds trust, cooperation, and self-assurance. Caregivers, who themselves grew up in dysfunctional homes, often have no model of appropriate discipline and may unconsciously emulate their own inadequate parents. Consequently, these parents may use means of controlling and instructing their children that inspire fear, anger, and rebellion.

A learned pattern of inappropriate discipline may be further compounded by the effects of a parent's own drug or alcohol use. In chemically involved families, parental decisions about what is or is not acceptable behavior and judgment about what constitutes an appropriate parental response to that behavior may vary from one moment to the next. The dramatic mood swings that accompany drug use and withdrawal as well as the profound, often chronic psychiatric disorders that result from or coexist with long-term substance abuse can make it very difficult for chemically involved caregivers to exercise good judgment and respond appropriately and consistently to their children's behaviors.

- **Children need parents who are responsible for dealing with community agencies and major social systems, and who are capable of making the decisions that affect the well-being of all family members.** Children lack the experience and the legal authority to interact successfully with school systems, housing authorities, health care providers, and other community agencies. It is the parents' responsibility to interact with these systems, deciding when and how they need to be accessed in order for family needs to be met. However, chemically involved parents often may be physically or psychologically absent when such needs arise. Consequently, many chemically

involved parents do not obtain medical care or needed educational services for their children. These parents may forfeit eligibility for low-cost housing, public health services, public assistance, vocational rehabilitation, and a range of other opportunities that, if accessed, could greatly enhance the quality of life for all family members. When parents are unable to accomplish these tasks for their children, tasks that children cannot accomplish for themselves, basic family needs are not met.

- **Children need parents who accept the primary responsibility for home maintenance and housekeeping.** Although this responsibility can and should be shared among family members, it ultimately falls to the parents to ensure that the home environment is both safe and clean. Chemically involved parents often find it difficult to accomplish the tasks associated with running a household, and basic maintenance and housekeeping tasks are either neglected or left to young children, who may lack the skills or motivation needed to accomplish them successfully. When bottles and dishes aren't washed, soiled diapers and garbage aren't disposed of properly, and plumbing isn't operable, unsafe and unhealthy conditions exist for all family members.
- **Children need to be free of the primary responsibility for child care.** Child care is a task that can be shared, particularly within large families, but the ultimate responsibility for seeing that children's needs are met resides with the parents. Although the "parentified" child in a chemically involved family often does care for younger children, this child almost certainly lacks the judgment, experience, and maturity to care safely and properly for other siblings over time. It is destructive for older children as well as for younger siblings if the locus of child care is placed in children's hands.
- **Children need nurturing families.** Loving and caring within families can and should flow freely in both directions between older and younger members. It is the responsibility of parents to make sure that this nurturing is available. Sober and emotionally stable parents are usually able to defer their own emotional needs or surmount obstacles such as fatigue and ill health when their children need care and attention. However, chemically involved parents may become so caught up in the cycle of alcohol and other drug abuse that they remain largely unaware of their children's need for nurturing. Children in such families often experience the pain, uncertainty, and loneliness that result from feeling a lack of caring and love.
- **Children need to experience appropriate roles and boundaries within the family.** In healthy families, it is clear to all members precisely who are the adults and who are the children, and who is in charge of whom. Unfortunately, in families in which one or both caregivers is a substance abuser, roles and boundaries are often ill-defined. It is not unusual in chemically involved families to see a toddler "ruling the roost" with a heavy and tyrannical hand. Nor, with boundaries so blurred and roles confused, is it at all unusual for children to become victims of sexual abuse.

SUMMARY

To begin to establish an effective treatment alliance with a substance-abusing family, it is important for professionals to acknowledge the following basic principles regarding alcohol and other drug abuse:

- To work effectively with a substance-involved family, professionals must explore their own attitudes, feelings, and experiences related to alcohol and/or other drug abuse. Substance abuse is a

complex problem, and objectivity can only be maintained if service providers are able to distance themselves from their own personal experiences, prejudices, and preconceptions. A basic understanding of addiction and its impact on individuals and families, therefore, is also critical. Further, an informed team approach is essential in effectively serving substance-abusing families.

- An individual may become involved in the abuse of alcohol and/or other drugs for a wide variety of reasons. These issues can be ferreted out over time by professionals working with the family, and this information can help professionals and family members determine the most appropriate treatment and intervention strategies.
- It is essential to recognize that parents may not be ready to engage in treatment when the professional first becomes involved with them. However, this does not mean that service providers cannot help parents become ready to consider treatment. This process is often time-consuming, but it can lead to successful intervention.
- Although relapse is an inherent part of substance abuse, a failure in treatment may not necessarily be due to the disease. Rather, some treatment failures occur because the treatment program is not well suited to the individual substance abuser. Thus, professionals need to explore with the parent the possible causes of any unsuccessful treatment effort.
- Professionals also need to be aware of the range and variety of treatment services that are available within their individual communities. Unfortunately, some communities offer only a limited array of substance abuse treatment services that may not address many clients' needs. (For instance, many programs will not enroll women who have children.) In such cases, professionals can become advocates to inform their communities about the need for new and expanded services.

In summary, in order to provide effective services, professionals should understand the power and tenacity of substance abuse, including its chronic and relapsing nature, the central role that it plays in the chemically involved parent's life, and the parent's attachment to the substance(s) used. Professionals also need to remember that the substance-abusing parent often has multiple, long-standing problems, some of which may not even surface until the parent has entered treatment and attained sobriety. Further, the abuse of alcohol and/or other drugs is not merely a disease of the individual, but, rather, a problem that affects the whole family. Chemically involved parents are often the victims of intergenerational substance abuse. Involving them as well as their children in treatment can be a beginning step in breaking a cycle of substance abuse, ineffective parenting, family violence, and child abuse and neglect.

CHILDREN OF CHEMICALLY INVOLVED PARENTS: SPECIAL RISKS

CASE VIGNETTE: Although born full term, Lisa's baby boy, Timmy, remained in the hospital for over a week following birth because of his small size and feeding difficulties. He also was very irritable, difficult to soothe, and slept only for brief periods of time. At 5 months of age, Timmy continued to demonstrate bizarre fisting and stiffness of his hands. Because of ineffectual sucking, each feeding took over 45 minutes. Timmy was also easily upset but enjoyed being held. By 1 year of age, the stiffness and irritability had resolved, and Timmy's weight gain and development appeared to be well within the normal range. However, he continued to have difficulty sleeping through the night, and this was very stressful for his caregiver. Eventually it became clear that this little boy's cognitive and language behaviors were average, and by age 4 Timmy's preschool teacher reported that he was well-behaved, although concerns remained regarding his short attention span and the difficult time he had sitting still and following directions. During his first 2 years in elementary school, Timmy's short attention span interfered with his ability to concentrate, and he needed extra help from a research teacher to keep up with reading and arithmetic skills. School staff continue to watch Timmy for potential learning difficulties related to short attention span and hyperactivity.

This chapter describes the health and development of children exposed prenatally to alcohol and/or other drugs. The neurodevelopmental consequences of such exposure, particularly in the long term, are not all known. Research is currently being conducted to help us better understand these consequences. In discussing the common health concerns and developmental patterns that have been observed in this population, it is important for professionals to consider the following issues:

- **Polysubstance abuse.** Most substance abusers use multiple drugs or drugs, alcohol, and nicotine in combination. In some cases, this polysubstance abuse may occur without the user's knowledge because it is common practice among street dealers to substitute drugs and to "cut" the purity of illicit substances with a variety of adulterants. Furthermore, although parents may report use of only alcohol, nicotine, or a single drug, such statements regarding drug and alcohol use during pregnancy are often unreliable, in part because of parental inaccuracy in recalling their actual drinking or drug use during periods of intoxication.
- **Range of outcomes.** Any alcohol or other drug use during pregnancy potentially can affect fetal health and well-being. There are no known "safe" levels of prenatal drug, alcohol, or nicotine use. However, among infants who have been prenatally exposed to these substances, a wide range of health and developmental patterns have been observed. The medical and developmental complications associated with prenatal substance abuse will be discussed later in this chapter. Because there is a broad continuum of effects of prenatal drug, alcohol, or nicotine exposure (varying from severe to mild to no apparent effect), outcomes for individual children cannot be predicted.
- **Multiple etiologies.** There clearly are adverse immediate and long-term effects of alcohol and other abuse during pregnancy, but there are also a number of other maternal health, nutritional, and lifestyle factors that greatly impact fetal growth and development. These factors also significantly contribute to the increased risk of developmental difficulties throughout childhood. Substance-

abusing mothers often have compromised health, no matter what their socioeconomic status. Smoking, poor nutrition due to excessive dieting or inappropriate selection of food, poverty, or other lifestyle influences may complicate the effects of substances on the fetus.

- **Environmental impact.** Children in substance-abusing families are at double jeopardy—they are both biologically and environmentally at risk. Moreover, the interplay between biological and environmental factors is extremely significant because biological problems can be exacerbated or mitigated by environmental influences. For example, a home environment that is responsive and nurturing can help reduce the negative developmental effects of low birth weight. On the other hand, an environment that does not provide adequate nurturing can increase the risk of negative developmental outcomes associated with low birth weight.
- **Limitations of research.** Obtaining accurate self-reports about alcohol or other use is difficult and limits epidemiological and clinical research on causality. Most documentation about the serious side effects of prenatal alcohol and other drug exposure in infants and children has been noted in cases of alcoholic and drug-dependent mothers. Little is known regarding the effects of experimental or sporadic drug and alcohol use during pregnancy, in part because the identification of occasional users is much more difficult. Even less is known about the effects of paternal substance abuse. Furthermore, the standardized measures currently used to evaluate infants and young children of chemically involved parents are not sufficiently sensitive to subtle behavioral and cognitive deficits.

Keeping in mind the above issues and the fact that many important questions regarding the effects of maternal drug and alcohol abuse remain unanswered, the following sections will discuss the common neonatal and infant complications that have been described in some substance-exposed infants and young children as well as the developmental patterns that have been observed in this high-risk population. It is important to note that the descriptions contained in this chapter are intended to provide general information and followup guidelines. Concerns about individual children need to be discussed with the child's pediatrician, a child psychiatrist, other health care providers, family members, and any other professionals who are involved in providing care.

NEONATAL AND INFANT COMPLICATIONS

There are a number of pediatric medical complications associated with prenatal substance abuse. These include neurological disturbances, prematurity, infectious diseases, Fetal Alcohol Syndrome (FAS), Sudden Infant Death Syndrome (SIDS), failure to thrive (FTT), intrauterine growth retardation (IUGR), and central nervous system (CNS) disorders.

Neurological Symptoms

Various neurological disturbances have been noted in newborns who have been exposed prenatally to drugs and alcohol. The following symptoms are most commonly observed:

- irritability,
- tremors or jitteriness,
- prolonged or high-pitched crying,

- increased or decreased muscle tone,
- alternating periods of lethargy and irritability,
- frantic sucking of hands,
- uncoordinated sucking,
- seizures,
- fever,
- sweating,
- diarrhea,
- excessive vomiting,
- unusual or rapid (nystagmus) eye movements, and
- disturbances in sleep patterns.

Infants born to mothers who abuse stimulants such as cocaine and methamphetamine may appear lethargic and unresponsive during the first few days following birth. When such infants are alert, however, they are often easily overstimulated and may progress from being asleep to a state of loud crying within seconds. As they become older, infants who were lethargic during the immediate postnatal period often become more irritable and difficult to console. However, these behaviors often are self-limiting and may subside by age 2.

The majority of infants born to mothers who have used narcotics such as heroin or methadone during pregnancy become symptomatic within 72 hours after birth. Although irritability and tremulousness often decline over the first month of life, some narcotic-exposed infants remain symptomatic for many months. Initially, infants may have red, dry skin on their knees, elbows, and cheeks as a result of their excessive body movements. Frequently, these infants have diarrhea and episodes of vomiting that interfere with weight gain. These newborns may require medication in order to calm them, help them suck and swallow more successfully, and also limit their bouts of diarrhea.

Medication for symptomatic infants is warranted when the infant's vomiting or diarrhea cause weight loss or dehydration. The Neonatal Narcotic Abstinence Scale is used to determine which infants require medication.⁶ Commonly used medications include paregoric and phenobarbital. Infants who have seizure activity require immediate treatment with anticonvulsants.

- Ideally, all infants receiving drug therapy for symptoms of prenatal substance exposure should be weaned from these medications before hospital discharge. Those children who are on medications at time of discharge need to be carefully monitored. Overdoses can occur, and it is important to be certain that parents or other caregivers are administering medications properly. If an infant is on phenobarbital, the amount of medication circulating in the blood stream (the blood level) needs to be checked at regular intervals.

- Infants with seizure disorders may require ongoing medication and followup with a pediatric neurologist.

Prematurity

Prematurity is defined as birth at less than 37 weeks of gestational age. Usually, premature infants weigh less than 2,500 grams. However, low birth weight also may occur in full-term infants of substance-abusing women. Prematurity in and of itself poses a distinct set of biological risks that can result in chronic illness for the infant and interfere with normal growth and development. In general, preterm delivery occurs in less than 10 percent of the newborn population. However, the risk of prematurity among substance-exposed infants is higher.

The problems commonly observed in preterm infants, including those who were prenatally exposed to drugs, are intracranial hemorrhages, bronchopulmonary dysplasia (BPD), retinopathy of prematurity (ROP), respiratory distress syndrome (RDS), and disorders that interfere with normal feeding ability. Infants who display these conditions are often termed "medically fragile."

Intracranial Hemorrhages

Intracranial hemorrhages refer to bleeding into the brain tissue. Such an occurrence is known to be a risk factor for later physical and/or intellectual problems. Cerebral palsy, or impaired motor movements, for instance, can occur when there has been an intracranial bleed or an interference with the blood flow to specific areas of the brain.

Because a hemorrhage can obstruct the normal flow of cerebral spinal fluid that circulates around the nervous system, some preterm infants who experience intracranial bleeding require treatment for hydrocephalus, an accumulation of serous fluid within the cranium that can interfere with physical and/or intellectual development. Treatment for hydrocephalus involves the surgical insertion of a ventricular peritoneal (VP) shunt, or tube, that provides drainage of the fluid from the brain into the abdominal cavity.

- Infants with hydrocephalus require followup by a neurosurgical team to ensure that the shunt does not obstruct or become infected. In addition, parents need to know how to identify signs of infection and obstruction.
- For infants with developmental delays or motor problems, evaluations by developmental disabilities specialists are needed to ensure that appropriate early intervention is made available.

Bronchopulmonary Dysplasia (BPD)

One of the most well-recognized complications of prematurity is BPD, a condition that affects lung tissue and interferes with normal breathing functions. Following their discharge from the neonatal intensive care unit (NICU), children with this condition may continue to require oxygen, have complex medication regimens, and need special home-monitoring of their heart and respiratory rates. Children with BPD are at increased risk for poor weight gain, serious respiratory tract infections, multiple hospitalizations, and delayed development.

- The health care team needs to ensure that parents/caregivers are able to use equipment and administer medications properly, as well as detect signs of respiratory infection.

- Caregivers for children who have periods of apnea (prolonged cessation of breathing) and who require apnea monitors also must be able to perform cardiopulmonary resuscitation.

Retinopathy of Prematurity (ROP)

Preterm infants are at risk for developing a disease involving the vessels in the eye called ROP. Multiple causes of this disorder have been suggested; however, no specific cause has been identified to date, and no fully adequate treatment modalities have been developed. All preterm infants should receive a thorough eye evaluation by an ophthalmologist before they are discharged from the nursery. In some cases, ROP improves over time, but in other cases, children may be left with varying degrees of a visual handicap.

- Those babies who have symptoms of ROP, noted by changes in the vessels of the retina, must have followup eye examinations.
- Those children who do develop a visual handicap need to be involved in early intervention programs specifically aimed at assisting them to learn about their environment through tactile and auditory channels as well as through their remaining visual abilities.

Diseases That Interfere With Normal Feeding Ability

There are several medical problems that may interfere with an infant's ability to take all of its daily nutrition by mouth. Infants with certain neurologic conditions may not be able to suck and swallow normally. Infants with BPD may expend too many calories working to breathe or may become short of breath while feeding. In such cases, supplemental gavage/forced feeding (formula given through a small tube that passes through the mouth or nose into the stomach) may be required. In more severe cases, a gastrostomy tube (feeding tube) is surgically placed into the stomach to augment caloric intake or to bypass oral feeding when an infant is unable to suck or swallow effectively.

Another, less common medical complication that may interfere with feeding is necrotizing enterocolitis (NEC). The cause of this disease is not known; however, it sometimes results in damage to the gastrointestinal tract making it impossible for the child's intestines to absorb food. In such cases, some type of total parenteral nutrition (TPN), for example, intravenous (IV) feeding, may be required.

- Before hospital discharge, caregivers of infants requiring gavage feeding, gastrostomy tubes, or intravenous lines must be carefully trained and supervised in providing the specialized care their children need. Caregivers must receive detailed instruction regarding how to care for equipment and how to administer the feeding solutions through the catheters (tubes). In-home followup and close contact with the health care team are essential.
- Because their feedings may be so disruptive and technical, infants who require gastrostomy tubes or TPN may not receive the social stimulation that usually accompanies feeding (i.e., holding, rocking, and talking). Therefore, it is important to help parents find alternative ways to provide these experiences in order to minimize adverse developmental effects.

Infectious Diseases

Infants with prenatal substance exposure are frequently exposed to infectious diseases of the mother, either prenatally or at the time of delivery. A mother who has multiple sexual partners, a history of prostitution, or

a history of injection drug use is at increased risk of acquiring a variety of infectious diseases that can be passed to the child. Because many infectious agents cross the placenta, infants born to infected mothers are at increased risk of acquiring their mothers' infections during pregnancy. The infectious diseases most commonly seen in infants of substance abusers with multiple sexual partners are gonorrhea, syphilis, herpes, chlamydia, hepatitis B, and human immunodeficiency virus (HIV) and/or acquired immunodeficiency syndrome (AIDS). Multidrug resistant tuberculosis (TB) is yet another infectious disease experienced by some infants.

Gonorrhea

Gonorrhea may be transmitted from the mother to the infant during a vaginal delivery. The most common neonatal manifestation of gonorrhea is an infection of the eye (conjunctivitis) with a purulent discharge (pus) appearing 2 to 7 days after birth. As a preventive measure, it is standard medical practice to put silver nitrate or erythromycin in the eyes of all newborns at delivery. Untreated, gonorrhea of the eye can result in blindness. Conjunctivitis in any newborn must be evaluated.

Syphilis

Syphilis in newborns is acquired from an infected mother. Most often, newborns who have been exposed to syphilis prenatally are without physical symptoms. In such cases, a newborn's infection is discovered through a routine blood test at delivery. Congenital syphilis (syphilis that is acquired prenatally) must be treated with antibiotics or it can proceed to cause significant illness, affecting the CNS, bones, joints, and other organ systems. The long-term effects of congenital syphilis depend on the length of time the infant was infected before treatment.

- Typically, antibiotic treatment for congenital syphilis is completed before the infant's discharge, with followup blood tests at 3, 6, and 12 months to ensure the adequacy of initial therapy.
- If an infant's infection occurred shortly before birth, the blood test at delivery may be negative. Therefore, if maternal infection is suspected, many physicians currently recommend repeating the test for syphilis (VDRL) when the infant is 2 months of age.

Herpes

Congenital herpes infection occurs prenatally or by transfer from mother to fetus as the newborn passes through the vaginal canal and is exposed to the herpes virus. The mother may be completely without symptoms, or she may have vesicular (blisterlike) lesions on her genitals that contain the virus. Symptoms in infected infants range from a few herpes lesions on the skin to viral invasion of all organ systems, including the CNS. The effects can be quite serious and include severe mental and/or motor impairments, seizures, and/or visual disability. Infected infants are at increased risk for developmental problems.

Because initial symptoms may appear shortly after birth or as long as 1 month after delivery, careful followup for signs of blisterlike lesions or illness is recommended for all infants born to mothers known to have genital herpes infections.

Chlamydia

Chlamydia is a bacterial infection that may be transmitted from the mother to the infant during vaginal delivery. Generally, an infant's first symptom of infection with chlamydia is conjunctivitis that usually appears

from a few days to a few weeks after birth. The eye often appears red and swollen with a watery discharge. If an infant infected with chlamydia is not treated, he/she may develop a pneumonia that generally is recognized at 1 to 4 months of age when the baby develops a chronic cough. Both chlamydia conjunctivitis and chlamydia pneumonia must be treated with oral antibiotics. Topical eye drops administered at birth do not prevent chlamydia infection. Because symptoms of chlamydia infection often do not appear until after hospital discharge, any infant who develops conjunctivitis, cough, or respiratory infection should be evaluated by his/her health care provider.

Hepatitis B

Hepatitis B is an infection of the liver that usually is transmitted in adults by sexual contact or sharing of contaminated drug needles. The hepatitis virus can be acquired by infants in utero or during the delivery process. Neonates who are at risk for hepatitis B infections include infants born to injection drug-using mothers, prostitutes, and mothers who have relationships with men who are at risk for hepatitis B infection. Untreated, infected infants may develop chronic liver disease. They also are at increased risk of developing liver cancer later in life.

- Because of the increasing prevalence of this disease, many physicians recommend screening all substance-abusing mothers for hepatitis B infection prior to and at the time of delivery.
- Infants whose mothers carry the hepatitis virus are treated with hepatitis B immune globulin (HBIG) and hepatitis B vaccine within the first day of life. Subsequently, hepatitis B vaccines are given at 1 and 6 months. A blood test is usually performed at 9 months to determine if an additional dose of the vaccine is needed. Caregivers need to coordinate this ongoing health care with a pediatrician.

Human Immunodeficiency Virus (HIV) Infection

Most newborns who have HIV infections contract them from their infected mothers. This virus, which causes AIDS, can be transmitted prenatally, at the time of delivery, or through breast milk. Infants born to mothers in the following groups are at increased risk for HIV infection:

- women with evidence of HIV infection;
- women who are injection drug users;
- women who are prostitutes;
- women with multiple sexual partners;
- women who are sexual partners of bisexual men, men who are injection drug users, men with multiple sexual partners, or HIV-infected men; and
- women who have lived in countries with high rates of heterosexual transmission of HIV.

Not all infants born to HIV-infected mothers will acquire the disease. The precise rate of infection is currently unknown. Those infants who test positive for HIV infection and subsequently develop physical signs of pediatric AIDS during the first year have a very poor prognosis. The long-term prognosis for infants who

test positive for HIV infection but remain asymptomatic is unknown. The prognosis for infants who test negative despite their mothers' infection is also uncertain, because an infant who initially has a negative test may later show evidence of infection.

- Testing for the HIV virus in all infants of mothers in high-risk groups has been recommended to provide early diagnosis and aggressive treatment of HIV-related infections as well as prevent viral transmission to caregivers.
- Infants born to mothers who test positive for the HIV virus must have repeated periodic testing, even if their initial tests are negative.
- All HIV-positive infants should be referred to a specialized health care team. A modified vaccination schedule is indicated for infants with the HIV virus, and specialized treatment is required for appropriate health care management.
- Caregivers of HIV-positive infants will need special training and may require a range of supportive services.

Tuberculosis (TB)

TB is an infectious disease caused by tubercle bacilli. Infection may occur anywhere in the body, but the lung is the most common site. After the airborne tubercle bacilli are inhaled, they generally multiply in the lungs, sometimes reaching the bloodstream via the lymphatic system and passing to other areas of the body. TB may develop either immediately (most often the case in infants and adolescents) or after a period of latency. Symptoms may include fever, cough, night sweats, weight loss, and breathing difficulty. The most common methods of diagnosis include a history of exposure to someone diagnosed with TB, the Mantoux (PPD) skin test, chest x-ray, and sputum smear/culture. However, diagnosis in newborns and young infants can be difficult.

There has been a recent resurgence of TB in the United States, especially among children under 5 years of age. Some possible reasons for this increase may include a shift in the incidence of TB from the elderly population to the 25- to 44-year-old (i.e., child-bearing) population, the lack of screening programs for high-risk children (e.g., children in poverty, new immigrant children), lack of funds for public health investigation of possible carriers, and the coexistence of TB with HIV infection in some areas of the Nation.

Although it generally involves at least a 9-month course of medication, early treatment has a high success rate. Nevertheless, the extent of the disease and the recent emergence of drug-resistant TB strains have made it essential to consult an infectious disease expert whenever TB infection is suspected.

- Research suggests that there is no racial predisposition to TB. However, the incidence of TB is especially high among impoverished populations with a high rate of substance abuse.
- TB can be transmitted from mother to infant through breast feeding. A mother who is receiving treatment for TB should not breast feed because the medications are not contained in breast milk in sufficient quantities to destroy the TB organisms that are passed on to the child.
- It is important that high-risk groups, including new immigrants and individuals living in poverty, receive an annual PPD test. Thus, professionals need to acquaint themselves with the prevalence

of TB within their particular service areas and contact their local public health departments for assistance in treatment and followup protocols, if necessary.

Fetal Alcohol Syndrome (FAS)

Alcohol consumption during pregnancy may result in a pattern of birth defects known as FAS. The diagnosis of FAS is based on three factors: prenatal and postnatal growth retardation, including low birth weight and microcephaly (abnormally small head); CNS abnormalities, including intellectual impairment, developmental delays, behavior dysfunction, and neurological abnormalities; and abnormalities of the face. Children with a confirmed history of prenatal alcohol exposure, who display some of the symptoms associated with FAS but who do not meet all of the diagnostic criteria, are diagnosed with Fetal Alcohol Effect (FAE). As the child matures, problems with learning, attention, memory, and problem solving are common, along with incoordination, impulsiveness, and hyperactivity.

Facial characteristics associated with FAS include small eyes, short eye openings, epicanthic folds, flat upturned nose, indistinct philtrum (groove in the midline of the upper lip), thin upper lip, crossed eyes, droopy eyelids, and malformation of the external ear.

- Careful monitoring of growth as well as screening for any additional physical problems that may accompany either FAS or FAE is required for all affected children so that appropriate services can be provided.
- Involvement in an early intervention program designed for children with special needs is also recommended for children who exhibit developmental delays.

Sudden Infant Death Syndrome (SIDS)

Children who have been prenatally exposed to drugs may have an increased risk of dying from SIDS. SIDS, sometimes called "crib death," is defined as the sudden death of an infant under 1 year of age that remains unexplained after autopsy, investigation of the death scene, and review of the case history. In the United States, SIDS is the leading cause of death in infants between 1 and 12 months of age. SIDS may have multiple causes, and it is almost impossible to predict when it will occur. Children who die from SIDS commonly exhibit no other sign of illness immediately prior to their death.

- Home apnea/cardiac monitoring is recommended for preterm infants who experience recurrent apnea and for fullterm infants who present with severe acute life-threatening episodes (ALTEs), sometimes referred to as "near-miss SIDS."
- The decision to institute home monitoring should be based on medical assessment and reached in collaboration with the caregiver. There is no guarantee that SIDS can be prevented, and it can occur in spite of appropriate monitor use.
- Caregivers of children who require apnea monitors must be able to perform cardiopulmonary resuscitation (CPR).

Failure To Thrive (FTT)

FTT is a syndrome of disordered growth and development characterized by a marked deceleration in weight gain and a slowing in acquisition of developmental milestones. There are many reasons why an infant may

not gain weight. Medical reasons resulting from biological causes include vomiting, excessive diarrhea, poor swallowing, cystic fibrosis, and congenital heart disease. Of course, infants also will fail to gain weight if they are given insufficient protein and calories. This may occur if the caregiver mixes formula improperly, does not feed frequently enough, or fails to respond to the infant's signals when he/she is hungry. FTT can also result from psychosocial deficits in the caregiver-infant relationship, such as failure to provide adequate physical nurturing in the form of contact comfort (holding, cuddling, or touching).

In infants who were prenatally exposed to drugs and alcohol, FTT may be due to both medical and environmental factors. A pattern of poor sucking, swallowing difficulties, and distractibility has been observed in many of these infants. In addition, children who live in dysfunctional, chemically involved families are at increased risk for parental neglect and for receiving inadequate nutrition on a consistent basis. Furthermore, some infants prenatally exposed to drugs are born very small for gestational age and, in spite of adequate caloric intake, may never attain average growth parameters.

Accurate diagnosis of FTT often entails hospitalization in order to determine the exact causes. In cases of environmental FTT, once adequate calories and/or appropriate nurturing care are offered, weight gain usually occurs immediately. Unfortunately, this simple medical treatment cannot be effective on a long-term basis unless a thorough evaluation is made to determine the reasons for the child's poor weight gain.

In cases of environmental FTT, an individualized, interdisciplinary treatment program should be developed to address the interrelated needs of both the parent and the child. Such a program may include any or all of the following: parent education; individual, conjoint, and/or family counseling; medical services; and substance abuse treatment. Close in-home monitoring also can be an important support for the family as well as an essential safeguard when the child remains within the parental home.

Intrauterine Growth Retardation (IUGR)

The term IUGR is used interchangeably with small for gestational age (SGA) to describe fetuses with sub-optimal growth (generally with birth weight below the 3rd percentile for age).⁷ Causes for IUGR vary. It often is associated with congenital infections (that is, infections that are present during pregnancy and passed on to the fetus) such as rubella, cytomegalic virus (CMV), or HIV. Genetic abnormalities, such as those seen in rather rare chromosomal disorders (trisomy 13 and 18), also may result in IUGR. However, the most common causes of IUGR are related to conditions that result in reduced transport of nutrients from mother to fetus via the placenta during pregnancy. Hypertension (high blood pressure), for instance, frequently causes constriction of the blood vessels, including those that lead from the placenta to the fetus, thus restricting the transport of nutrients that are important for growth. Although many individuals suffer from hypertension because of a genetic predisposition, obesity, and/or stress, drugs such as cocaine, methamphetamine, and PCP also may bring about this condition. Further, IUGR may be seen in cases of insufficient maternal caloric intake. Depending on the cause, interference with fetal growth may begin during the first trimester, or its onset can occur later, during the second or third trimester of pregnancy.

Central Nervous System (CNS) Disorders

A CNS disorder is any condition or malformation that affects the brain. These disorders may originate in utero, or they may be caused by postnatal factors. Prenatal CNS disorders include viral infections [e.g., HIV, rubella, CMV, or toxoplasmosis] or congenital malformations of the brain (e.g., hydrocephalus, microcephaly, or porencephalic cysts). During delivery, certain conditions, including severe perinatal asphyxia, in some cases may lead to CNS impairment that results in physical disabilities such as cerebral palsy or vision and hearing deficits. Postnatal events may also lead to CNS disorders. These include bacterial or viral infections (e.g., meningitis or encephalitis), tumors (malignant or benign), and intracranial bleeds (usually seen in preterm infants).

Specific to children who have been exposed prenatally to alcohol and/or other drugs, reports have shown an increased incidence of decreased brain growth in utero in newborns, in some cases leading to microcephaly. Some infants who were exposed to cocaine and methamphetamine have been reported to have experienced three separate CNS lesions prenatally—hemorrhage into the ventricles, areas of necrosis in the brain matter, and cavitory lesions.⁸ In a few cocaine-exposed newborns, there have been reports of infarctions, or severe constrictions of major blood vessels, that have resulted in damage to certain areas of the brain.⁹

A very important CNS condition that is seen in children under 2 years of age is inflicted trauma to the head, sometimes including skull fractures. In infants younger than 4 months of age, when children have only minimal head control, cases of Shaken Baby Syndrome are sometimes observed. This syndrome has been noted to occur when a caregiver is under stress, becomes frustrated with an irritable baby, and holds the infant by the shoulders or arms, shaking or forcibly slamming the child against a surface, such as a crib mattress. Only rarely are there obvious physical signs of abuse. However, resulting injuries may include intracranial bleeding, retinal hemorrhages, or occasional skull fractures, with long-term consequences that may include cerebral palsy, blindness, seizure disorders, or even death.^{10 11}

MEDICAL FOLLOWUP RECOMMENDATIONS

All newborns who have been prenatally exposed to alcohol or other drugs require careful medical followup. The preceding paragraphs have described the array of medical conditions that are not infrequently present in children who were prenatally substance-exposed and that require careful observation. Further, a parent's chemical abuse often can interfere with his/her ability to meet a child's basic needs. Therefore, prior to discharge, it is imperative that members of the health care team, the infant's parent/caregiver, and child welfare professionals actively communicate to clarify the infant's existing medical condition, followup needs, and required level of caregiving. It is the joint responsibility of the health care team and the staff of all involved community agencies [Child Protective Services (CPS) caseworkers, drug treatment counselors, attorneys, judges, and child advocates] to ensure that substance-affected children receive appropriate followup and coordinated care.

- Arrangements should be made for the parent/caregiver to visit the hospital before the child's discharge to learn about the infant's special needs and to be instructed in any special caregiving skills.
- A home visit by a public health nurse or other appropriate professional before the infant's discharge is important to assess the adequacy and safety of the home environment as well as the family's preparation for the child's arrival. Such visits also can help identify older siblings or other children within the home who are in need of medical care. Post discharge, in-home followup should occur within the first week after discharge, with followup visits scheduled according to family needs. In-home followup should be provided for all caregivers, including parents, relatives, and foster parents.
- The infant's parent/caregiver should be provided with a written summary of the infant's diagnoses and medical complications after birth, treatments provided, and needed followup care. This is especially critical for infants who will not be receiving their medical followup with practitioners who are familiar with their histories (see Table 1).
- Pediatric well-baby care should be provided more frequently than is customary. An initial appointment should be made with the child's pediatrician within 2 weeks after discharge. Subsequent well-baby appointments should be scheduled at 1, 2, 4, 6, 8, 10, and 12 months. This increased

Table 1
HOSPITAL FORM FOR DISCHARGE OF INFANTS

DISCHARGE INFORMATION SHEET FOR THE NEWBORN			
DATE:			
RE: INFANT'S NAME	AKA:	D.O.B.	HOSPITAL I.D.#
REASON FOR OUT-OF-HOME PLACEMENT, IF APPLICABLE			
☐ POLICE OR DCS HOLD		☐ VOLUNTARY PLACEMENT	
☐ ADOPTION		☐ PLACEMENT FOR MEDICAL REASONS	
BIRTH INFORMATION: WEIGHT AT BIRTH:		LENGTH:	HEAD CIRCUMFERENCE:
APGAR	1 MINUTE:	5 MINUTES:	GESTATIONAL AGE BY PHYSICAL EXAM:
PERINATAL COMPLICATIONS:			
ADMISSION DATE:		DISCHARGE DATE:	DISCHARGE WEIGHT:
ABNORMAL FINDINGS	CURRENT STATUS		REQUIRED FOLLOW UP
1.			
2.			
3.			
GENERAL CONDITION UPON DISCHARGE:			
NURSING INFORMATION:			
FEEDING/DIET			
MEDICATIONS			
SPECIAL OBSERVATIONS/INSTRUCTIONS			
SCHEDULED APPOINTMENTS:			
LOCATION:	DATE:	TIME:	PHONE:
1.			
2.			
3.			
Home Health Referral		Agency Name:	
☐ yes ☐ no		Contact Person:	
		Phone Number:	
Signature:		M.D.	Phone:
		Social Worker	Phone:
In emergency, if above professionals cannot be reached, contact: Weekdays 8-5 PM: (213) 825-5431 Weeknights/Weekends/Holidays (213) 825-2111			

DIST: (1) White—Medical Record(2) Canary—Children's Services Worker(3) Pink—Foster Parents(4) G/Rod—Clinical Social Work

DISCHARGE INFORMATION SHEET FOR THE NEWBORN

frequency is desirable in order to give parents/caregivers increased support and to provide needed anticipatory guidance. Frequent medical followup also enables better monitoring of a child's ongoing physical care.

- Pediatric well-baby care is especially critical for medically fragile infants. In addition to subspecialty followup, such infants also require regular well-baby followup with a primary physician to ensure appropriate immunizations and preventive health care services.
- Supportive followup services, including home visits, parenting education, and counseling are essential to maintain and enhance the parent-child relationship.

Often, ancillary supports are also required to ensure that needed followup services are provided. Such supports might include transportation, child care for other children in the family, assistance in coordinating multiple appointments with health care specialists to minimize the number of trips, or even assistance with filling out required forms. This type of coordination requires the collaboration of every member of the service team.

DEVELOPMENTAL CONCERNS

Prenatally drug-exposed infants and young children are at increased risk for developmental problems. Regardless of their health status, all such children need to be evaluated from a developmental standpoint at least once during the first 6 months of life, again at 1 year, and at least every year thereafter until they are school age. Children with recognized developmental problems will need more frequent assessments.

Developmental screening in drug- and alcohol-exposed children is critical because early intervention and early identification of developmental problems are key to optimizing the children's social, language, cognitive, and motor development. As has been demonstrated in other high-risk groups of children (e.g., preterm children, children born small for gestational age, and children with diagnosed physical and/or mental disabilities), infants who experience responsive caregiving environments and young children who are in center-based programs generally show better developmental outcomes than children who do not have these experiences. Through home-, center-, and school-based programs, children affected by parental alcohol and/or other drug abuse can be exposed to enriched environments and given opportunities that will foster their developmental potential.

Developmental Assessment

To evaluate the developmental progress and needs of infants and young children, specialists (e.g., pediatricians, occupational therapists, and psychologists) use standardized tests such as the Bayley Scales of Infant Development, the Gesell Developmental Schedules, and the Denver Developmental Screening Test. These structured measures evaluate the personal/social, language, adaptive/cognitive, and motor skills of the infant and young child. Findings from the evaluation of these four developmental areas provide information about the child's current strengths and problem areas and may help predict later moderate to severe mental retardation. However, these measures are not sensitive enough to identify a specific child who may have a short attention span, learning disability, hyperactivity, or other developmental problems later in life.

Beginning at about 3 years of age, standardized intelligence quotient (IQ) tests such as the Wechsler or the McCarthy scales are used for evaluating a child's cognitive abilities. Measures such as the Achenbach Child Behavior Checklist are useful for assessing social and behavioral problems in older children. Although they may be helpful in providing "warning signs" (e.g., delayed language development, fine motor incoordination,

hyperactivity, short attention span) for future learning difficulties, these measures indicate risk status only and cannot be used to predict specific learning problems. Only during the school-aged years can more precise measures be used to detect existing learning disabilities (e.g., attention deficit disorder, dyslexia, etc.).

Developmental Patterns of Prenatally Drug-Exposed Children

Infants and young children exposed prenatally to drugs or alcohol display a wide array of developmental patterns that range from normal to deviant. It bears repeating that these patterns are the result of complex interactions among biologic and environmental factors. It is important to keep in mind that children of substance abusers, whether they reside in poor, middle-class, or wealthy households, are at high-risk for environmental deprivation, a critical factor in determining a child's long-term emotional, social, and intellectual development. We can do little to alter biological influences, but we can often mitigate biological risks by promoting healthy environments.

Infancy (0 to 15 Months)

Unpredictable sleeping patterns. Most infants develop predictable sleeping patterns by 4 to 6 months of age. Although newborns generally have short periods of sleep throughout the 24-hour cycle, the typical infant is able to sustain a 6- to 7-hour nighttime sleep sometime between 4 and 6 months of age. Some infants who have been prenatally exposed to drugs or alcohol continue to demonstrate sleeping patterns more typical of a newborn throughout the first year.

- Medications have not proven useful in helping these infants organize sleep/wake states.
- Respite care is often extremely important in these situations because the infants' erratic sleeping schedules, coupled with their increased irritability, can be exhausting for even the most experienced caregiver.

Feeding difficulties. By the time they are 2 weeks old, most infants have established a somewhat regular pattern of feeding and are able to suck effectively enough to have regained their birth weight. However, infants prenatally exposed to drugs or alcohol may have a variety of feeding difficulties.

Feeding problems commonly reported by caregivers of prenatally drug and alcohol-exposed infants include prolonged feeding time due to uncoordinated and ineffective sucking movements or lethargy, infant distractibility during feeding, frequent spitting up of formula, and increased need to suck (hyperphagia). The following are some suggestions that professionals may find useful in helping parents or other caregivers to deal with these concerns:

- The parent can swaddle and hold the baby during feeding. Propped bottles should not be used.
- The parent should use bottles for feeding liquids only and use spoons for solid foods.
- For a baby who spits up a lot, the parent should burp the infant more frequently (some babies need to be burped after each ounce).
- For an irritable baby, the parent can feed the infant in a quiet place away from other children and distractions and avoid sudden movements.

- For an unusually sleepy baby, the parent should allow more time for feeding and provide extra encouragement to keep the baby awake such as massaging the back or rubbing the soles of the feet while talking softly.
- For a baby who has an intense need to suck even after the infant's stomach is full, the parent can offer a pacifier to avoid overfeeding.

Irritability. A range of temperaments is seen in all neonates. Some infants tend to be easygoing and are readily soothed when fussy, but others tend to be more irritable and are harder to calm. Caring for these infants is more difficult. Infants who have been prenatally exposed to drugs and alcohol often display such irritability. They can be easily overstimulated and, once aroused, have great difficulty calming themselves. For such infants, professionals can offer the following recommendations to parents/caregivers:

- Swaddle the baby, with hands exposed.
- Walk and hold the baby close to the body, using a front carrier (the combination of swaddling, body contact, and gentle motion puts many fussy babies to sleep).
- Bathe the baby in warm water, followed by a gentle massage.
- Place the infant face down on the parent's/caregiver's abdomen and gently massage his/her back.
- Offer a pacifier.
- Speak softly.
- Gently rock the baby in a windup cradle or swing, insuring that his/her head is well supported.
- Play soft music in a quiet room, and avoid bright lights, jostling, and loud noises.
- Support the baby's bottom with one hand and his/her head with other hand, hold the baby away from the parent's/caregiver's body in an upright position, and rock the baby gently in an "up and down" motion.

Atypical Social Interactions. Social interactions begin at birth. When awake, the newborn infant will respond by turning toward a voice and will visually connect and look at the caregiver. These are brief behaviors, but they are especially rewarding to parents as they begin the attachment process. By 4 months of age, the typical infant is cooing in response to social exchanges, makes direct eye contact, and has a social smile for persons in the immediate environment. At 6 months of age, this highly social child becomes more discriminating and smiles less at strangers.

Infants who have been prenatally exposed to drugs and/or alcohol may have a number of atypical social responses, including indirect gaze, gaze aversion, and less marked stranger discrimination during the second half of the first year. Professionals should:

- Provide explanations to help parents/caregivers to keep from personalizing the infants' interactive behaviors.

- Remind parents/caregivers that the children's social responses and interactions will improve if they are given appropriate time and opportunities. When gaze aversion occurs, it may indicate a need for decreased stimulation.
- Encourage consistency of parents/caregivers to support the children's early attachment needs.

Delayed language development. Language development during early infancy involves cooing, smiling, chuckling, squealing, and crying. Infants who have had prenatal exposure to drugs and alcohol may demonstrate fewer vocalizations and less babbling. Language development can be promoted if professionals encourage parents/caregivers to:

- Talk with the infant during bathing, feeding, and changing times.
- Respond to the infant's attempts to vocalize, reinforcing responses with eye contact and animated facial expressions.

Increased muscle tone and poor fine motor development. Motor development follows a similar pattern in all healthy infants. However, there is some variation in the age at which individual milestones are normally achieved. Young infants exposed prenatally to heroin and methadone generally reach gross motor milestones at appropriate ages. However, these infants frequently exhibit increased muscle tone (stiffness). In contrast, young infants exposed to stimulants such as cocaine may have decreased muscle tone and variable motor development, though most demonstrate attainment of milestones at an appropriate age. Furthermore, among older infants who were prenatally substance-exposed, there may be problems with fine motor coordination, unsteadiness in the movement of extremities, and mild problems with balance. For such babies, professionals should recommend that parents/caregivers:

- Encourage activities that provide safe opportunities for rolling over, crawling, and pulling to a standing position.
- Provide opportunities to practice reaching for and grasping small, lightweight toys. Encourage feeding with finger foods, such as cereal or crackers.

Toddlerhood (15 to 36 Months)

Atypical Social Interactions. Toddlers see themselves as the center of the universe, around which all activities focus. The pronoun "mine" epitomizes this particular age. The building of trust in one's own social relationships is an important behavior learned during this period.

An important factor that determines later successful social interaction relates to the kinds of early experiences children have with their parents/caregivers. If a child has a secure attachment relationship with his/her primary caregiver, there is increased likelihood that the child will later have effective social interactions. Because children who are raised in chaotic home situations are at high-risk for later problems with appropriate social behaviors, one of the important tasks professionals face is to ensure that children have opportunities to acquire the trust needed for later healthy interpersonal relationships.

Toddlers who have had prenatal drug or alcohol exposure, or who live in environments in which there is unpredictability in caregiving may demonstrate atypical social behaviors, including overfriendliness, withdrawal, and impulsive behaviors. For toddlers who display such behaviors, professionals can encourage the parent/caregiver to:

- Provide consistent and nurturing caregiving within the home setting.
- Enroll the toddler in an early intervention program that can provide daily substitute nurturing and consistency when the parents/caregivers are not readily available.

Delayed language development. Toddlers have a growing vocabulary but understand (receptive language) more words than they are capable of speaking (expressive language). Toddlers who were prenatally substance-exposed or who live in substance-abusing households tend to have decreased vocalizations and immature pronunciation of single words. Professionals can recommend several specific intervention strategies, including the following:

- Parents/caregivers can use body language and direct eye contact to reinforce verbal directions.
- Parents/caregivers can use objects and pictures to augment the meaning of spoken words and read simple picture books with the child.

Minimal play strategies. Play is central to the young child's early cognitive development. A toddler's pretend play with dolls, baby bottles, cooking utensils, and trucks becomes more elaborate. Children's interactions with toys and other objects within their environment become more purposeful and organized, and their activities are sequenced, with a beginning, middle, and end. For instance, most toddlers will hold a baby doll, feed it, and then put it to bed. In testing situations, some substance-affected children appear less able to independently organize a meaningful sequence of play with such common toys. Intervention techniques for children that professionals can recommend include the following:

- Parents/caregivers can discuss daily events and activities in a way that highlights cause-and-effect relationships, sequences of events (i.e., emphasizing the beginning, middle, and end), and social relationships and characteristics (e.g., the differences between relationships with family members and with strangers). This can be done simply while looking at picture books, during meals, at bath time, on trips to the grocery store or park, and after watching a children's television program together.
- Parents/caregivers can model play with toys in a meaningful sequence with use of words and body language so that the child can imitate and, eventually, generalize this behavior.

Preschool Years (3 to 5 Years)

Preschoolers are more socially independent and are able to learn to share and take turns. Their language skills are more sophisticated, and their attention spans are sufficient to allow them to learn within a group setting that provides less individualized attention.

Many children who live in chaotic environments and/or who have suffered prenatal substance exposure show increased activity levels, short attention spans, impulsivity (e.g., they lose control easily), mood swings, and problems with moving from one activity to another.

Some substance-affected preschoolers also may continue to demonstrate difficulties in the auditory processing of spoken words as well as visual processing of material presented to them in the form of pictures. Furthermore, some demonstrate "sporadic mastery of tasks," in which the skills they demonstrate one day are absent another. Concern about the social development of substance-affected preschoolers also has led to ongoing research into the patterns of attachment and social interaction within this high-risk population of children.

Professionals working with drug- and alcohol-affected preschoolers have developed the following recommendations for addressing the special problems of this population within a classroom setting:¹²

- For the child who is easily overstimulated, it is helpful for professionals to limit the number adults and children in the classroom and regulate the number and types of toys available at any given time.
- For the child who has difficulty with social interactions, professionals should provide consistent and explicit expectations of his/her behavior and use verbal cues and physical contact to direct or redirect the child's activity and model behavior that emphasizes taking turns.
- For the child who has difficulty with task mastery, professionals can verbalize the steps in task performance, ask the child to verbally repeat these steps, and model approaches to completing the task.
- For the child who has difficulty with transitions (changing from one activity to another), professionals can provide a predictable daily routine that includes a regular pattern of play, rest, and meals. They also should provide consistent praise for accomplishments and prepare the child for transitions by discussing planned changes in activities in advance.
- For the child who displays behavioral problems, professionals can encourage dramatic play, allow time for him/her to express emotions, and assist the child in developing alternative ways of expressing feelings.

School and Teenage Years

Little is known about the long-term biological effects of prenatal exposure to drugs; longitudinal prospective studies are needed to build a solid base of knowledge. However, children who exhibit language delays, distractibility, and/or problems with fine motor coordination during the preschool period are at increased risk for learning problems during their school and teenage years. For children who were prenatally exposed to alcohol, there is growing information about the cognitive development of school-aged children with FAS. By the time such children reach elementary school age, many demonstrate cognitive skills that fall within the mentally retarded range. Other less severely affected children display attention deficit disorder and specific learning problems related to difficulties with visual and auditory processing.

In the absence of research data describing the long-term effects of prenatal substance exposure, there are still a number of ways in which professionals can provide services for children and adolescents from substance-abusing families. Sometimes, older children may come to professionals' attention because of the birth of a younger substance-exposed sibling in the family. Other children may demonstrate problem behaviors in school (e.g., depression, learning difficulties, repeated absences) that can alert professionals to a possible problem with alcohol and/or other drug abuse within the family. Additionally, children may come to the attention of professionals through the child welfare system. The children also may begin experimenting with or abusing drugs and/or alcohol themselves. Further, law enforcement professionals also may be in a position to identify family substance abuse problems when adolescents engage in acting-out behaviors.

Whatever behavioral symptoms a child may demonstrate (and whatever their cause), as he/she passes from preschool into elementary school and beyond, available testing measures become increasingly more sensitive in identifying learning strengths as well as problems. A team of teachers, psychologists, speech and language

therapists, hearing and vision specialists, nurses, and other professionals can be called in to assess difficulties with learning that may be related to short attention span, speech and language problems, impulsivity, difficulties with short-term memory, auditory and visual processing, etc. Based on such an evaluation, school personnel can more readily develop effective educational programs to help the child or adolescent compensate for identified problems.

However, more often than not, this educational intervention alone is not sufficient to support ongoing success in learning for children who live in substance-involved households. Unlike many children who have learning difficulties but who have grown up in stable family environments, the majority of drug-affected children have experienced environmental instability that may have included multiple placements, child abuse and neglect, inconsistent parenting (possibly including extended parental absences), domestic violence, and other stressors related to alcohol and/or other drug abuse. Thus, social workers, other mental health professionals, and members of the clergy may also need to provide services to help identify, treat, and prevent mental health disorders in such children.

For children who experience problems in school and who also are growing up in dysfunctional homes, the cumulative effects of both academic failure and environmental instability may greatly impair their functioning in a variety of other areas. Poor peer social relationships and low self-esteem place such children and adolescents at high-risk for depression, suicide, substance abuse, teenage pregnancy, and school dropout. In terms of primary prevention efforts, professionals can:

- Advocate for needed specialized educational services within the school system, tutoring for academic underachievement, and assessment and intervention for neuropsychological problems.
- Encourage participation in school or community-based, teen-oriented support groups, such as AIAteen or AIAnon if alcohol abuse is a concern.
- Encourage a stable relationship with an adult role model through participation in programs such as Big Brothers or Big Sisters.
- Explore recreational and work experiences whereby the older child or adolescent will have opportunities to experience success.
- Refer parents to support groups that provide education and guidance for dealing with difficult childhood and adolescent behaviors.
- Provide individual and family therapy.

SUMMARY

The point at which a substance-affected child becomes visible to professionals usually depends on the child's age, and it is important to remember that the child welfare system may not always be the primary identifier. A prenatally substance-exposed newborn is most likely to be identified within the health care system on the basis of maternal or infant signs and symptoms, as is a toddler, who may have problems with infections, FTT, etc. A preschooler, on the other hand, may be more visible within programs such as Head Start or early intervention programs for special-needs children, in which the child or his/her parents may demonstrate behaviors that are suggestive of a substance abuse problem within the family. Teachers and other educational professionals may identify school-aged children from alcohol- and/or other drug-abusing families on the basis

of child or parental behavior or the content of the children's conversations with staff and peers. Adolescents from substance-abusing families also may demonstrate problem behaviors at school, or within the community, thus coming to the attention of law enforcement professionals.

At any one of these points of visibility, professionals can garner their resources and provide intervention. An interdisciplinary approach that encompasses the children's problems as well as those of other family members is most likely to be effective in helping families with problems related to alcohol and/or other drug abuse. Further, it is important to remember that child development is an ongoing process. Just as early intervention has been shown to have a positive impact, comprehensive, coordinated efforts can be helpful at whatever stage they are begun.

REPORTING CHILD MALTREATMENT IN CASES INVOLVING PARENTAL SUBSTANCE ABUSE

CASE VIGNETTE: Based on Lisa's history of substance abuse and an abusive relationship with the baby's father as well as positive urine toxicology screens at delivery and birth, Lisa and Timmy were reported to Child Protective Services (CPS) for evaluation of Lisa's ability to provide daily care and protect Timmy from harm.

Determining if and when parental substance abuse should be reported to a CPS agency is a difficult but important issue. To make such a determination, it is necessary to understand the requirements related to mandatory reporting of child abuse and neglect. Although it is a matter of serious debate whether these reporting laws apply to the unborn, there is no doubt that they do apply to infants and children who receive neglectful or abusive care from their chemically involved parents or who are in imminent danger of receiving such care.

REPORTING OBLIGATIONS

State laws, policies, guidelines, and definitions govern the reporting of child maltreatment, including cases involving parental substance abuse. Readers are advised to check the reporting mandates and procedures specific to their States in each of the areas discussed below.

Reporting Parental Substance Abuse

We are all aware that all reasonable suspicions of child maltreatment must be reported. However, without specific State legislation, parental substance abuse (in and of itself) is not reportable as a form of child maltreatment. Only when there is reason to believe that the parent's alcohol or other drug abuse is so severe that the child has been or is likely to be harmed due to such substance abuse, should a report to CPS be filed.

Reporting Substance Abuse During Pregnancy

Problems arise in determining whether fetal exposure to harmful substances during pregnancy should be reported under child abuse and neglect reporting laws. The mother's right to privacy must be balanced against the fetus' right to a safe, healthy environment. In many States, a fetus is not defined as a minor child or juvenile ("any child from birth to 18"), thus precluding any child abuse or neglect action within the child welfare and juvenile court system.

However, there are a number of States that weigh the rights of the fetus more heavily than the mother's right to privacy. CPS agencies in these States accept reports of prenatal substance abuse so that they may offer services for the pregnant mother and the unborn. One State has a provision that specifically allows applications by a relative or an agency for the care or custody of an unborn when the unborn's welfare is in danger and the pregnant mother is in the State at the time of application for services.¹²

Until explicit laws are created to deal with the question of reporting substance abuse during pregnancy, professionals will need to continue to infer the answer on the basis of existing State child abuse and neglect reporting laws.¹³

Reporting Drug- and Alcohol-Affected Infants

An increasing number of States have dealt with the issue of prenatal alcohol and other drug abuse by mandating that substance-affected infants be reported at the time of birth. Some States specifically mention prenatal drug exposure in their statutes defining child abuse and neglect. However, these States often limit the definition of "drug exposure" to illegal substances. Although prenatal exposure to alcohol is a leading cause of mental retardation, only four States currently require that Fetal Alcohol Syndrome (FAS) be reported.

The condition of the infant that triggers mandatory reporting laws varies from State to State. Some States require only a positive toxicology screen at birth. Other States require physical signs of addiction or dependence. Still others require reporting of drug- and alcohol-affected infants based on a more general assessment of the newborn's imminent risk of harm or need for protection.

Most States, however, have no explicit laws requiring the reporting of prenatal substance exposure. In these States, the determination of whether professionals should report such cases requires a legal analysis of existing child abuse and neglect reporting laws. For more information on mandated reporters, the reader is referred to a companion manual in this series, *A Coordinated Response to Child Abuse and Neglect: A Basic Manual*.

Variations in Reporting

Professionals mandated to report reasonable suspicions of substance abuse that may cause risk to a child sometimes choose not to report. Private physicians, for instance, may not want to risk the loss of paying clients or the control that they maintain over their patients' care. On the other hand, physicians in public clinics, emergency rooms, or hospitals tend to report a much higher proportion of their patients. While their reports seem to indicate a higher use of substances among poor clients, the settings themselves may in fact be at cause, and clients' help-seeking is often what is measured rather than incidence of abuse.

Additional factors also may come into play. In a study of reporting practices of mandated reporter professionals, Zellman found that those who believed that reporting would do more harm than good failed to report.¹⁴ Reporting may also be influenced by statutes that require hospital staff to conduct a thorough medical and social assessment of each infant prenatally exposed to drugs to determine whether the newborn's condition should be reported. In California, for example, the assessment of risk factors includes not only the toxicology screen, but also the child's physical condition as well as parental and environmental factors in the home that may place the infant at risk (See California Penal Code, Sec. 11165.13). Other States that require reporting of every newborn with a positive toxicology screen conceivably could have more reports made as a rule, particularly if these additional factors can constitute the basis of a report.

The National Clearinghouse on Child Abuse and Neglect Information is developing a State statute database that will provide information on a number of elements in State reporting laws, including substance abuse. This resource will be helpful if individuals need to know about specific State laws or wish to make comparisons of reporting requirements among States. For additional information, the reader is referred to a recent National Institute on Drug Abuse publication, *Legal Interventions Directed at Women Who Use Drugs During Pregnancy: What Decision-Makers Need to Know*.

CONFIDENTIALITY

The Child Abuse Prevention and Treatment Act requires confidentiality of child abuse records to protect the rights of the parents and the child in civil but not in criminal proceedings. Federal funding statutes require

States to make unauthorized disclosure of these records a criminal offense. However, States are permitted to except disclosures when requested by the following:

- agencies or organizations, including a designated multidisciplinary case consultation team, that are legally mandated to receive and investigate reports of known and suspected child abuse and neglect;
- courts (which may subpoena records in some restricted cases);
- grand juries;
- a properly constituted authority investigating a report of known or suspected child abuse or neglect or providing services to a child or family which is the subject of a report;
- a physician who has before him/her a child for whom the physician has reasonable suspicion of abuse or neglect;
- anyone legally authorized to place a child in protective custody and who needs the information to determine whether to place the child;
- agencies with authority to diagnose or treat a reported child;
- anyone who is the subject of a report (the identity of the reported cannot be revealed if to disclose would endanger the life or safety of the reported; most States protect this confidential disclosure);
- the child, attorney, or guardian ad litem for the child;
- State or local officials responsible for administration of the CPS caseworker or for oversight of the enabling or appropriating legislation;
- individuals, agencies, or organizations conducting bona fide research, with no identifying information made available;
- the original reporter, who may be provided with feedback or a summary of the outcome of the report;
- agencies or persons conducting background screening for child-related employment; and
- the U.S. Department of Health and Human Services and the Comptroller of the United States or any of their representatives (45 CFR 1340.14).

Confidentiality normally protects the patient or client from any unauthorized disclosure of information. However, all States now have mandatory child abuse reporting laws that abrogate the professional/patient or client privilege. Mandated reporters are protected from civil or criminal liability for any report made in good faith. In many States this immunity extends to participation in judicial proceedings arising from the reports. It is also important to note that individuals providing treatment services under programs funded through the

Federal Alcohol and Drug Rehabilitation Act are required to report suspicions of child abuse pursuant to State child abuse reporting laws.

Furthermore, many States have statutory exceptions that allow discriminant sharing of multidisciplinary agency information about children who are alleged or found to be abused or neglected. Information from normally confidential sources should be shared in order to coordinate service delivery and provide effective support to the family. Sharing medical, mental health, social welfare, substance abuse treatment, criminal, probation, and educational information is crucial to providing protection for a child, especially when the child is living in the home or when a return to the parents is anticipated.

Table 2 illustrates a form that can be useful for accessing multiagency information in jurisdictions when confidentiality is a roadblock to services.

Table 2
SAMPLE INTERAGENCY CONSENT FORM

NAME OF CHILD:

DATE OF BIRTH:

ADDRESS:

ADDRESS OF PARENTS, IF DIFFERENT FROM CHILD'S:

TO WHOM IT MAY CONCERN:

I, _____, the undersigned juvenile, and I, _____, the undersigned legal guardian(s) of the above named juvenile, hereby authorize, unless excluded below, the Juvenile Court Counseling Office, _____ County Department of Social Services, _____ Mental Health Center, _____ County Youth Services, _____ County School Personnel, Evaluation Committee of _____ County, _____ Health Department, and _____ (other), or their authorized representatives or employees, bearing this release or a copy thereof, to obtain any information pertaining to my:

- ☐ Educational records (including but not limited to academic achievement, attendance, athletics, personal history, and disciplinary records)
- ☐ Medical records
- ☐ Psychological and psychiatric records
- ☐ Employment
- ☐ Family history and other information regarding services received.

Excluded is _____.

We hereby direct you to release such information upon request of the bearer. The doctrine of informed consent has been explained to us. We understand the contents to be released, the need for the information, and that there are statutes and regulations protecting confidentiality of authorized information. The release is executed with full knowledge and understanding that the information is for official use by the agencies. We hereby acknowledge that this consent is truly voluntary and is valid for one year. We further acknowledge and understand that we may revoke in writing this consent at any time, except to the extent that information has already been released before we revoke it, and except to the extent that action based on this consent has been taken.

We hereby release you as custodian of such records, any school, institution, hospital, or other repository of medical records, social services agency, any employer, or retail business establishment including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind which may at any time result to us, or heirs, family, or associates because of compliance with this authorization and request for information or any other attempt to comply with it.

The information hereby obtained is to be used only for the purposes of investigation, evaluation, and report.

Signature of Juvenile

Date

Signature of Guardian

Date

Witness

Date

COMPREHENSIVE FAMILY ASSESSMENT

CASE VIGNETTE: Following the referral to CPS by newborn nursery personnel, Lisa became angry at the hospital and its staff and did not want to bring Timmy back to the hospital for well-child care. She also refused to cooperate with the CPS assessment, and Timmy's father became verbally abusive towards the CPS workers. The maternal grandmother was contacted. Although she was hurt and angry about CPS involvement with her daughter and grandchild, Lisa's mother eventually shared what she knew, describing her daughter's unstable lifestyle and addiction. Upon questioning, she indicated that she would be willing to care for Timmy and encourage her daughter to enter a substance abuse treatment program. Further assessment revealed that the grandmother's home life was stable and that she would be able to provide a safe and nurturing environment for her grandson.

The assessment process for any troubled family that has come to the attention of professionals should involve an inquiry that addresses both the problem of substance abuse and the problem of child maltreatment. In addition to the initial determination of risk of harm to the child, information about family dynamics and the service needs of parents and children needs to be addressed. Thus, the initial assessment of chemically involved families overlaps substantially with the initial assessment process for nonsubstance-abusing families, and the reader is referred to the companion manual in this series, *Child Protective Services: A Guide for Caseworkers*, for a detailed description of factors that need to be evaluated to determine a child's immediate safety.

Once the initial assessment has revealed a family problem related to alcohol and/or other drug use, a more comprehensive assessment of the chemically involved family's functioning is critical to the overall intervention process. Such an assessment lays the groundwork for building on family strengths and selecting services to meet the complex needs of both parents and children. Because parental abuse of alcohol and other drugs impacts all family members and all aspects of their life together, it is essential that the assessment process be family focused. Furthermore, since the circumstances within chemically involved families, especially those with special needs children, can change rapidly (sometimes in ways that can be dangerous to children) the process of assessment must be ongoing. A comprehensive, culturally sensitive, and continuing assessment is pivotal to the development of a realistic service plan and provides a framework for evaluating the effectiveness of intervention whether the assessor works in CPS, health care, education, substance abuse treatment, mental health, or the juvenile justice system.

This chapter begins with a discussion of how to gather family assessment data and then details the types of information professionals should explore during the assessment process. The reader should remain aware that the comprehensive assessment is a process that takes time. As professionals become more experienced with the general areas of the comprehensive assessment, and as they become more familiar with individual families, the assessment questions will become more evident, often becoming part of the intervention process itself.

GATHERING INFORMATION

To gather sufficient information regarding the chemically involved family's functioning, professionals need to:

- Conduct interviews with parents and other family members.
- Make a series of visits to evaluate the home environment, family dynamics, and interactions among family members.
- Contact other service providers and agency representatives who have been, or are currently, involved with the family.
- Obtain or arrange for a variety of standardized evaluations for the parents as well as for the children.

Interviews With Family Members

Interviewing all family members is important. Alcohol and other drug problems affect every member of the family, and it is important for professionals to assess how a parent's substance abuse has affected the health, schooling, and social life of each individual within the immediate and extended family.

Professionals should not rely solely on interviews to gather information. Observation of nonverbal behavior, appearance, and environment may substantiate or contradict information gained during the interview process. For example, a parent may deny substance abuse but exhibit behavior that is suggestive of drug or alcohol use such as slurred speech, staggering gait, and/or drowsiness.

Home Visits

Home visits are critical because the home environment can reveal a great deal about a family's day-to-day functioning, cultural beliefs and affiliations, strengths, and problems. Compared with a clinic or office interview, a home visit provides less structure, and families may present themselves quite differently. Further, many families feel more comfortable being interviewed in their own homes.

Collateral Contacts

Denial of alcohol or other drug abuse is common in chemically involved families. Moreover, parents may minimize the extent of their drug and/or alcohol use or deny any relapses because of fears that their children will be removed from their custody. Thus, to make an accurate assessment, it is important to obtain information from knowledgeable sources outside the family system. These sources may include physicians, nurses, social workers, teachers, members of the clergy, employers, neighbors, child care providers, mental health professionals, substance abuse counselors, parole and probation officers, and CPS caseworkers. In gathering information from these sources, the interviewer should be familiar with the guidelines for confidentiality that govern individual and agency practice with respect to the sharing of information. Federal Law 42 CFR, Part 2, for example, governs the release and exchange of confidential information about an individual's use of alcohol and other drugs.

Standardized Evaluations

Standardized assessment tools are used to monitor a child's developmental progress and to help identify developmental and educational service needs. Use of standardized evaluations with parents, as well, can be

helpful in identifying developmental disabilities and underlying psychiatric problems. For a description of specific evaluation tools, the reader is referred to companion manuals in this series, *Treatment for Abused and Neglected Children: Infancy to Age 18* and *The Role of Mental Health Professionals in the Prevention and Treatment of Child Abuse and Neglect*.

AREAS OF ASSESSMENT

Appropriate planning and intervention with substance-abusing families begins with a careful assessment of a number of infant/ child, parental, and environmental factors. It is the combination and interaction among these factors that helps the professional evaluate the child's safety in the home and determine the types of services needed by the family. The following sections are intended to provide guidelines for the professional regarding factors that should be explored as part of a comprehensive family assessment.

Assessment of the Infant and Child

Children prenatally exposed to alcohol and other drugs, and children living with substance-abusing parents are vulnerable populations. Often, such children are both biologically and environmentally at risk of developmental lags; many have special needs.

Infant Assessment

Because the minimum standards for adequate parenting may be higher for an infant prenatally exposed to drugs, it is especially important for the professional to assess carefully the infant's health and care requirements. This information generally is gathered through standardized examinations and observations of the infant as well as through interviews with the primary caregiver(s) and involved health care personnel.

In assessing the infant's needs, professionals should consider the following:

- Does the newborn exhibit symptoms of drug exposure? (These may occur within several hours of birth, although some newborns may not show symptoms until much later.) Of particular concern are infants who have diarrhea, sleep poorly, are lethargic or irritable, or are on medication for drug-related symptomatology.
- Were toxicology screens conducted? If so, what were the results?
- Was the infant born prematurely (before 37 weeks of gestational age)? Symptoms related to prenatal substance exposure may be masked by the infant's degree of illness or the immaturity of the CNS.
- Will the infant require special medication and/or equipment such as an apnea monitor or oxygen? If so, caregivers may require special instruction or training.
- Does the infant have medical or physical problems that could significantly impact critical life functions or long-term physical and intellectual development? For example, does the infant have a cardiac defect, seizures, or other congenital anomalies? Will the infant require close medical monitoring and frequent pediatric visits? If so, does it appear that the parents' substance abuse may interfere with their ability to provide the needed level of care and to obtain the medical followup required?

Child Assessment

Children can be harmed not only through prenatal drug and alcohol exposure, but also by being raised in environments in which these substances are abused. Often, the basic care of children is inadequate in households with chemically involved caregivers. In comparison with the general population, child maltreatment occurs with greater frequency in substance-abusing families.¹⁵ Alcohol and other drugs can be passed to an infant through breast feeding; fumes from drugs that are smoked may be inhaled by children within the home; substances may be accidentally ingested by children; and youngsters can be deliberately given drugs or alcohol by substance-abusing adults. Professionals should consider the following:

- How many children are there in the home? What are their ages?
- With whom do the children spend most of their time? What are their activities as well as their relationships with their parents, peers, and other adults? Chemically involved parents/caregivers frequently provide inadequate supervision. Without appropriate parental oversight, young children are at increased risk for victimization and injury.
- Are there adequate and appropriate supplies and provisions for the children? Chemically involved parents may use money that should be spent on basic life necessities for the purchase of drugs and/or alcohol.
- Are the children receiving ongoing health care? Do any children have chronic illnesses? Are immunizations current? Are there any untreated medical conditions? Do any children have histories of prior injuries, and if so, were these accidental or inflicted? Are the children's growth patterns within expected ranges or is there evidence of failure to thrive?
- Are the children enrolled in school? Do the parents meet with school personnel when indicated? Do the children generally appear clean and appropriately dressed when they go to school? How are the children functioning academically? When a chemically involved family has had repeated disruptions in daily routine or frequent changes of address, the children may have missed much school or had to change schools often. Because learning deficits and short attention spans may occur as a result of prenatal substance exposure or environmental instability, it is important to assess all children living in the home with respect to these problems. Children may appear to be physically healthy but may nonetheless have developmental and educational deficiencies.
- Because role reversal is common in chemically involved families, has a child assumed the role of a parent by performing adult caregiver tasks? If so, what resources are needed to support the family so that the child can be freed from inappropriate and/or dangerous responsibilities?

Careful observation of all children in a chemically involved family is essential in assessing and planning for the family as a whole, and for making appropriate health care and educational referrals for the children.

Assessment of the Adolescent

Adolescents with alcohol or other drug use problems are often experiencing other problems as well. These problems may include mental health problems, violence between family members, child abuse, and involvement with the criminal justice system. Adolescents living in such troubled environments are likely to be experiencing difficulties in a number of areas, including family relationships, physical abuse/sexual victim-

ization, educational performance, and emotional/psychological functioning. Many of these difficulties can be traced to an early age and, if not addressed, place these youths at high risk of future drug use and delinquency/crime.

In view of the often interrelated nature of these problems, it is important that the assessment of adolescents in substance-abusing households be holistic and comprehensive—rather than in one-problem-at-a-time terms. Information needs to be collected on their experience of specific problems so that service needs can be identified and appropriate interventions developed.

Before comprehensive assessment begins, it is important for the assessor to determine what constitutes the “family” for the adolescent who is to be evaluated and to be respectful of cultural and ethnic variations in family structure. For many members of society, the traditional definition of family is no longer applicable. A given adolescent may derive his/her physical (e.g., food and shelter), emotional, spiritual, and cultural needs from different individuals. Persons who serve as family in the adolescent’s life by virtue of providing for physical, emotional, and/or spiritual needs should be included in the assessment process.¹⁶

Within available time and resources, efforts should be made to assess the adolescent in a range of domains, including health history, psychosocial background, educational experiences, and community agency involvement, as detailed below:¹⁷

- medical history (including illnesses, infectious diseases, and HIV status);
- mental health problems and history (including previous evaluations and treatment);
- family environment and how the adolescent perceives this situation—including perceptions and evaluations of any parental alcohol and other drug use, mental or physical health problems (e.g., chronic illnesses), family interrelationship problems, incarceration, or illegal activity;
- physical or sexual abuse experiences, as well as other developmental issues;
- strengths or resiliency factors, including self-esteem, family, other community supports, and coping skills;
- alcohol and other drug use, including the use of over-the-counter and psychotherapeutic drugs, tobacco, and caffeine;
- peer relationships, including gang involvement;
- leisure and spare-time activities;
- educational history, including academic performance, learning difficulties, and school behavior or attendance issues;
- history of involvement with social service agencies, including child welfare and foster home placements; and
- nature and degree of involvement with the juvenile justice system.

It is important to appreciate that assessment of the adolescent does not constitute an end in itself. Rather, the assessment process carries the implicit promise that identification of problems in the various domains that are assessed will lead to a written report that will be used as a basis for linking troubled adolescents with needed services. The report should specify treatment recommendations as well as need posttreatment services. It should represent an action plan that the family and the adolescent can accept and support. Rather than serving as a passive agent in the assessment process, the assessor should be a broker who sees to it that needed services are arranged for and provided.

Assessment of the Parent

Professionals working with chemically involved families may experience difficulty assessing the parents. First, their training may not have provided these professionals with a knowledge base for understanding substance abuse and its impact on individual and family functioning, parenting, and child health and development. Second, some professionals may feel uncomfortable and intrusive when inquiring about alcohol or other drug use and related lifestyle activities because of the legal and moral implications of illicit use. Third, often child abuse, substance abuse, developmental disabilities, and mental and physical health care problems are connected in chemically involved families, whereas individuals working in each of these specialized areas commonly have little contact with each other or knowledge about each other's related fields. Fourth, stereotypes of drug-addicted or alcoholic individuals may lead professionals to mistake or overlook chemical dependency.¹⁸

To overcome these obstacles, it is imperative that professionals learn to recognize, identify, and assess for substance abuse and to determine how substance abuse is perceived within the family and within the context of the family's culture. Only then can they develop a service/treatment plan that is appropriate to the needs of the family. In addition, by having supervision and consultation services readily available, professionals can be assisted in developing and maintaining an empathic, nonjudgmental, and informed approach. As part of the comprehensive assessment, the following parental factors should always be evaluated, including substance abuse history, drug and alcohol treatment history, health and health care, mental health and history of psychiatric treatment, criminal history, level of cooperation, awareness of the impact of alcohol and other drug use on the child, parenting skills and responsiveness to the child, history of abuse and/or neglect, and work history and education, as detailed below.

Substance Abuse History

Exploring a parent's history of alcohol or other drug use provides the professional with an understanding of the chronicity of the problem, and also helps in determining which treatment resources are most appropriate for individual parents. Although the information obtained during an initial interview may not be complete, talking with parents over time frequently reveals accurate information regarding substance abuse. Communication with members of the extended family, significant others, and professionals from other agencies can be particularly helpful in gathering a parent's substance abuse history. For many reasons, parents frequently deny the length and severity of their drug or alcohol use.

In assessing a suspected alcohol and/or other drug abuse problem, it is important to keep questions open-ended and assume use in order to elicit more realistic responses. The following are possible questions a professional might ask to gather information about patterns of use and the parent's perceptions about use:

- How often do you drink beer, wine, liquor?
- How many drinks do you generally have when you are drinking?
- How old were you when you had your first drink?

- When do you tend to want a drink? When alone or with others? If you drink with others, with whom? When bored or when you want to "party"? When you are angry, frustrated, or stressed?
- What drugs have you tried?
- How often do you use?
- How do/did you use/take it?
- How long have you been using? How long did you use?
- How much do you smoke?
- When do you usually want a cigarette?
- When you were pregnant, what was your drinking/use like?
- How does your behavior change when you drink/use?
- How do you feel when you drink/use?
- What impact has alcohol and/or other drug use had on your own health?
- What legal problems have you encountered as a result of your alcohol and/or drug use?
- How has the use of alcohol and/or other drugs affected your employment?
- How has your use of alcohol and/or other drugs affected your social relationships?
- Has the use of alcohol and/or other drugs resulted in violence or abuse in the home?
- What concerns do you have about your use of alcohol and/or other drugs?

It is also helpful to assess the impact of use on the family, since this information can be used in developing an effective intervention plan. The following are areas a professional can explore with other family members to gather information about a parent's alcohol and/or other drug abuse problem:

- How do family members view alcohol and/or other drug use?
- Do family members deny use and/or its impact?
- Do family members express worry about the user?
- Do family members feel tense, anxious, or overly responsible?
- Are family members angry with the user?
- Do children in the family exhibit adult behaviors or assume adult parenting roles?

Drug and Alcohol Treatment History

Professionals also need to explore parents' attempts at substance abuse treatment in order to understand how parents have dealt previously with their abuse of alcohol or other drugs. Obtaining the parents' treatment history helps ensure that current treatment referrals will be appropriate. For example, parents who have been repeatedly unsuccessful in outpatient treatment may benefit more from a referral to a residential setting than from a referral to yet another outpatient program. Professionals should determine the following:

- Have the parents ever been in a drug or alcohol treatment program? If so, where and for how long? What was the motivation for seeking treatment, and what were the circumstances under which the parents left treatment? Any indication of motivation should be pursued as a possible strength.
- For parents currently participating in a treatment program, what is the frequency and extent of their participation? Some parents, for example, may attend a treatment program only sporadically, whereas others may attend regularly but still continue to abuse drugs or alcohol. Other parents may be appropriately engaged in treatment. In evaluating compliance, it is important to remember that, although the parents' participation may provide a clue to their level of commitment, it also may indicate the need for different or supplemental treatment approaches.

Health and Health Care

Often, substance-abusing parents have health problems related to their alcohol and other drug use. Such problems can adversely affect the parents' ability to care for both themselves and their children. Thus, professionals should assess the following:

- What is the parents' general state of health? Are there any untreated medical problems or chronic illnesses? Chemically involved parents are at high-risk for communicable diseases such as tuberculosis and sexually transmitted diseases, including acquired immunodeficiency syndrome (AIDS), and may need to be referred for medical evaluations.
- If medical care is needed, does the parent have financial and logistical access to services?

In situations of perinatal substance abuse, the professional should determine whether prenatal care or drug treatment services were available to the mother during pregnancy. It then is important to learn whether the mother obtained regular and consistent care; this information can reflect a parent's ability to use health care systems and also may be an indicator of the mother's ability to plan and obtain appropriate medical care for her infant. In this respect, it is important to communicate with health clinic personnel or private physicians who may have treated a mother during pregnancy. Although it would be of concern if a mother had obtained no prenatal care, this information could be viewed quite differently if the woman had sought services and none existed, or if services were difficult to access.

Mental Health and History of Psychiatric Treatment

Parental mental health problems require careful evaluation but may be difficult to assess due to current intoxication or chronic substance abuse. However, identification and assessment for coexisting psychiatric problems is essential for appropriate case management. In evaluating mental status, it is imperative for professionals to determine the following:

- Have the parents ever obtained assistance from a mental health counselor? Have they ever been hospitalized for psychiatric reasons? If so, the history of hospitalization, length of stay, and reasons for admission should be explored.
- Have psychotropic medications been prescribed for the parents? If so, why were they prescribed, and are the parents currently taking the medications? This information is particularly relevant to making an appropriate substance abuse treatment referral because some chemical dependency treatment programs may be reluctant to accept clients who are currently taking psychotropic medications. In addition, a lapse in taking necessary medications or the mixing of psychotropic medications with other substances may exacerbate psychiatric symptoms that can place a child at risk of maltreatment.
- Do the parents have a history of violence toward others? Is there a history of domestic violence? Substance abuse, psychiatric problems, and problems with impulse control can be closely intertwined.

Criminal History

Because chronic substance abuse often entails contact with law enforcement agencies, reviewing a parent's criminal record is an important part of the assessment process. Professionals should determine the following:

- Does the parent have a criminal record? If so, what was the charge?
- Is the parent currently on probation or parole?
- Has the parent ever served time in jail or prison? Parental incarcerations mean that a child has been separated from a parent and also may have been left with nonparental caregivers.

Exploration of a criminal history can help the professional gain further information about the parent's lifestyle and about unhealthy situations and illegal activities to which children in the family may have been exposed. Further, information about how the family handled periods of incarceration (including visitation and reunification) can help the professional determine family members' sensitivity to the child's feelings and need for security.

Level of Cooperation

Parents' willingness to work with professionals to strengthen the family and protect their children is of considerable importance. A parent who initially seems disinterested, evasive, or hostile may, in fact, prove uncooperative with service/treatment plans. However, here, as in all other areas of assessment, clinical judgment is extremely important. A parent's initial uncooperativeness may also indicate feelings of guilt about substance abuse and defensiveness about the assessment process. Parents may be angry or feel vulnerable because of the power differential between themselves and the professional, and they may perceive a loss of control. Parents also may be fearful of legal consequences. To evaluate cooperation, professionals should consider the following areas:

- Does the parent verbalize a willingness to work with the agency?
- Does the parent generally follow through with various aspects of the service/treatment plan?

Subsequent behavior and follow through are critical in accurately evaluating cooperation. A parent may appear to be compliant and yet, in fact, may be unable or unwilling to meaningfully engage in the service/treatment plan.

Awareness of the Impact of Alcohol and Other Drug Use on the Child

It is important to assess parents' understanding of the relationship between their substance abuse and their children's care. Parents' willingness to acknowledge the impact of their substance abuse may indicate their receptivity to services for themselves as well as for their children. Professionals should consider the following:

- If the parents were under the influence when the suspected child abuse or neglect occurred, and this was a contributing factor, do the parents acknowledge this relationship, and are they willing to make the changes necessary to avoid repeated injury or neglect?
- How have the parents provided for their children's needs in situations of relapse? It is helpful to determine whether parents have exercised the judgment to leave their children in the care of responsible relatives or friends, or whether the children have been left with strangers or brought along with the parents into dangerous situations.
- In cases of prenatal substance abuse, how do the parents view the infant's symptoms? Initially, parents may deny that symptoms or developmental problems exist. Although this initial denial can serve as a protective coping mechanism for parents, continual denial may interfere with the parents' obtaining needed services for their children.

Parenting Skills and Responsiveness to Child

Evaluation of parents' caregiving skills and responsiveness to their children's needs is a particularly critical aspect of the assessment process. Because many chemically involved parents themselves were poorly parented as children, they may lack healthy role models for parenting their own children. The professional can obtain much information by listening sensitively to parental comments and by observing parent-child interactions. Such information can help the professional determine the need for parents' involvement in parenting education programs or individualized counseling.

- How do the parents react to the children's behavior? How do they provide praise and discipline? Are the parents' expectations age-appropriate? When the parents' expectations are incongruent with the children's capacities or when parents are prone to extremes in physical discipline, the children's risk for abuse may be increased.
- How do the parents respond to their children's emotional needs? For example, how do the parents respond to the children's crying? Do the parents and children make eye contact? For a hospitalized child, how frequent are parental visits? Such information may be used to determine the need for therapeutic counseling and educational services to strengthen the attachment between parent and child.

History of Abuse and/or Neglect

Chemically involved parents may already be involved with child welfare agencies, have children in foster care, or have suspected or substantiated histories of child abuse or neglect. Professionals need to determine the following:

- Have there been previous child abuse or neglect investigations, substantiated reports of abuse or neglect, and/or other children under juvenile court jurisdiction? The facts surrounding these situations should be obtained and integrated into the total assessment so that plans and decisions can be made on the basis of long-term patterns rather than on the basis of an isolated and perhaps ambiguous situation. The professional will need to contact appropriate child CPS agencies for this information.
- If the parents have other children in out-of-home care, what were the reasons for placement? What arrangements have professionals made to support parental visitation? What has the parents' level of participation with these children been? Do the parents phone or visit the children? Do they respond appropriately to their children and the foster parents during home visits? Have the parents ever visited while under the influence?

Work History and Education

Information regarding parents' work histories and educational backgrounds can help professionals better understand the parents' level of literacy and survival skills as well as the extent to which their substance abuse has had an impact on their day-to-day responsibilities.

- What are the parents' occupations? When were the parents last employed?
- What are the parents' educational levels? How do they describe their school years? Do the parents have difficulty with reading, writing, and/or comprehension? This is critical to understanding parents' ability to function within community programs and will help the professional minimize barriers to appropriate treatment and services.

Assessment of the Home Environment

Much of the information described above may be obtained during interviews conducted outside the family home, but there is some information that can only be obtained through home visits. Because home visits allow the professional to assess the physical and social environment in which the family lives, these visits may reveal crucial information about family functioning and the parents' ability to provide safety for their children. For example, chemically involved parents sometimes give false addresses that turn out to be parking lots or empty stores. These parents also may list addresses of residences where they do not live. In some instances, parents may not actually have a permanent residence because they move frequently to avoid detection by authorities or because they have used their income to purchase drugs and/or alcohol. A family's situation may appear to be stable on the basis of interviews within an agency setting, but home visits may reveal a different picture. Assessment of environmental conditions, partners or parent substitutes within the home, and family support systems can help provide a more realistic picture.

Environmental Conditions of the Home

It is important to evaluate the family's environment because general living conditions can pose risks for illness or accidents. Furthermore, certain environmental conditions may be essential to a child's basic health and, in some instances, may even be lifesaving.

Here, as in the other assessment areas, sound clinical judgment and cultural sensitivity are of the essence. A family may live in poor circumstances, on the street, or in a shelter because of poverty, bad fortune, or hardship. However, a family's lack of residence or impoverishment also may be due to parental substance abuse. Understanding the reasons for a family's impoverishment is useful for determining the types of services that should be offered. In evaluating the home environment, professionals should assess the following:

- How long has the family resided at the current address? Is a recent move related to an attempt to provide a safer environment for family members? Is there a pending eviction? Is this a stable residence? Often, planning for services, especially in-home services; depends on a family remaining at a particular address or within a specific geographic area.
- Are there safety or health hazards? Are there rodents or other infestations? It is helpful to determine whether the family has attempted to remedy these situations as well as whether the family's housekeeping habits have contributed to these problems. Depending on the situation, advocacy, homemaking services, or parental education may be needed.
- Is there food in the home?
- What is the condition of the electrical system, gas lines, water supply, and sanitary facilities? Does the family have a telephone? If not, is there a nearby phone where messages can be left? These factors are particularly critical when a child in the family is medically fragile. For example, because children who have problems with their immune systems are highly susceptible to infections, unsanitary conditions may be life-threatening. Likewise, refrigeration is required for safe storage of many medications and special feeding supplements. For some children, such as those who require apnea monitors, a telephone in the home is essential.
- If there is a newborn child, what supplies do the parents/caregivers have for the baby? Has a sleeping space for the infant been prepared? Assessment of these factors may tell the professional much about the parents' ability to plan ahead as well as about their understanding and acknowledgment of the infant's needs. If there are limited preparations for a newborn child, it is important to attempt to determine the extent to which poverty has played a role, or if the need for drugs or alcohol has greater priority than the infant's needs.
- For older children, has basic clothing been provided? For example, do children have clothes that are appropriate for the season?
- What toys are available for the children? Do they have a safe play space? This information can help the professional gain a better understanding of the way children's developmental needs are currently being met, as well as determine the need for referrals to day care, preschool, or Head Start programs.

Partners or Parent Substitutes Within the Home

Partners or other parent substitutes living in the home may be supportive, stabilizing individuals who can help with caregiving. However, these persons may be substance abusers, involved in illegal or violent activities, or may have histories of abusing or neglecting children. Because substance abuse can lead to a lessening of inhibitions and controls and because family stresses can increase in connection with the quest to maintain an addiction, chemical dependency on the part of persons living within the home can easily lead to violence. In assessing the home environment, professionals should note the following:

- Who else lives in the home? What are these individuals' relationships with the children? Do they provide child care?
- Is there a suspicion that others living in the home are involved in the use, manufacture, or sale of illicit substances or other criminal activities?
- Do others within the home display poor impulse control? Is there evidence of domestic violence? Child abuse? Other forms of violence in the home?

Family Support Systems

Another important part of the assessment process includes learning about the family's support systems. As a result of their substance abuse, some chemically involved parents lead isolated lives or have few friends, relatives, or contacts within community groups who can be helpful to them. Parents who have more resources upon which to rely during difficult times are more often able to provide a "safety net" for their children. Community and family supports are particularly significant for this population of vulnerable parents and children. Professionals should determine the following:

- What are the parents' relationships with extended family, friends, and neighbors? Do family members live in the area? Are they a source of support or stress?
- Are the parents involved with a church, temple, or community or social group? Is there a member of the clergy who can become involved in strengthening and counseling family members?
- Are the individuals identified by the parents as supports alcoholics or involved with other drugs? (The professional can explore this factor by asking about these individuals' employment and lifestyle, as well as about the kinds of support they provide.)
- How do relatives and friends support parental attempts to make lifestyle changes? Do they collude in the parents' denial?

In assessing the family support system, it is critical for the professional to talk with relatives and friends to determine their level of commitment and the circumstances under which they can be available to help and support the family.

Assessment of Relative Caregivers

When they cannot be protected from harm within their own parental home, children must be placed elsewhere to ensure their safety. Placement with relatives is often the first choice in such cases. To ensure that infants

and children receive appropriate care from relatives and that services will be provided to relatives that will support them in the care of the children, it is essential that professionals assess the relatives' abilities and vulnerabilities in the areas of parenting skills and history of abuse, neglect or violence; alcohol and/or other drug use; quality of the relationship with the parent and ability to protect and nurture the child; and cooperation, receptivity, and access to services.

Parenting Skills and History of Abuse, Neglect, or Violence

Because of the intergenerational nature of substance abuse and child maltreatment, it is important to carefully evaluate relatives' past and present functioning with regard to their ability to meet the child's basic needs and to ensure that the child is protected from harm. Professionals should assess the following:

- Has the relative had previous involvement with CPS agencies? If so, when did this occur and for what reasons? How was the situation resolved?
- Does the relative have a history of poor impulse control evidenced by violence in the home?
- Does the relative have a history of criminal activity that potentially could impact the care of the child?
- Does the relative have emotional, physical, or intellectual limitations that would impair his/her ability to provide adequate care and supervision for the child?
- How do the relative and the child relate to each other? What has been their pattern of interaction? How does the relative respond to the child's behaviors? How does he/she provide praise and discipline? Are expectations age-appropriate?
- If the child has special needs, does the relative have access to needed services, and are services properly utilized?

Alcohol and/or Other Drug Use

Assessment of the relatives' drug and/or alcohol use is critical. Because intergenerational substance abuse characterizes so many chemically involved families, it is helpful to inquire into this area so that a child is not placed with another substance-abusing caregiver. Professionals need to assess the following:

- Does the relative have a history of chemical dependency? If so, what was the extent of the addiction? How long has the relative been in recovery?
- What impact has substance abuse had on this relative's life and functioning?

Quality of the Relationship With the Parent and Ability to Protect and Nurture the Child

It is essential to assess the dynamics of the relationship between birth parents and relative caregivers. Often, this relationship has implications for the child's physical safety and emotional well-being especially in situations in which there is ongoing conflict between parents and extended family members. In kinship situations, it is important for professionals to evaluate the following:

- How have the parent and relative handled past conflicts? Is the parent violent or disruptive such that placement of the child with the relative might threaten the safety of either the child or the caregiver?
- Does the relative acknowledge that the parent has a substance abuse problem? Does the relative acknowledge its impact on the child? Is the relative familiar with signs of drug and alcohol intoxication? Is the relative able to report honestly about parental visits and behavior? Such information may help the professional better assess whether the relative caregiver has the will, ability, and strength of character to set limits on the parent's behavior in order to protect the child.
- Is the relative angry with the parent or so "burned out" with the parent's behavior that support for the parent-child relationship will be compromised?
- Is the child likely to be used in a power struggle between the parent and the relative caregiver?
- Is the relative caring for other children? If so, how many? How does the relative manage the care of all the children in the home?

Cooperation, Receptivity, and Access to Services

A relative caregiver's receptivity to education and intervention significantly affects the child. For some relative caregivers, access to medical, psychological, and educational services may not have been as critical in raising their own children as it is for a special-needs child, and therefore they may be unfamiliar with how to use community resources and unaccustomed to asking for assistance. Further, some relatives have difficulty acknowledging substance abuse on the part of persons close to them. They may perceive substance abuse as a "moral failure" and may wish to keep family problems private, considering involvement with professionals to be stigmatizing. Other relative caregivers may have histories or backgrounds of their own that they do not wish to discuss, and thus the involvement of other agencies may be viewed as intrusive or threatening. Relatives who are more accustomed to privacy may be confused and overwhelmed by the comprehensive assessment process. However, because a relative's willingness and ability to work with agencies can be critical to the child's health and safety, it is important for professionals to assess the following:

- Does the relative only give "lip service" to being cooperative with agencies' service/treatment plans, or does the relative demonstrate appropriate follow-through?
- Is the relative able to share concerns and problems related to the child's placement as they arise?
- Does the relative have access to transportation and a telephone? Is there access to medical resources? What arrangements can be made in the case of an emergency? For some children with special needs and equipment, the presence of a telephone and access to transportation may be life-saving.

Assessment of Foster Parents

At times, foster care placement may be required. In order to identify services that are required to meet the child's needs in foster care, the foster parents' attitudes towards the birth parents, caregiving, perceptions and expectations of the child, receptivity to services, and family supports should be carefully evaluated.

Attitudes Toward Birth Parents

The foster parents' feelings and attitudes toward birth parents greatly influence reunification and case management services. Professionals should explore the following:

- What is the foster parent's attitude toward alcohol and other drug abuse? Does the foster parent believe that chemical dependency is treatable? If foster parents have a hopeless and punitive attitude toward substance abusers, this can negatively impact a child's feelings about his/her parents as well as the child's own self-esteem. This attitude also may affect a foster parent's willingness to cooperate with the visitation plan.
- What is the foster parent's attitude about having contact with parents who have a history of substance abuse? Is the foster parent fearful for his/her own family's safety? Does the foster parent feel able to set limits on parental behavior when necessary? Eliciting and evaluating a foster parent's concerns can help the professional in determining whether visitation schedules and locations need to be modified or whether, instead, more guidance and education for the foster parent are indicated.
- Is the foster parent appropriately supportive of the relationship between the chemically involved parent and child? Does the foster parent respect the biological family's cultural/religious beliefs? This is a critical area for evaluation because a foster parent's ability to work with chemically involved parents will have an impact on reunification plans and can affect how children feel about themselves and their families of origin. When there are concerns about a foster parent's attitudes toward biologic parents, professionals may need to increase their own involvement with the foster parent as well as facilitate referrals for further education and guidance for the caregiver.

Caregiving

Because some children in chemically involved families have special medical or educational needs, it is critical to assess the foster parent's ability to care for special-needs children. Professionals need to consider the following:

- If the child has had prenatal alcohol or other drug exposure, has the foster parent ever cared for a prenatally substance-exposed baby? If not, is the foster parent willing to attend training programs or work with professionals to acquire the necessary skills?
- If the child has special needs, is the foster parent able and willing to keep multiple appointments, or do the needs of other family members in the home make this too difficult? Does the foster parent have access to necessary pediatric and subspecialty care, or does the foster parent need advocacy and referrals for such services?

Perception and Expectations of the Child

The foster parents' observations of the child can help professionals determine the need for health, developmental, or educational services. In addition, foster parents' perceptions and expectations can greatly affect the quality of care provided. Because there is much misinformation about children from chemically involved families and often much uncertainty about how a child's vulnerabilities may manifest, it is important for professionals to determine the following:

- Does the foster parent have concerns about the child's health or development? Foster parents may observe previously unrecognized conditions that may require further evaluation.
- Is the foster parent able to identify the child's positive attributes? Are expectations age-appropriate? Are difficult behaviors personalized? When there are difficulties in these areas, a foster parent may require counseling and education to help him/her find strengths within the child, understand the dynamics that underlie the child's behavior, and learn how best to help the child with these problems.

Receptivity to Services

It also is necessary to assess a foster family's receptivity to help and services. Because children from chemically involved families often require a range of services, professionals need to consider a foster parent's willingness to work with a variety of agencies and individuals. Questions that the professional should consider in this area include:

- Is the foster parent open to new information, strategies, and resources?
- Does the foster parent demonstrate willingness to work with the agency and follow the service/treatment plan?
- Does the foster parent recognize the need for recommended services?

Family Supports

The professional needs to explore the effect of an infant's or child's placement on the entire foster family system. Because caring for children from chemically involved families can be stressful for the whole family, the professional needs to assess the following areas to determine the need for respite services or referrals for foster family support:

- If the child has special needs, how is the foster family handling the increased stress caused by this placement? Are supports in place to help with caregiving and provide respite?
- Are the child's special needs placing excessive stress on other children in the family?

GUIDES FOR ASSESSMENT

To help professionals better assess the comprehensive needs of chemically involved families, relative caregivers, and foster parents, special assessment/intervention guides have been included in Tables 3, 4, and 5.¹⁹ Divided into three broad areas (the child, the caregiver, and the environment), these guides rely heavily on an ecological model of human development and family functioning and on the assumption that child abuse and neglect is determined by the interactions of multiple factors within the individual, the family, the community, and the culture.²⁰ These guides are not intended for use in a mechanical fashion; no numerical scores should be assigned as the basis for decision making.²¹ Rather, these assessment guidelines are intended to be used as tools to enhance professional clinical judgment. Although these guides are not predictive of future child abuse or neglect, they may be helpful to staff in a number of ways:

- They can help remind professionals of the kind of questions they need to ask parents and the kind of information they need to gather during home visits and through collateral contacts. Used in this way, the guides may help standardize the assessment process, ensuring that all areas of risk of child maltreatment are covered during each assessment.
- The guides can help professionals prioritize interventions for families and assist them in matching families with appropriate services.
- Professionals can use the guides longitudinally, comparing families along the various factors at certain intervals to examine the effects of intervention and family changes over time.
- Professionals may elect to use the assessment/intervention guides with chemically dependent parents to help them see areas of strength as well as areas of concern. This can help family members understand the criteria by which they will be evaluated, which in itself can be empowering.
- The guides can provide a common language and framework for clinicians from different agencies who are working with the same family. This common reference point can help minimize inter-agency friction and professional misunderstanding.
- When used as an interagency tool, the guides encourage the development of a common plan for intervention and can be used to determine the appropriate professionals and agencies to address each area of need.

SUMMARY

A thorough assessment of all family members is the key to determining the specific constellation of support services that can foster the overall health and well-being of an individual substance-involved family. In order to do a thorough assessment, professionals need a solid knowledge base within their own disciplines as well as an understanding of the problem of alcohol and/or other drug abuse. Further, an awareness of the importance of other professional disciplines in working with substance-affected families is critical.

Assessment is a dynamic and ongoing process. During the initial period of involvement with a family, professionals generally will be able to elicit only partial information regarding family strengths and needs. Additional information can be obtained over time as professionals work together, moving the family forward towards alleviation of stressors and resolution of identified problems. In order to accomplish this goal, it is important for professionals to develop strategies for putting various pieces of assessment information together and for updating service plans on a periodic basis. One professional, one agency, or a core group needs to take the lead in compiling and communicating the facts that lead to decisions about appropriate services for the family. This approach also helps to relieve family stress, since it means that family members, not to mention other professionals, can count on a single designated "contact," rather than needing to go to various sources for information.

Table 3
ASSESSMENT/INTERVENTION GUIDE: BIOLOGIC FAMILY

CHILD

PARENT

Biologic Family Assessment/Intervention Guide			
Factor	(a) Low Risk	(b) Intermediate Risk	(c) High Risk
1. Infant's drug withdrawal symptoms	Withdrawal symptoms not apparent	Mild tremors; sleeps at least 3 hrs. after feeding; feeding well; normal stools	Vomiting; watery stools; fever; sleeps less than 2 hrs. after feeding; marked tremors; poor feeding; high pitched cry; seizures; lethargic; on meds for drug withdrawal
2. Special medical &/or physical problems	No apparent med. or phys. prob.	Minor med. or phys. prob. which do not significantly affect infant's vital life functions or physical & intellectual development	Any pre-term inf. (born at or before 36 wks.) &/or phys. or med. prob. which significantly impact vital life functions or phys. & intel. developm. (e.g., cardiac defect, apnea monitor, visual or hearing handicap, seizure disorder)
3. Special care needs of child	Only routine pediatric care; no special equipment or medication	Monthly pediatric care visits & no medicine or special equipment	Requires 2 or more monthly visits for pediatric care &/or special equipment or medication
4. Current drug user	Not currently using any drugs	Occasional 1-2x wk. or wknd. use	Use more than 2x wk.; any use of PCP or Crack
5. Drug treatment history	Entered drug trtmt. early in pregnancy, remains in program & considered compliant	Entered drug trtmt. early in pregnancy, remains in program, but attendance sporadic &/or continues to use drugs	Not in drug trtmt. program or entered in 3rd trimester
6. Prenatal care	Sought early prenatal care and consistent with follow-up	Sought prenatal care in 2nd trimester but inconsistent w/ prenatal follow-up/medical advice	Did not seek prenatal care until 3rd trimester; no prenatal care
7. Parent's physical, intellectual, or emotional abilities/control	No intellectual/physical limitations; realistic expectations of child; in full control of mental faculties	Mild physical/emotional handicap; mild intellectual limitations which would not significantly impact ability to care for child	Mod. to severely handicapped; poor perception of reality; unrealistic expectations/perceptions of child's behavior; severe intellectual limitations; incapacity due to alcohol/drug intoxication; past criminal/mental illness; poor impulse control (i.e. demonstrated evidence of violence in home)
8. Parent's level of cooperation	Willingness & ability to work w/agency to resolve problem & protect child	Overtly compliant w/investigator &/or presence in home of non-drug using adult to assure minimal cooperation w/agency & follow thru w/med. recommend.	Doesn't believe there is prob.; refuses to cooperate; disinterested or evasive
9. Parent's awareness of impact of drug use on child	Expresses concern/interest about drugs; effect on child & sought professional advice & counseling	Displays concern/interest in child but denies symptoms & special needs	Displays lack of concern/interest for child & denies symptoms

Table 3 (cont.)
ASSESSMENT/INTERVENTION GUIDE: BIOLOGIC FAMILY

Biologic Family Assessment/Intervention Guide			
Factor	(a) Low Risk	(b) Intermediate Risk	(c) High Risk
PARENT (cont.)	10. Parenting skills & responsiveness to infant	Parent exhibits appropriate parenting skills & knowledge re: special medical follow-up care and is responsive to infant's needs	Parent may prov. appr. phys. care but is unresponsive to infant's needs (i.e. lack of response to crying of infant. Poor eye contact, infrequent visits, inappropriate expectations and criticism of child)
	11. History of abuse/neglect	No known history of abuse/neglect	Pending child abuse/neglect investigation; previous abuse/neglect of serious nature/prior/dependency
	12. Father or parent substitute (F or PS) in home. name: _____ (Circle F or PS to specify)	F or PS in home, who is a supportive/stabilizing influence & available to assist w/caretaking	Stable F or PS in home, but assumes only minimal caretaker responsibility for child
ENVIRONMENT (Physical & Social)	13. Strength of family support systems	F or PS who resides w/family & has poor impulse control (i.e., demonstrated evidence of violence in home), &/or is involved in drug activity	No relatives or friends available/committed; geographically isolated from community services; no phone; no transportation available
	14. Drug use in home	Family, neighbors, or friends available & committed to help; membership in church, community, or social group	Family supportive but not in geographic area; some support from friends & neighbors; limited community services available
	15. Sibling assessment (use standard Risk Assessment Guide for sibs.)	No member of household suspected to be involved in drug activity (sale, use, and/or mfg.)	Anyone in the household suspected to be involved in drug activity
	16. Environmental condition of home	Education, medical & environmental needs being met for all sibs.	Some but not all educ., med., & environ. needs being met for all sibs.
		Home relatively clean w/no apparent safety or health hazards; utilities operable; no infestation of rodents & vermin. Evidence of preparation for infant's arrival (clothing, furnishings, formula)	Home rel. clean (see (a)) but no evid. of prep. for infant's arrival. . .or vice versa
			Home unclean w/safety or health hazards; no evidence of prep. for infant's arrival

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Table 4
ASSESSMENT/INTERVENTION GUIDE: RELATIVE CAREGIVER

Relative Family Assessment/Intervention Guide

The assessment factors for the child are described on the BIOLOGIC FAMILY ASSESSMENT/INTERVENTION GUIDE. Please refer to that Guide for specific information on assessment of the prenatally substance-exposed infant.

Factor	(a) Low Risk	(b) Intermediate Risk	(c) High Risk
1. Relative's drug/alcohol use	Not known to currently be using drugs or allowing drug use in the home		Known use of drugs or alcoholism
2. Relative's history of abuse/neglect/violence	No known history of abuse/neglect or violence in the home		Prior involvement with DCS or law enforcement or a history of abuse/neglect or violence in the home
3. Relative's physical/intellectual or emotional abilities	No intellectual/physical limitations; realistic expectations of child; in full control of mental faculties	Mild physical/emotional handicap; mild intellectual limitations which would not significantly impact ability to care for child	Mod. to severely handicapped; poor perception of reality; unrealistic expectations/perceptions of child's behavior; severe intellectual limitations; incapacity due to alcohol/drug intoxication; past criminal/mental illness; poor impulse control (i.e., demonstrated evidence of violence in home)
4. Relative's level of cooperation	Willingness to work with agency, to follow case plan, and provide for child's special medical and physical needs	Overtly compliant or appears to give "lip service" only; superficial understanding of their role and responsibility	Disinterested or evasive, doesn't believe there is a problem with parent or child
5. Relative's parenting skills and responsiveness to infant	Evidence of prior successful parenting	No prior experience with parenting but indicates willingness to acquire necessary skills	Evidence of inadequate prior parenting; unrealistic expectations
6. Quality of relationship between relative and parent	Relative supportive of parent/child relationship but able to set limits; acknowledges parent's problem		Unable to set limits with parent and/or denies problem; conflict that will interfere with parent/child relationship or is unable to support parent/child relationship
7. Relative's ability to protect child	Parent's behavior would not compromise safety of child		Parent is violent or disruptive and threatens the safety of the child or caretaker
8. Relative's access to medical resources	Has own transportation, own phone; close to medical resources	Access to transportation and a phone	No transportation or phone; substantial distance from medical resources
9. Relative's living environment (furnishings/health/safety)	Home relatively clean w/no apparent safety or health hazards; utilities operable; no infestation of rodents & vermin; evidence of preparation for infant's arrival (clothing, furnishings, formula)	Home rel. clean [see (a)] but no evid. or prep. for infant's arrival	Home unclean w/safety or health hazards, no evidence of prep. for infant's arrival

RELATIVE

ENVIRONMENT (Physical & Social)

Table 5
ASSESSMENT/INTERVENTION GUIDE: FOSTER FAMILY

FOSTER PARENT

ENVIRONMENT (Physical & Social)

Foster Family Assessment/Intervention Guide The assessment factors for the child are described on the BIOLOGIC FAMILY ASSESSMENT/INTERVENTION GUIDE. Please refer to that Guide for specific information on assessment of the prenatally substance-exposed infant.			
Factor	(a) Low Risk	(b) Intermediate Risk	(c) High Risk
1. Experience with Special-Needs Children	Prior caregiving experience and training with drug-exposed infants	Prior caregiving experience but no training, or training but no experience with drug-exposed infants	New foster parent; no training or experience with drug-exposed infants
2. Level of Cooperation/Receptivity to Services	Willing to work with agency, follow case plan, and provide for child's special medical and physical needs	Overtly compliant but cooperates only minimally with agency case plan	Unwilling to follow through with agency case plan, does not recognize need for recommended services; resistant to home visits
3. Perceptions/Expectations of Infant	Realistic recognition & understanding of infant's vulnerabilities and difficult behaviors, as well as of infant's positive qualities and attributes	Realistic recognition and understanding of infant's vulnerabilities and difficult behaviors, but inability to see infant's positive qualities and attributes	Denial of infant's special needs so that his/her capabilities are not maximized; personalization of infant's symptomology
4. Parenting Skills	Appropriate parenting skills and knowledge regarding special follow-up care; responsiveness to infant's needs	Provides appropriate physical care, but is unresponsive to infant's needs (no response to crying, poor eye contact, inappropriate acceptance or criticism of child)	May or may not provide appropriate physical care, and is unresponsive to infant's needs (no response to crying, poor eye contact, no visits, inappropriate acceptance or criticism of child)
5. Attitudes towards Biological Parent(s)	Supportive regarding parent/child relationship and able to set limits; acknowledges parent's problem		Creates unnecessary physical obstacles and emotional barriers which interfere with parent/child relationship; is unable to set limits with parent, denies parent's problem
6. Physical/Intellectual/Emotional Functioning	No intellectual/physical/emotional limitations	Physical/emotional/intellectual limitations which would not significantly impact ability to care for infant	Physical/emotional/intellectual limitations which would negatively impact ability to care for infant
7. Access to Resources	Own transportation; own telephone; ability to access appropriate services for child; home accessible by public transportation		Limited access to transportation and/or phone; required services for infant not available
8. Home and Family Supports	Supportive family members and/or significant others available; committed to help foster parent	Supportive family members and/or significant others, but not available to help foster parent	No help or support from family members and/or significant others; isolated
9. Foster Parent's Living Environment	Home relatively clean w/no apparent safety or health hazards; utilities operable; evidence of preparation for infant's arrival (clothing, furnishings, formula)	Home relatively clean w/no apparent safety or health hazards; no evidence of preparation for infant's arrival	Home unclean w/ safety or health hazards; no evidence of preparation for infant's arrival

JUVENILE COURT INVOLVEMENT WITH CHEMICALLY INVOLVED FAMILIES

CASE VIGNETTE: Following the initial assessment, Child Protective Services (CPS) was sufficiently concerned about Timmy's safety to take the case to court. In spite of the maternal grandmother's cooperation during the assessment process, she became extremely upset just prior to the court proceedings because of her loss of control over her family and the entire situation. The involved professionals, however, were able to reassure her, and she agreed before the judge to assume responsibility for her grandson. Lisa, on the other hand, remained angry. She initially refused to complete the treatment program mandated by the court to enable her to be reunited with her child. Only after 5 years of court involvement, multiple attempts at drug treatment, a shift from PCP and cocaine use to use of heroin and cocaine, a second pregnancy, separation from her children's father, and a period of incarceration followed by intensive residential treatment did Lisa finally attain sobriety.

The preceding chapters have discussed the problem of parental substance abuse and its impact on families as well as the need for a comprehensive assessment of all family members and caregivers. Whether or not child endangerment is substantiated, strong interdisciplinary case management and coordination of services are needed in order to improve the complex situations of families reported to CPS with substance abuse problems.

Although only a small percentage of substantiated child abuse and neglect cases go to court,²² those that do are heard exclusively in the juvenile courts civil proceedings. One exception, however, is severe physical abuse or neglect or sexual abuse by a substance-abusing parent. In such cases, criminal prosecution may be concurrent with juvenile court proceedings. In addition, there have been isolated attempts to criminally prosecute pregnant substance-abusing women and women who have delivered drug- or alcohol-affected newborns. In general, however, criminal prosecution is not a common legal intervention in child maltreatment cases that involve either prenatal or parental substance abuse. Rather, such cases are usually brought before the civil court, where the aim is protection of the child while the parent is in treatment.

In making decisions regarding the juvenile court's involvement in drug- and alcohol-related dependency cases, four guiding principles have proven useful:

- Parental substance abuse is detrimental to the well-being of a child and may create a substantial risk of harm.
- Reasonable efforts must be made to provide the services necessary to keep a child in the home.
- The authority of the juvenile court may be necessary to gain the parents' cooperation in obtaining/receiving services, including the treatment of substance abuse.
- Out-of-home placement should be ordered only on demonstrating a substantial risk of harm if the child remains in the parent's custody or if there is a likelihood that the parent will flee the jurisdiction of the court with the child.²³

This chapter focuses on the legal issues affecting juvenile court involvement in determining a child's overall safety in cases in which parental substance abuse has been identified. As the reader will note, many of these

same issues are addressed throughout the assessment process. In addition, this chapter provides guidance regarding permanency planning for children of substance-abusing parents in cases in which it has been determined that, despite reasonable efforts and following a realistic period of time, termination of parental rights is indicated. Because State laws, policies, and procedures vary with respect to legal intervention and permanency planning, it is important for professionals to be familiar with the requirements specific to their States.

CONSIDERATIONS OF THE JUVENILE COURT IN CASES OF PARENTAL SUBSTANCE ABUSE

In considering the level of protection needed by children in chemically involved families and the treatment services required by their parents, a number of factors typically are weighed by the juvenile court. These include the child's health, development, and educational status; the child's age; parental history of alcohol or other drug abuse and substance abuse treatment; parenting profile; safety of the home; family supports; and treatment resources.²⁴ Decisions regarding the family's functioning and progress must be based on the comprehensive assessment information contributed by a variety of disciplines and agencies, as described in the previous chapters. The following guidelines are recommended for professionals who are providing reports and testimony specifically for the juvenile court.

Child's Health, Development, and Educational Status

Reports containing specific information regarding a child's medical, developmental, and educational needs provide guidance for the court in determining the level of caregiving skills required to meet the child's needs. If a child has special needs, the court considers the caregiver's ability to provide this specialized care before releasing the child into the care of parents, extended family members, or foster parents. Testimony or court reports should specify:

- the child's general health status, medical care requirements, and special care needs;
- in the case of newborns, toxicology screen results and/or the presence or absence of withdrawal symptoms and/or signs and symptoms that are consistent with prenatal drug or alcohol exposure;
- the child's developmental status and educational needs—for a child with disabilities, this includes the individual family service plan (IFSP) for an infant or preschool-aged child or the individual education plan (IEP) for a school-aged child (Note: In 1977, Public Law 94-142, the Education for All Handicapped Children law, specified that IEP's should be provided for children with disabilities, in the least restrictive environments. In 1987, Public Law 99-457, the Education of the Handicapped Amendment, mandated the individual family service plans IFSP's be developed for children from birth to 3 years of age);
- school attendance patterns and records; and
- known behavioral problems or emotional disorders.

Child's Age

The child's age is an important factor in making a decision regarding the child's custody. Infants and preschoolers are highly dependent on their parents to meet basic needs and provide protection from harm. Furthermore, until children reach school age, they often are "invisible" to social service and educational

agencies. Thus, abuse or neglect may go unnoticed. In preparing reports for the court, professionals should note:

- ages of all dependent children within the home,
- availability of day care or preschool services that could provide daily monitoring of the child's care as well as developmental and social enrichment, and
- availability of supportive and therapeutic in-home services.

Parental History of Substance Abuse and Treatment

The parent's record of substance abuse and treatment can provide information that assists the court in evaluating the degree of risk to the child as well as the parent's treatment needs and level of commitment to dealing with his/her substance abuse problem. The more severe and extensive the history of parental substance abuse, the more serious the threat may be to a child's safety. Professionals providing information for the court should include descriptions of:

- the parent's substance abuse problem (substances abused, length of abuse, and frequency of use);
- the parent's typical behavior when under the influence (e.g., violent, absent, or dazed and bizarre);
- parental participation in substance abuse treatment (attendance patterns, level of involvement in treatment, and indicators of progress);
- parental acknowledgment of alcohol and/or other drug abuse as a problem;
- urine toxicology results (a series of results is preferable to a single report); and
- behavioral indicators of sobriety or continued alcohol and/or other drug use.

Parenting Profile

The juvenile court is interested in information that demonstrates parents' concern for their children's welfare as well as their ability to provide protection and proper care. Agency reports or testimony from neighbors, family, or others should include information relevant to:

- records of prior child abuse and neglect allegations and investigations;
- significant physical or mental health impairments that interfere with the parents' ability to care for their children;
- parents' perceptions of the impact of their substance abuse on family life and parenting;
- parents' participation in parenting education classes or response to in-home instruction (attendance patterns, level of involvement, and indicators of progress);

- observations of parent-child interactions;
- parents' behavior toward their children when using drugs or alcohol; and
- visitation patterns, if a child is in out-of-home care.

Home Environment

The condition of the family home environment is critical to determining a child's need for protection. Obviously, the use, sale, or manufacture of drugs by parents or others within the home will significantly impact the child's safety. Furthermore, the risk to the child is also increased when homelessness or lack of food and basic necessities are the consequences of a parent's use of family resources to purchase drugs or alcohol. The court is particularly interested in the following types of information concerning the home environment:

- indications of illegal activity or violence within the home;
- environmental conditions within the home (hygiene, food, furnishings, and the functioning of utilities);
- steps taken by parents to remedy environmental hazards;
- household composition; and
- relationship of other adults in the household to the child and parent, their responsibility for child care, and their knowledge of and involvement with the parent's substance use.

Family Supports

The strength of the family's support system can be pivotal in providing protection for the child, maintaining the family unit, and supporting the parent's treatment. When communicating with the juvenile court, professionals should include information relevant to:

- willingness and ability of extended family members and significant others to help with the care of dependent children who remain in parental care;
- extended family's ability to provide care and protection for the child if out-of-home care is required; and
- family involvement with church, temple, or other community groups.

Treatment and Support Services

The juvenile court depends on child welfare, health and mental health care, substance abuse treatment, and educational professionals to assess the treatment needs of children and parents, identify appropriate treatment resources, and to provide evaluations of the progress made by parents and children in treatment. In communicating with the juvenile court, it is important that professionals specify:

- specific treatment needs, including the recommended frequency and duration of treatment;
- available and appropriate resources (e.g., treatment for pregnant or postpartum women and their infants and children or treatment programs for clients who require medical supervision);
- involvement and progress in treatment (patterns of attendance, level of participation and indicators of progress);
- a description of therapeutic and supportive services provided for the family, including housing; day care; transportation; clothing; food stamps; child support and the Women, Infants, and Children (WIC) program;
- outreach efforts made to engage resistant clients in treatment; and
- documentation that noncompliance with treatment is not related to waiting lists, cultural or language barriers, or transportation problems.

SPECIAL ISSUES AFFECTING LEGAL INTERVENTIONS WITH CHEMICALLY DEPENDENT FAMILIES

With respect to chemically dependent families, there are a number of special issues that professionals need to consider throughout dependency proceedings. These issues relate to reasonable efforts, realistic time frames, termination of parental rights, and permanent placement.

Reasonable Efforts

States receiving Federal funds for foster care must make reasonable efforts to prevent unnecessary placement of children out of the home and to return children to their homes as early as possible. With respect to reasonable efforts, the question of removing the child from the home in cases of parental substance abuse depends on the potential danger to the child and the services that could be provided to the family in order to minimize child endangerment. Before initiation of foster care, both the mother and the father should be carefully evaluated with respect to their ability to provide care and protection for the child. If it is determined that neither parent can adequately care for a child, the extended family should then be evaluated as alternate caregivers.

Placing a child in foster care should only be considered when parental or extended family supervision cannot provide adequate protection for the child. In such cases, it is preferable for the foster care setting to be in close proximity to the parent to prevent a change of school or day care for the child and to facilitate the visitation plan. In cases of prenatal substance abuse, the availability of a residential treatment program for the mother, infant, and any other children should be explored as an alternative to foster care.

In some States, a positive toxicology screen at birth is considered indicative of child abuse or neglect. In this situation, making reasonable efforts to prevent placement of the infant at birth may require that the State offer adequate prenatal care to all pregnant women as well as substance abuse treatment to meet the unique needs of pregnant substance abusers. In recognition of this requirement, many communities are moving toward developing comprehensive preventive prenatal services.

Reasonable efforts to keep families intact in cases of parental substance abuse might include:

- assisting the parent in obtaining substance abuse treatment services;
- providing home-based services to build family skills;
- assisting parents to relocate out of an environment where drug or alcohol use is pervasive;
- providing financial assistance and child care while parents are in treatment;
- assisting parents in obtaining supportive services such as Aid to Families With Dependent Children (AFDC), Social Security Income (SSI), food stamps, and child support; and
- when a child is in foster care, encouraging frequent visitation in a homelike atmosphere.

Careful documentation of all efforts made to support the mother's and the father's parenting should be made to avoid legal delays if parental rights subsequently must be terminated.

Realistic Time Frames

A child's initial development and subsequent mental health are greatly influenced by the quality and stability of their early relationships. On the other hand, chronic substance abuse is a serious health disorder that frequently requires long-term treatment before sobriety can be attained. Professionals must weigh both of these factors as they make decisions about family treatment plans and reasonable goals for family members. Often, this is one of the most challenging dilemmas faced by professionals serving substance-abusing families.

Professionals need to move quickly and effectively to provide a safe and permanent home for infants and young children whose parents' alcohol or other drug abuse has resulted in foster care placement. Intensive reunification efforts should be made at the beginning of placement to give the parent the support needed to enter and engage in treatment and to resume parenting responsibilities. Out-of-home care for up to 2 years, depending on State laws, is generally used as a time line standard for terminating parental rights and attempting to place a child in a safe, caring, and permanent home. However, strict time frames pose special problems for addicted or alcoholic parents when treatment resources are scarce. Furthermore, a high recidivism rate for even the best treatment programs suggests that a parent with complex, long-term health and social problems must be seriously committed to change in order to resume parenting responsibilities within a reasonable period of time.

Courts recognize the importance of balancing reasonable efforts to reunite a chemically involved family against the child's need for timely placement in a stable, long-term living situation. For substance-exposed children, the unique conditions that exist when parents are addicted may increase the need for stability and continuity. Thus, realistic time frames are especially important.

Termination of Parental Rights

In most cases when reasonable efforts and realistic time frames have not succeeded in enabling a substance-abusing parent to function as an adequate caretaker for a child, a petition should be filed for termination of parental rights. Terminating parental rights is the most serious decision made in any juvenile proceeding. It usually results in completely severing all ties between the birth parents and their child. Only after termination

proceedings are completed can a child be released for adoption. Not only do the birth parents lose custody forever, but unless adoptive parents choose to maintain a relationship, birth parents also forfeit the right to correspond, visit, or have any communication with the child.

The most common grounds for termination of parental rights in cases involving parental substance abuse are abandonment, willful nonsupport, severe or chronic physical abuse or neglect, chronic parental mental or physical illness rendering the parent incapable of caring for the child, willfully leaving the child in foster care for an extended period of time without responding to reasonable efforts for reunification, and severe alcohol or drug dependency that endangers the child's welfare.

With regard to termination of parental rights, there are several special considerations that arise in cases involving chemically dependent parents:

- **Jurisdiction.** Jurisdiction is the legal power to act. Filing a petition within the county where the child resides initiates termination proceedings and establishes personal jurisdiction over the child. A summons with a copy of the petition must be served on the parents, wherever they reside, and, in some States, on older children, as well. This process can be complicated when a substance-abusing parent does not have a permanent or known address. However, the agency can provide proof that diligent efforts were made to serve the parent at the last known address and/or by publication.
- **Parental Notice.** The parent has the right to receive notice of the hearing and contest the petition by filing an answer or appearing in court. The substance-abusing parent may have special needs regarding notice. Because the parent may be disoriented when under the influence of drugs or alcohol or may have residual mental impairment even when sober, child welfare caseworkers should make special efforts to ensure that the parent is aware that termination of parental rights is pending. These special efforts may include visiting the parents and reading them the legal notice as well as explaining the implications of termination and encouraging the parents to request legal representation. Additionally, it may be helpful to discuss termination with parents in the presence of another, sober family member.
- **Burden of Proof.** Evidence of the harmful effects of parental substance abuse on the child must be presented to support the petition to terminate parental rights. Clear, cogent, and convincing evidence must be presented to meet the heavier burden of proof in termination cases. This burden can be met by submitting in court accurate records of the assistance offered by staff of social service agencies, health care providers, day care centers, schools, substance abuse treatment programs, and mental health agencies. Records of parents who have attended drug or alcohol treatment programs receiving Federal funds can be obtained through a specific court order from the juvenile court judge. The order will specify the need for the confidential use of these records in determining disposition in cases of termination of parental rights.

Insufficient evidence (such as parental alcoholism or drug addiction with nothing more or a poor record of service delivery) impedes the termination procedure and may indicate the need to redouble efforts at reunification.

- **Child's Interest.** In some States, an adoptive home must be located before termination of parental rights; in other States, the first order of business following termination is to begin looking for an

appropriate adoptive placement. Finding an adoptive placement for the special needs substance-exposed child is a challenge all professionals need to bear in mind from the time a case is opened.

- **Appeal.** Any party to a termination proceeding may appeal a termination decision within the number of days allowed by statute. Pending the appeal, a child can be placed in the proposed adoptive placement to minimize the emotional trauma that children experience related to multiple placements and caregivers. Continuity of placement and caregiver attachment is important for all children. Every effort should be made to limit the possible number of moves the child must make and the length of stay in temporary care.

Permanent Placement

Seeking termination of parental rights is the natural and legal outcome of parental failure to respond to reunification and treatment services.

When a child is permanently removed from the custody of a substance-abusing parent, there are several permanent placement options. These include adoption, legal guardianship, and long-term foster care. Consideration should be made to locate this permanent placement within the child's own racial, ethnic, and religious group. The object of permanency planning is to select the option that maximizes the child's opportunities for healthy social, emotional, and cognitive development. Although children from substance-abusing families may pose special obstacles, nevertheless attempts should be made to place all permanently removed children, including prenatally substance-exposed infants, in settings that can accommodate their emotional and physical needs and that are respectful of their cultural backgrounds.

Adoption

Adoption is the first placement choice when children cannot be cared for by their birth parents and when parental ties are legally severed. In many cases, relatives, significant others, or foster parents may be ideal adoptive parents.

Adoptions workers need to carefully sort out the financial impact of adoption (e.g., in some cases, foster care funds or Medicaid for the child may no longer be available). In many cases, to encourage adoption, State and Federal Governments provide monthly supplements and Medicaid coverage, although the supplement generally is less than the foster care payment. Health coverage is especially helpful for those substance-affected children who have preexisting disabilities and who might not qualify for coverage under their new adoptive parents' insurance.

Finally, whether the adoptive parents are family members, significant others, or strangers to the child, long-term supportive services (including counseling and educational programs) should be available to the adoptive parents as well as the child.

Guardianship

Legal guardianship provides adult protection to a child who is deprived of the natural guardianship of his/her parents. The guardian has the right to custody, the right to make decisions for the child, and the right to represent the child in legal actions. The guardian is not responsible for support and education of the child, except on the basis of resources available through public programs such as AFDC or SSI.²⁵

Unlike adoption, guardianship does not require termination of parental rights. Thus, parents can retain the right to visit, consent to adoption, and provide support. This may be a viable alternative for children whose

parents have become sober during the period required for reunification efforts but who still suffer incapacity that leaves them unable to manage the responsibilities of full-time child rearing. This option leaves open the possibility of continued parental involvement with the child. It is suggested for parents who have meaningful relationships with their children but, because of their disability, are unable to provide around-the-clock care.

The permanence of legal guardianship allows attachment to the guardian and eliminates the continuous threat of separation that is often experienced by children in foster care. It often gives children the continuity and stability they need. If termination has occurred and the agency has not been able to place a child in an adoptive home, guardianship is a good alternative.

Long-Term Foster Care

Long-term foster care is an option that keeps a child in the custody of the State. For an older child, long-term foster care can also provide a continuous noncustodial relationship with the birth parent if that is what the child desires, and if it is in the child's best interest for the relationship with the parent to continue. Although long-term foster care is designed to provide a stable foster care home, it can result in multiple moves. Such moves are difficult for any child, since early experiences that promote attachment and trust are directly related to better mental health in later life.

In working with caregivers, it is important for the professional to bear in mind the fact that long-term foster parents may need ongoing family support to help them continue to successfully cope with the emotional and behavioral problems displayed by some substance-affected toddlers and older children.

As older adolescents prepare for release from the foster care system (which can happen as early as 18 years of age for those who are no longer in school), it is the responsibility of the CPS worker to develop an appropriate emancipation plan that will promote a smooth transition from foster care into independent living.

SUMMARY

Any professional who works extensively with families is very likely to encounter a problem related to alcohol and/or other drug abuse on the part of a family member at some point in time. If a substance-abusing family member is the primary caregiver for a young dependent child or children, involved professionals need to become concerned about the welfare and safety of children in the household. Not infrequently in cases of chronic substance abuse on the part of a parent or other primary caregiver, the juvenile court may become involved. Once this happens, a range of interventions may occur. In some cases, court intervention leads to better conditions and rehabilitation of the family unit. However, in extreme situations it may result in termination of parental rights, with the aim of affording the child a permanent family in which to grow.

Throughout this process, involved professionals need to be aware that chemical dependency is a serious health disorder that may result from multiple causes, including traumatic and stressful life events, intergenerational patterns of substance abuse, genetic predisposition, etc. Although it is not uncommon for society to view this condition as resulting from causes that lie primarily within the substance-abusing individual's control, professionals need to be aware that this is rarely the case. Substance abuse is a complex problem requiring a wide range of interventions. The juvenile court system can be viewed as one such intervention in that it can help ensure safety for children and encourage substance-abusing family members to begin moving toward recovery.

INNOVATIVE APPROACHES TO INTERVENTION: IMPROVING THE ODDS

CASE VIGNETTE: Repeated, court-mandated participation in a series of substance abuse treatment programs continued to be ineffective. Five years after Timmy's birth, while under the influence of heroin, Lisa was involved in a hit-and-run accident. Terrified that she might have killed an elderly man, Lisa burst into her mother's home and told her that she needed help. After a 3-month prison sentence followed by 9 months in an intensive residential treatment and job training program, Lisa finally attained sobriety. Two years later, she continues to work full-time, has developed a supportive relationship with her mother, and has regained custody of her two children.

Since the 1960's, the scope of the problem of substance abuse and its devastating consequences for families have become increasingly apparent. However, our understanding of the phenomenon of chemical dependency and what constitutes effective treatment for substance abusers and their children remains limited.²⁶ Better information is needed about what treatment efforts are most successful in helping mothers and fathers to stop abusing alcohol and other drug, what supportive services are most effective in helping chemically involved families stay together, and what approaches are most effective in promoting family reunification. We also need to learn more about how to best intervene to help children whose health and development have been compromised by their parents' substance abuse, how to better support and encourage extended family care, and how to recruit and retain appropriate foster homes for children unable to remain with their parents.

Many of the model programs and interventions described in this chapter were developed in the attempt to find solutions for these as yet unanswered questions. These programs represent innovative and hopeful approaches for dealing with the complexities of parental substance abuse and demonstrate that chemically involved families can indeed be helped to become more functional with appropriate interventions and adequate resources.

It is important to remember that chemically dependent families may benefit from many of the services that are described in companion manuals in this series, such as *A Coordinated Response to Child Abuse and Neglect: A Basic Manual*. However, because of their unique needs, substance-abusing parents and their children often also require additional services or adaptations of conventional service delivery approaches. The purpose of this chapter is to provide examples of model programs and innovative strategies that have been developed to more effectively meet the special needs of this population in the areas of substance abuse treatment, child welfare services, foster care, health care, and education. For communities without such specialized programs, the chapter also provides suggestions for developing collaborative and coordinated services at the local level.

COMPREHENSIVE TREATMENT APPROACHES

Programs for Pregnant and Parenting Women with Children

The multiple needs of infants and mothers produce a strong impetus to treat mother and baby separately. However, the true clinical challenge is to provide interventions to support the mother and protect the infant, while additionally promoting positive mother-infant interaction and the formulation of a positive relationship.²⁷

Innovative day treatment programs have been developed to address the specific and unique needs of pregnant and parenting women caring for young children. These programs commonly provide health care, social services, and substance abuse treatment as well as a continuum of rehabilitative and case management services that focus on both the mother and the child.

In general, programs for pregnant and parenting women differ from traditional treatment modalities in several respects. First, key services are integrated and colocated to reduce the fragmentation that commonly occurs when families are involved with multiple agencies. Second, in contrast to conventional approaches that tend to emphasize the treatment needs of single males and use confrontational methods, programs for pregnant and parenting women commonly use a supportive approach that is family focused. For chemically involved women, the supportive approach is more effective in addressing their backgrounds, which often include physical and sexual abuse, as well as their shared feelings of low self-esteem and powerlessness.

Programs for pregnant and parenting women also provide a wide range of ancillary services, including transportation and child care, to further reduce the logistical barriers that are known to prevent women from seeking treatment. Unlike conventional programs, model projects provide aggressive community outreach that commonly includes home visits and enhanced after-care to reduce recidivism. The range of services typically provided by model programs includes:

- prenatal care (obstetrical services, health education, and nutritional counseling);
- chemical dependency treatment (individual and family therapy, group counseling and support, urine testing, 12-step participation, and pharmacologic intervention);
- parent education and training;
- pediatric care (medical services, developmental testing, and psychological assessments);
- social services (assistance with housing, legal, welfare, and basic survival needs); and
- supportive services (onsite child care, transportation or bus passes, vocational counseling).

Residential Treatment

Most pregnant addicts seeking treatment already have children and, if the treatment program is residential, a woman may be faced with the choice of foregoing treatment or placing her children in foster care.²⁸

Residential treatment facilities designed specifically for pregnant women and women with children allow mothers and children to remain together during the course of the family's treatment. As an intensive intervention modality, residential programs serve those chemically involved families with the most severe substance abuse problems and the fewest social supports as well as those for whom outpatient treatment has proven unsuccessful. For families involved with the child welfare system, residential treatment may offer an alternative to the children's out-of-home placement.

Model programs vary in length from 9 to 24 months and commonly provide a range of psychological, social, medical, educational, and vocational services for parents as well as counseling and developmentally appropriate play and educational activities for children. Through highly structured programming, residential treatment facilities attempt to promote lifestyle changes that support sobriety and healthier patterns of family

interaction. Although this intensive treatment approach is costly, in comparison with outpatient programs, residential care offers several important advantages for families. These include a consistent, safe, and supportive environment for children, drug-free housing, and removal of the family from the destructive environments that may have contributed to or supported parental addiction.

Specialized Child Protective Services (CPS) Units

Children often blame themselves for their families' problems and perceive out-of-home placement as "punishment" for something they have done wrong. The child's removal is often equally difficult for the parents, and may only exacerbate parental stresses and feelings of inadequacy.²⁹

CPS units that work only with chemically involved families provide knowledgeable and intensive case management services designed to avoid out-of-home care by immediately linking the family with needed and appropriate community resources. To adequately address the complex and special needs of this high-risk population, these CPS caseworkers commonly have low caseloads that allow for frequent home visits, heightened involvement with families, and close collaboration with treatment agencies. Other characteristics of specialized CPS units include extensive training on topics related to alcohol and other drug abuse and vertical case management. Vertical case management promotes continuity of services with a single caseworker handling emergency response, family maintenance, family reunification, and permanency planning services for a given family.

An intensive, generic approach by CPS has several advantages. Parents are usually better supported and assisted in addressing their substance abuse. Additionally, specialized units may enhance CPS caseworkers' ability to document that reasonable efforts were made to keep families together or achieve family reunification. Finally, this intensive approach also may promote earlier implementation of alternative permanent plans for children in cases where family preservation or reunification cannot be achieved.

Family Preservation Programs

More intensive and longer lasting services to children at home are needed to maintain families in times of stress.³⁰

Innovative family preservation programs that target substance-abusing families provide intensive in-home interventions with the goal of reducing the need for foster care placement. Typically, although family preservation services are generally provided only on a short-term basis (2 to 5 months), these services are intensive because treatment staff caseloads are extremely small, with experts available for consultation on a 24-hour basis. Staff in such units may at times work in teams to provide mutual consultation and support.

In contrast to traditional service delivery models, family preservation programs use the family home as the primary site for intervention. The services provided by treatment staff can range from concrete "hands-on" assistance with household tasks and child care to more conventional interventions that include individual and family counseling, parent education, and advocacy and referrals for assistance with needed health care, substance abuse treatment, and community services. Family preservation programs typically provide intervention for the family as a unit rather than focusing only on the parent or child. As we gather more data from family preservation programs serving substance-abusing families, we may find that this model will need to be modified to better serve some families.

INNOVATIONS IN OUT-OF-HOME CARE

Transitional Group Care for Foster Children

*"You still here, Baby?" Marissa's nurse says, shaking her head. "I thought you'd be long gone." Marissa should be gone. She has been medically cleared for discharge for 3 days. . . . If only she had a home to go to. . . ."*³¹

Transitional group care centers have been developed as an alternative to children waiting in hospitals until more permanent foster placements can be found (the so-called "boarder babies") and as a resource for children whose medical, developmental, and familial needs make locating a suitable foster home difficult.

Model group care centers typically provide a range of diagnostic and therapeutic services for children as well as intensive clinical and social services for parents. To diminish the impact of the institutional setting, such programs commonly are designed so that children are cared for by a limited number of consistent caregivers in small familylike groupings. Because the children cared for in such settings are likely to have special medical concerns, pediatric and ancillary health care services generally are an integral part of the range of services provided for the children.

In addition, model transitional group care programs also offer enhanced reunification services for parents. Typically this includes individual, family, and group therapy as well as parent education. In order to strengthen the relationship between parents and children, model programs also encourage parents to visit frequently, and centers commonly are open for parental visits on a daily basis. Many centers also conduct extensive outreach activities by phone and through home visits to promote parental visitation and parent participation in reunification efforts.

Specialized Foster Homes

*The biggest obstacle standing in the way of foster parents making the commitment to care for drug-exposed infants is the lack of support in regard to the unique problems these special-needs infants bring into the home. . . . One of the infants we are now caring for has multiple anomalies so severe that she requires a tracheostomy and gastrostomy to maintain life. Just to go to the market requires planning. Jaime cannot go anywhere without a portable suction machine, an apnea monitor, and her medical supplies."*³²

Specialized foster homes have been developed in many communities as a new approach to caring for those drug-affected infants who have complex needs and who otherwise might require institutional settings. Such children include those with HIV infection (AIDS), children with chronic medical problems requiring complex medical regimens, and children who are equipment-dependent. With intensive training and supportive services, caregivers in specialized foster homes have proven able to provide excellent physical care while still maintaining children within a family environment.

In many programs, foster parents who care for these medically fragile children have had experience as foster caregivers. However, several programs have successfully recruited nontraditional foster families, including single parents and homosexual couples. Other programs have been successful in attracting nurses or other individuals with health care backgrounds. Once recruited, foster parents are supported and placements sustained through provision of specialized training, intensive in-home services, and financial incentives.

In model programs, preplacement and ongoing training are routinely provided not only for the foster parents, but also for all adult family members who may be involved in the children's care. Furthermore, home visits

by health care professionals such as visiting nurses and physical therapists are provided to reduce the need for clinic and hospital visits. In addition, frequent visits and telephone contacts from agency social workers are encouraged to help families cope with the stress of caring for a chronically ill child and to provide practical assistance with obtaining needed equipment, supplies, and community services. Finally, sponsoring agencies also often provide increased reimbursement rates to appropriately compensate caregivers, funds for respite care, or "respite foster homes" to relieve caregivers.

Foster Parent Training

There's really no preparation for foster parents, and there should be. We need to know what to look for with the babies . . . because it's really trial-and-error trying to figure out what to do.³³

Even experienced foster parents often find themselves poorly prepared to care for drug- and alcohol-affected children. Burnout is common among the foster families who care for this high-risk population, and substance-exposed children are at increased risk for multiple failed placements. To help ensure that children from chemically involved families are placed with foster parents who are equipped to accommodate the child's special needs, specialized foster parent training curricula have been developed to better educate caregivers.

Typically, training takes place over a period of several weeks. It is designed to increase the foster parents' knowledge and enhance caregiving skills as well as to better acquaint foster parents with relevant community agencies. The training also encourages empathy for the chemically involved parent and the family's circumstances. Model curricula typically address the following areas:

- alcohol and other drug abuse;
- the chemically involved family;
- common medical problems of substance-exposed infants and children;
- normal child development, developmental needs, and age-appropriate toys and play activities;
- special techniques for caring for drug-affected infants and toddlers;
- nutrition;
- first aid and cardiopulmonary resuscitation;
- impact of caring for special-needs children on the foster family;
- working in partnership with social service and health care professionals; and
- community resources.

Successful completion of training programs generally is linked with increased foster care payments.

Grandparent Support Groups

You'd think it's time for me to enjoy my life and work and eventually get my little pension. . . . But I'm stuck with children all over again.³⁴

Increasingly, grandparents are caring for grandchildren whose parents, because of their abuse of alcohol and other drugs, are unable to provide for their children's needs. In many instances, those grandparents are elderly or have health problems that limit their stamina or restrict their mobility. Many also live on fixed incomes and have few resources for providing for their grandchildren's special needs.

Even middle-aged grandparents, however, frequently find themselves overwhelmed by the responsibility of assuming full-time care for a young child. For some grandparents, a child's placement may necessitate early retirement. For others, it may mean deferring lifelong plans that were made in anticipation of the time when their own children would be raised and gone from the home. To enable these caregivers to cope with this inordinate burden of responsibility, grandparent support groups have been developed specifically for grandparents caring for drug- and alcohol-affected children.

Typically, such programs provide a range of services designed to assist grandparents in caring for their dependent grandchildren while still maintaining their own physical and psychological health. Such services generally include education about addiction, codependency, and stress management, and information related to child development, nutrition, and parenting. Grandparent programs also offer specific training to help grandparents acquire skills to care for grandchildren who may have special medical or behavioral needs. In addition, programs typically provide information about community resources and practical help with such things as how to obtain legal custody of grandchildren and how to apply for extra food stamps. Grandparent support groups also serve as advocates for caregivers and assist them in dealing with complex and unfamiliar bureaucracies. Finally, these support networks provide mutual assistance and peer counseling that can help decrease grandparents' isolation and thus better support them in times of personal and family crisis.

MEETING HEALTH AND EDUCATIONAL NEEDS

Comprehensive Health Care Clinics for Substance-Affected Children

The pediatrician I take the kids to is a real old-fashioned family doctor. And he's great for everyday problems, but he doesn't really know about drug babies. . . . For instance, he says they've got colic. But I've seen colic, and it doesn't resemble this at all. So then I go home frustrated, because I have no more information on how to deal with them.³⁵

The multiple medical and developmental problems of some substance-exposed infants and children require a wide range of health care services. To address this growing need, specialized pediatric clinics have been developed in many communities to provide these children and their caregivers with high-quality, "one-stop" medical and developmental services.

Such clinics are staffed by specially trained interdisciplinary teams of physicians, nurses, social workers, and psychologists. These facilities provide well-baby and pediatric care; psychosocial, developmental, and educational assessments; and coordination of subspecialty medical care when needed. In addition to services for children, model clinics also often provide a range of supportive and case management services for parents as well as relative and foster caregivers. These services may include individual counseling, parenting education, group counseling and peer support, advocacy, and referral assistance. Many clinics also have an aggressive outreach component that helps ensure adequate medical followup through home visits and frequent phone calls to families.

Early Childhood Programs

One 4-year-old child in Ann Doherty's classroom started this school year violent and self-destructive. He hit, bit, and spat at other children and had difficulty controlling his movements.³⁶

Infant, toddler, and preschool programs for drug- and alcohol-affected children have been developed to more effectively address the unique developmental and educational needs of substance-exposed children and the parenting concerns of their caregivers. Model programs offer children a consistent, nurturing, and safe environment on a daily basis and help caregivers acquire the skills needed for providing more appropriate and effective parenting.

Typically, specialized programs are staffed by an interdisciplinary team of teachers, social workers, psychologists, and health care professionals who work with both the children and their caregivers as well as with siblings or other children in the home. Classroom activities reflect this population's heightened need for predictable routines and structured environments. Active parent involvement in the classroom and in parent groups is required by most programs, and in some programs, such parental involvement may be court-ordered. In many projects staff routinely make home visits to reach out to caregivers and to better ensure that classroom curricula are meeting the needs of both children and parents.

In many cases, these specialized programs have served as pilots in order to identify components that can be incorporated into more inclusive settings, such as Head Start, child care, and public school-funded preschool settings.

SUPPORT PROGRAMS FOR PARENTS

Twelve-Step Programs

I can live my life only one day at a time. . . .³⁷

All 12-step programs are based on the principles and traditions of the original 12-step program created by Alcoholics Anonymous (AA). AA is, to use the program's own language, "a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from alcoholism." AA is a peer support program with a strong spiritual foundation. It uses the strength of the group and the wisdom of the 12 steps to encourage the kinds of behavioral and cognitive changes that can support the acquisition and maintenance of a sober lifestyle for both fathers and mothers.

The original 12-step programs for alcoholics have been adopted and adapted to the purposes of various other populations grappling with addictions, both their own and those of loved ones. Other 12-step programs include:

- Narcotics Anonymous (NA)—not to be confused with NarcAnon, which is a separate program affiliated with the Church of Scientology—is a 12-step program that was founded in the 1950's by and for people addicted to drugs other than alcohol.
- AlAnon and Families Anonymous were developed to help family members cope with the addictions of parents, partners, children, and other loved ones and family members.
- AlAteen, Children of Alcoholics (COA), and AlAtot are programs for teenagers, school-aged children, and younger children whose parents are addicted to drugs and/or alcohol.

- Marijuana Anonymous was developed for people whose marijuana use has caused them to lose control of their lives.
- Cocaine Anonymous (CA) is a support program for cocaine abusers.
- Adult Children of Alcoholics (ACA or ACOA) is a 12-step program for adult children of alcoholics.
- Survivors of Incest Anonymous is an international 12-step program for adult survivors of incest.

Each of these programs is autonomous, but all share the same 12 steps and traditions, and all rely on the fellowship of the group and a commitment to anonymity as fundamental to recovery. For parents who are not comfortable with the spiritual aspects of the 12-step philosophy, a number of alternative self-help support groups, such as Rational Recovery (RR), Secular Organization for Sobriety (SOS), and Women for Sobriety (WFS) provide peer support without a spiritual emphasis.

There are 12-step programs in almost every community, and no membership dues or charges are associated with attending meetings. Because the social characteristics of individual groups vary, professionals are encouraged to attend open meetings to become familiar with the membership of the various 12-step groups within their local areas.

Programs for Adolescents

Programs for adolescents generally involve the public school system or school staff. These programs may provide support groups for adolescents who come from substance-abusing families or who use alcohol and/or other drugs themselves.

Another model is Project PALS (Positive Adolescent Life Skills), a research demonstration program at the University of California, San Diego, funded by the National Institute on Drug Abuse. This after-school project serves pregnant adolescents who are using drugs or who are at risk for using drugs and nonpregnant adolescents who are either using drugs or at risk for using drugs and who are at risk for pregnancy. At-risk status is determined if an adolescent has problems in any two of the following areas: peer relations, family relations, mental health, or aggressive behavior/delinquency.

In addition to standard medical care, enrolled teens participate weekly in a 16-week educational program addressing the consequences of alcohol and other drug use, child and adolescent development, and sexual responsibility. Followup support groups are conducted at 3 and 12 months following program completion.

Programs for Incarcerated Women

*Are we going to send women back out who haven't yet recovered from their addiction?*³⁸

Most correctional facilities lack the technology and trained personnel needed to appropriately manage high-risk pregnancies, and substance abuse treatment is rarely provided within correctional institutions. Thus, in order to improve outcomes for incarcerated substance-abusing pregnant women and substance-abusing women with children, the criminal justice system has developed a number of innovative programs to assist mothers in their recovery from alcohol and other drug abuse and promote the birth of healthier infants.

Model programs developed within institutions provide expanded health care as well as educational and social services for women. Typically, programs offer comprehensive prenatal care either on-site or through collaborative

arrangements with local medical centers; substance abuse treatment (including supervised detoxification, counseling, and 12-step peer support); health education related to pregnancy, nutrition, sexually transmitted diseases (including AIDS), and birth control; and parent education. To better ensure appropriate linkages with community services upon the mothers' release, some programs also assign pregnant women to specially trained probation and parole officers. These officers are knowledgeable regarding community resources and can help women make needed connections with essential medical and social service programs.

Another approach to dealing with the growing population of incarcerated pregnant and parenting substance-abusing women has been the development of innovative residential programs. Such programs allow incarcerated women to live with their children in a residential setting while serving the remainder of their sentences. In general, these programs are limited to women who have been convicted of nonviolent crimes, women whose sentences are short-term, and women whose children are preschoolers or younger.

Typically, residential programs are highly structured and are specifically designed to address the issues of substance abuse, domestic violence, and lack of employment that often contribute to a woman's incarceration. Such programs commonly are staffed by specially trained correctional personnel and are located in or near a community where the mother will reside upon completing her sentence. The services offered by model residential programs generally include comprehensive medical care, substance abuse treatment, and mental health and family counseling. Programs generally require mothers to participate in educational or vocational training, and a strong emphasis is placed on developing skills needed for the family's subsequent community reintegration and independent living.

Day Treatment Programs for Pregnant Women and Their Husbands/Partners

As more programs have been developed to serve substance-abusing mothers and their children, fathers have become involved in these programs through home- and center-based components. For example, the FOCUS Project at UCLA, funded by the National Institute on Drug Abuse, enrolls pregnant substance abusers and provides comprehensive services for women and children for a period of 2 years. Although they are referred to other community agencies for substance abuse treatment if needed, husbands and significant others are involved during home visits with FOCUS staff and are also invited to attend center-based parent education sessions. The entire family benefits when both caregivers work together in learning effective parenting practices, and when both receive coordinated supportive services.

INTERAGENCY APPROACHES

Interagency Coordinating Councils

A child's health often relies upon the coordination and integration of social, environmental, and health-based strategies.³⁹

In the absence of an umbrella agency capable of providing the continuum of services needed by substance-exposed children and their parents, communities across the country have developed local coordinating bodies to promote collaboration among professionals and the development of needed services for chemically involved families.

County-based interagency perinatal councils are one example of a successful organizational strategy that has been used in California to effectively mobilize community resources and develop interagency cooperation around issues of parental substance abuse. Perinatal councils are currently active in 29 California counties, and members on each council include representatives from local departments of health, public social services, CPS agencies, drug and alcohol treatment services, and education. Public and private hospitals, private treat-

ment agencies, and interested community members also are represented. In bringing together the local public and private agencies that serve chemically involved families, these councils have provided a catalyst for the development of coordinated policies and services among member organizations. Councils also have sponsored community awareness and training programs, developed locally relevant educational materials, and served as conduits for collaborative, interagency funding requests.

Interagency, Interdisciplinary Training

Staff of all courts, human service, and law enforcement agencies should be jointly trained in identification of substance-abusing parents and drug-exposed children and the appropriate interventions.⁴⁰

Interdisciplinary training for the various professionals who serve chemically involved families within local communities represents another strategy used successfully to improve services for substance-affected children and their caregivers. Commonly, the goals of interagency training are threefold:

- to help professionals gain a better understanding of the characteristics and treatment needs of children and parents;
- to provide trainees from various professional backgrounds with a common knowledge base and framework for working with families; and
- to familiarize professionals with each other's agencies, policies, and services.

To maximize the impact of cross-training ventures, experts recommend that programs target professionals from across the service delivery spectrum, including hospital-based physicians, nurses, and social workers; CPS caseworkers; judges and attorneys; public health nurses; substance abuse treatment specialists; educators; developmental disabilities counselors; and law enforcement personnel.

Model programs frequently use an interdisciplinary training staff. Curricula address the medical, developmental, and psychosocial characteristics of chemically involved families; the special service needs of this population; effective approaches for addressing the family's complex health, social, and educational problems; community resources; and strategies for developing interdisciplinary and interagency collaboration in case planning and management efforts.

Interagency Service Teams

In developing case plans, and even during the original investigation, CPS personnel may be dealing in issues beyond their expertise. It is critical that child protection and child welfare work in concert with alcohol and substance abuse departments.⁴¹

Chemically involved families often require simultaneous services from a variety of health care, child welfare, and substance abuse treatment agencies. Interagency service teams that include public health nurses, CPS caseworkers, and chemical dependency counselors have proven to be another very successful strategy for promoting a unified treatment approach across agencies. Such teams help coordinate and integrate social, medical, and substance abuse treatment services and reduce service fragmentation for families.

Commonly, these "teams" make joint home visits for the purpose of assessment and planning with birth and foster families, meet on a regular basis for formal staffing and sharing of information and ideas, and participate in ongoing joint training to enhance the team's overall knowledge of substance abuse and to develop

common approaches for assessment and intervention with families. To support the team case management approach, collaborating agencies in some communities have developed interagency agreements that describe each agency's role and responsibilities, specify guidelines for the exchange of information, and clarify issues of confidentiality. Appendix II contains an adaptation of such a model agreement.

In rural areas or in communities that lack a comprehensive intervention program, the team case management approach can help ensure appropriate health care, substance abuse treatment, and social services for family members as well as promote continuity and coordination of the various services provided through multiple agencies.

SUMMARY

Substance abuse can devastate families. However, alcohol and other drug abuse is treatable, and appropriate interventions can protect children as well as help parents better care for themselves and their offspring. Because of the complex needs of chemically involved families, it is clear that a multitude of services is needed to achieve recovery and rehabilitation. Further, even individuals who are already in recovery commonly require ongoing support because new stressors as well as contact with substance-abusing friends and family members can interfere with maintenance of a sober lifestyle.

Although there remain many unanswered questions about the types of intervention that are most effective, our understanding of substance abuse and the needs of families suggests we are most successful when we provide programs that are family-focused, nonpunitive, and supportive in orientation. It also is important that programs are sensitive to cultural and language issues and that staff are well-trained with respect to the special needs of this high-risk population of parents and children. Furthermore, we have a greater chance of being successful when we use an interdisciplinary approach and insist on collaboration among professionals and agencies.⁴²

Substance abuse among families with young children has increased during the past decades, and service providers need to keep in mind the fact that effective treatment strategies are just beginning to emerge. Long-term effects have not yet been reported, and, likewise, we know very little about interventions that can be beneficial over time for older children and adolescents from substance-abusing families. However, we do know that chemical dependency is a chronic, relapsing problem, and that a long-term commitment to supporting families by reducing stresses, enhancing overall family health, providing opportunities for learning, and improving the family and community environment can make a difference. Such carefully crafted, multidisciplinary interventions can improve the odds that all members of a family affected by parental substance abuse will more fully realize their potential. Patterns of intergenerational substance abuse and child abuse that are a tragic part of many parents' histories need not be written into the futures of their children.

CONCLUSION

In order to effectively use the information presented in this manual, the professional should proceed with a basic understanding of substance abuse as a serious health disorder:

- The problem of substance abuse is no respecter of persons. Alcohol and other drug abuse can occur in any family, rich or poor, educated or uneducated, across the entire ethnic and cultural spectrum.
- Denial is an inherent part of a substance abuse problem, often making identification of a substance-involved family member a complicated process. Denial also can seriously interfere with the process of rehabilitation and recovery.
- Because society tends to view alcohol and other drug abuse problems differently from other health disorders, professionals need to be aware of their own feelings and attitudes about addiction in order to effectively assess and intervene with substance-abusing populations.

Bearing this in mind, this manual has presented information about alcohol and other drug abuse in families with children because many of these families first become "visible" to professionals as their children become involved in the health and educational systems. Although Chapter 1 describes methods for identifying substance abuse (though client history, behaviors, and diagnostic tests), professionals need to be mindful of the limitations of such measures. Identification is often a more extensive process that requires ongoing contacts with family members.

Chapter 2 focuses on substance abuse among adults of child-bearing age and the impact of alcohol and other drugs on parenting ability. In working with chemically involved families, it is important to remember that parental substance abuse is rarely an isolated phenomenon. Individuals who abuse alcohol and/or other drugs themselves often come from abusive, traumatic, or substance-abusing backgrounds, and their own substance abuse, in turn, has a profound effect on their children. Not only does the intermittent altered mental status associated with chemical involvement affect parenting abilities, but such parents also often lack models for effective parenting. Underlying mental health issues as well as basic survival issues may also need to be addressed. Thus, professionals commonly must focus on a wide range of problems that require intervention in order to help substance-abusing parents meet their own needs as well as the ongoing needs of their children.

Fathers and mothers who abuse alcohol and/or other drugs often fail to seek nonemergency health care and other needed services for themselves and their preschool-aged children, and this often makes identification difficult. However, when a pregnant substance abuser delivers a child, health care professionals often become alerted to problems within the family. Newborns who were exposed to alcohol and/or other drugs in utero may present with a range of medical complications related to their parents' substance abuse and lifestyle. Lack of prenatal care, poor maternal nutrition, and infectious diseases (including sexually transmitted diseases and human immunodeficiency virus) are common health risks to drug-exposed neonates. Chapter 3 focuses on these risks as well as on developmental patterns that have been observed in children from substance-involved families.

All of the characteristics described above (the mind-altering effects of alcohol and other drugs; the lifestyle associated with substance abuse; a parental history of abuse, family violence, low self-esteem, or mental health problems; and medical and developmental problems in children) can increase the risk of child maltreatment in substance-involved families. Although specific regulations regarding the reporting of suspected child abuse and neglect lie beyond the scope of this manual, Chapter 4 contains a discussion of general reporting issues in cases of prenatal alcohol and/or other abuse.

In any case of parental substance abuse—whether or not child maltreatment is suspected and reported—a comprehensive assessment of the family is essential. Ideally, such an assessment, as described in Chapter 5, should be made by members of an interdisciplinary team and should encompass the health and behaviors of children and parents as well as an evaluation of the home environment, family support systems, and cultural beliefs. In cases in which the birth parents are not the primary caregivers, professionals must also evaluate the individuals who are responsible for providing care (i.e., relative caregivers or foster parents). The goal of such an assessment is to identify family strengths as well as needs so that an appropriate service plan can be developed.

This assessment information also can be helpful to the juvenile court in cases when professionals have reported suspected child abuse or neglect, and Chapter 6 describes the special issues that the court must consider in evaluating cases of parental alcohol and/or other drug abuse. Such court involvement does not need to be viewed as an isolated event for substance-involved families, but, rather, the court can be viewed as one of many service providers assisting the family. Professionals can contribute valuable information to the court regarding family strengths and needs, aiding in the development of appropriate plans. Further, besides helping to protect the safety of the child, court involvement often can provide clout to help other service providers urge parents to enter and remain in treatment or obtain other needed services for themselves and their children.

Although the ultimate goal of identification, assessment, and in some cases, court involvement with substance-involved families is to obtain appropriate services that can help parents and children, this represents a relatively new area of service provision. Only during the last few years have we had access to information describing programs that serve substance-abusing parents and their children. We now recognize that a family-oriented and culturally sensitive treatment approach is necessary for many parents, and that the more traditional, primarily male-oriented strategies (e.g., Alcoholics Anonymous) do not always work for everyone. Although the specifics of various treatment methodologies (e.g., preferred practices, problems encountered during the course of treatment, relapse prevention strategies, and factors that affect recovery) would encompass a manual in themselves, Chapter 7 highlights some of the more innovative approaches that have been implemented to serve substance-abusing families.

Over the past years, our professional knowledge base across all the disciplines that are involved with substance abuse and with families has grown enormously. There is no doubt that services have become more comprehensive and sensitive to family needs, and as professionals continue to work together in the field over time, we will see more families benefitting from these efforts.

Appendix I.

THE NATURE OF SUBSTANCES OF ABUSE

For many professionals, the terminology and lifestyle associated with the abuse of alcohol and other drugs are unfamiliar, creating barriers to identifying, interviewing, and helping chemically involved families.

This appendix provides a basic introduction to substances of abuse, important terminology for effective interviewing, and associated paraphernalia that can alert a professional to substance abuse within a client's home. For additional information, the reader is referred to the Substance Abuse Identification Guide published by the Drug Enforcement Administration, U.S. Department of Justice.

Although various substances and their effects are described individually, it is important to recognize that the use of multiple substances (polysubstance abuse) is often the norm. The effects of polysubstance abuse are not currently known, but it is important to note that the acute effects of each substance may be altered when used in combination.

MAJOR SUBSTANCES OF ABUSE

Alcohol (Ethyl Alcohol)

Alcohol is unique in that its use by adults is legal and widely accepted in our society. In fact, alcohol is one of the most popular drugs among adults in the United States. Alcohol addiction strikes all age, ethnic, and socioeconomic groups, and some studies estimate that about 10 percent of the population suffers from alcohol abuse and alcoholism. Research suggests that there may be a genetic predisposition to alcoholism and that a child of an alcoholic parent is at a greater risk of becoming an alcoholic than a child of a nonalcoholic parent.

Alcoholic beverages vary in alcoholic content. Beer is generally 4 percent, wine 12 percent, and "hard liquor" up to 50 percent alcohol. Once absorbed into the blood stream, alcohol acts on the central nervous system (CNS) as a depressant affecting speech, vision, and coordination. As with all drugs, the effects of alcohol use depend on many factors, including the user's age and gender, the concentration of the drink, the amount of alcohol consumed over time, the body weight and metabolism of the drinker, and the drinker's emotional state.

- **Street names.** Generically, alcohol may be referred to as "booze," "liquor," "hooch," or "juice." Users also may mention product brand names or names of mixed drinks.
- **Paraphernalia.** Paraphernalia associated with alcohol abuse may include bottles and cans.
- **Effects.** Physical effects of acute alcohol intoxication include altered perception, impaired muscular coordination, staggering gait, dulled sensations, blurred vision, bloodshot eyes, flushing, dizziness, slurred speech, nausea, and vomiting. Chronic alcohol abuse also has been linked to heart disease, high blood pressure, gastrointestinal bleeding, liver damage, and brain damage. Withdrawal from excessive and prolonged use can cause a violent delirium with tremors called delirium tremens (the "DT's").

- **Overdose.** Alcohol overdose can cause unconsciousness, respiratory failure, and death.

Stimulants

Stimulants are drugs that stimulate the CNS and produce an increase in alertness and physical activity. Cocaine and amphetamine are two of the most widely abused stimulants.

Cocaine

The most potent stimulant of natural origin, cocaine, is extracted from the leaves of the coca plant (*Erythroxylon coca*). This plant has been grown since prehistoric times in the highlands of the South American Andes, where its leaves are chewed for refreshment and relief from fatigue. Pure cocaine, the principal psychoactive ingredient, was first isolated in the 1880's.

Cocaine is usually distributed illicitly as an odorless white crystalline or chunky powder (cocaine hydrochloride). Sometimes, other substances (baking soda, sugars such as lactose and mannitol, or local anesthetics such as lidocaine) are used to "cut" cocaine in order to dilute the drug and increase the quantity for sale. Most often, cocaine is sold in aluminum foil, plastic or paper packets, or small vials.

Cocaine may be inhaled into the nose. It usually is chopped into a fine powder with a razor blade on a small mirror or some other hard surface, arranged into small rows called "lines," and then quickly inhaled ("snorted") into the nose through a short straw. Powdered cocaine also can be dissolved in water and injected into the blood stream.

Conversion of powdered cocaine to cocaine base ("crack" or "rock" cocaine) yields a substance that can be heated and smoked. Generally, this cocaine base, in the form of white or tan pellets, chips, chunks, or "rocks," is vaporized in a pipe or smoked with plant material, such as marijuana, in a "geek joint." When smoked, "crack" cocaine makes a crackling sound when ignited.

- **Street names.** Common names include "coke," "blow," "white," "snow," "snort," "flake," "nose candy," "toot," "white lady," or "cane."
- **Paraphernalia.** Paraphernalia associated with snorting cocaine includes mirrors, razor blades, and straws; items associated with injecting the drug include syringes, needles, spoons, cotton, and tourniquets (bandannas, belts, or surgical tubing used to constrict the veins). Triple beam scales are used by dealers to weigh the drug. Paraphernalia associated with crack includes glass pipes (base pipes), homemade pipes such as used beer or soda cans, and small vials used to sell and store the drug.
- **Effects.** The high from a typical snorted dose of cocaine lasts about 20 minutes. During this time, the user appears very alert, confident, and energetic. He/she may experience decreased inhibition and the perception of more acute hearing. Physical signs include dilated pupils, runny nose, rapid speech, more active reflexes, accelerated heart rate, elevated respiration rate, higher body temperature, tremors, sweating, itching, and little or no appetite. The high is followed by depression, an intense desire for another dose, mental fatigue, restlessness, and irritability. Chronic users may experience severe weight loss, paranoia, depression, and hallucinations, particularly about having bugs on or under their skin.

In contrast to cocaine that is snorted, smoked crack cocaine is absorbed into the blood stream through the lungs in just a few seconds, and the user experiences a brief but intense period of extreme euphoria, alertness, and increased energy. However, the high lasts only a few minutes, leaving a severe depression called a "crash" and an immediate desire for more of the drug. The intense craving associated with crack stems not only from a desire for the euphoria of the high, but also from a desire to escape the "crash." Often, alcohol, opioids, or sedative-hypnotic drugs are used to dampen the severity of these symptoms.

- **Overdose.** A cocaine overdose can result in extreme agitation, convulsions, respiratory failure, heart failure, stroke, coma, or death.

Amphetamines

Amphetamines were first used medically in the mid-1930's to treat narcolepsy. Currently they are used primarily in the treatment of obesity in adults and attention deficit disorders with hyperactivity (ADHD) in children. Pharmaceutical amphetamines include Dexedrine™ (capsules, tablet, and liquid); Dexamyl™ (capsules, tablets, liquid); Benzedrine™ (capsules, tablets); Eskatrol™ (capsules); Biphetamine™ (capsules); Desoxyn™ (tablets); Preludin™ (tablets); and Ritalin™ (tablets).

Methamphetamine (or methedrine) is one of the most widely abused amphetamines. Generally, it is found in powder or crystal form, in colors ranging from white to tan. It can be swallowed, inhaled through the nose, or injected. Manufactured in clandestine laboratories, usually it is sold illicitly in small plastic or paper packets or in plastic bags.

"Ice" is a smokable form of methamphetamine. The street term Ice refers to the drug's transparent appearance; its shiny crystals may be as small as rice grains or as large as peas. Although it is usually smoked, Ice can be injected or ground into a powder and snorted.

- **Street names.** "Uppers," "pep pills," "bennies," "dexies," or "black beauties" are common terms used for amphetamines; references specifically to methamphetamine include "speed," "meth," "moth," "crank," "water," "crystal" or "crystal meth;" Ice is also known as "ice cream," "batu," or "shabu."
- **Paraphernalia.** Paraphernalia associated with snorting are razor blades, mirrors, and straws; items associated with injecting include syringes, spoons, and tourniquets.
- **Effects.** As in the case of cocaine, the physical effects of amphetamines include increased alertness, hyperactivity, euphoria, appetite loss, dilated pupils, rapid speech, accelerated heart rate, increased respiration, and elevated body temperature. Other symptoms may include acne that resembles a measles rash, dry mucous membranes, sweating, headache, insomnia, and restlessness. Blurred vision, hallucinations, dizziness, loss of coordination, insomnia, anxiety, paranoia, mood swings, dramatic weight loss, malnutrition, and collapse can occur following prolonged use.

Symptoms associated with use of Ice are similar to those for amphetamines in general, but effects are reported to last significantly longer (from 14 to 24 hours).

After cessation of extended amphetamine use, withdrawal symptoms often occur. Signs include profound depression, apathy, fatigue, long periods of sleep, a lingering impairment of perception,

disorientation, and anxiety. Alcohol, opioids, or sedative hypnotics frequently are used to dampen the severity of these withdrawal symptoms.

- **Overdose.** Overdose of amphetamines can result in convulsions, high blood pressure, coma, stroke, heart failure, and death.

Narcotics

Narcotics (opioids) are drugs that dull the senses. Examples of narcotics include drugs such as morphine, codeine, and heroin that are derived from the opium poppy, as well as synthetic chemicals such as Darvon,TM Demerol,TM and methadone (used in the treatment of heroin addicts). Medicinal uses for narcotics include relief of pain, cough suppression, and the control of severe diarrhea.

When a person uses narcotics regularly, the body eventually demands more of the drug in order to achieve the same effects. This is called drug tolerance. When chronic use is abruptly stopped, withdrawal symptoms such as runny nose, watery eyes, perspiration, and yawning can develop 6 to 8 hours following the last use of the drug. Thereafter, depending on the duration of activity of the particular narcotic used, more severe withdrawal symptoms develop, including restlessness, irritability, tremors, loss of appetite, stomach cramps, diarrhea, and chills alternating with heavy sweating. Typically, it can take 10 to 14 days for these acute symptoms to abate.

Narcotics may be injected, sniffed (heroin), or ingested in tablet, capsule, or liquid form. Codeine, for instance, is frequently abused in the form of TylenolTM with codeine or in cough syrups.

Heroin

Heroin was first produced in 1874 as an alternative to morphine, but it proved even more addictive. On the street, heroin generally is sold as a white to very dark brown powder or as a brown or black chunky, tarlike substance that smells like vinegar. Heroin is packaged in small foil or cellophane packets or in small rubber or plastic balloons that have been closed off and folded over into a ball (known as a "spoon" or "balloon").

The most common form of use is by injection (called "mainlining" or "shooting"), but in its powder form, heroin can be snorted or smoked. It also can be taken orally or by rectal suppository. A heroin addict may administer the drug as many as four to six times a day. Many addicts will "chip" (use infrequently) for extended periods of time before becoming "righteously" (severely) addicted.

- **Street names.** Common names include "smack," "junk," "horse," "stuff," "boy," "eleven-fifty" (the code number under which police make an arrest for heroin possession), "H," "Harry," "Helen," "dynamite," "doo-jee," "China white," "Mexican brown," "mud," and "black tar."
- **Paraphernalia.** Usually heroin addicts who inject the drug have a "kit," "rig," or "outfit" that includes a hypodermic needle, small cotton balls to strain the drug, tourniquet, matches, water, and spoons or bottle caps used for "cooking" or liquefying the heroin. Paraphernalia for snorting or smoking includes razor blades, straws, and pipes.
- **Effects.** Once in the body, heroin produces a brief and intense feeling of euphoria called a "rush;" the high usually lasts 4 to 6 hours. Following the rush, the user experiences muscle relaxation (manifested by a slow gait, sleepy appearance, slurred speech, and droopy eyelids) as well as constricted pupils and a decrease in pulse, reflexes, blood pressure, and respiration rate.

- **Overdose.** Overdose can cause slow and shallow breathing, clammy skin, convulsions, coma, cardiac arrest, or death.

Methadone

German scientists first synthesized methadone during World War II because of a morphine shortage. Methadone was introduced as an analgesic in the United States in 1947 and became widely used in the 1960's as a treatment for narcotic addicts. When used to treat heroin addiction, methadone is administered orally. Methadone is considered to be a safe and effective treatment for opiate addiction when used as prescribed by a physician.

Methadone differs significantly from heroin in that it has a longer duration of action. Because a single dose can last up to 24 hours, methadone can be administered once a day in heroin detoxification and maintenance programs.

- **Street names.** Users commonly refer to methadone as "dolly" or "dome."
- **Paraphernalia.** Paraphernalia associated with methadone use generally includes pills or water-soluble wafers.
- **Effects.** When used appropriately in adequate doses under medical supervision, methadone has few significant adverse side effects. When abused, however, the effects are similar to those associated with addiction to other narcotics. Compared to heroin, the symptoms associated with methadone withdrawal are slower in onset and longer in duration.
- **Overdose.** Methadone overdose can result in respiratory depression, coma, or cardiac arrest.

Sedatives

Sedatives are commonly known as tranquilizers and sleeping pills. They have legitimate therapeutic uses when prescribed by physicians to treat anxiety, tension, insomnia, and muscle spasms. However, sedatives are often abused because of their intoxicating effects, as self-medication to allay the effects of stimulant drugs, to ease the anxiety of flashbacks associated with prior hallucinogen use, to treat heroin withdrawal symptoms, or, in some cases, as a means to commit suicide.

The various drugs included in this classification include barbiturates (Nembutal,TM Seconal,TM and AmytalTM), chloral hydrate, glutethimide (DoridenTM), benzodiazepines (Valium,TM Librium,TM and XanaxTM), and antianxiety medications such as PlacidylTM, Miltown,TM and Equanil.TM Although they occasionally may be intravenously injected, sedatives are most frequently ingested as pills, tablets, or capsules that generally are sold illicitly in plastic bags or bottles. Tolerance to the effects of sedatives can develop rapidly, leading to a progressive narrowing of the margin of safety between an intoxicating and a lethal dose. The risk is compounded when depressants are used in combination with alcohol or other substances. Withdrawal from barbiturates and benzodiazepines can be serious and should be treated as a medical emergency. Withdrawal from sedatives and hypnotics can lead to convulsions, delirium, and, in some instances, death; therefore, medical supervision is often required. Unrecognized and untreated withdrawal may be fatal.

- **Street names.** Common street names include "barbs," "downers," "yellow jackets," "yellows," "red devils," "blue devils," "ludes," and "sopers."

- **Paraphernalia.** Paraphernalia associated with sedative abuse generally includes capsules, tablets, or pills as well as pill bottles or plastic bags used as containers for the drug. When sedatives are injected, paraphernalia may include plastic or paper packets, plastic bags, syringes, needles, tourniquets, cotton, and spoons.
- **Effects.** As in the case of alcohol and hallucinogens, the symptoms of sedative abuse may vary not only from person to person, but also from time to time in the same individual. Abusers may appear to be in a state of intoxication much like that of alcohol abuse, with impaired judgment, slurred speech, staggering gait, and loss of motor coordination. Other symptoms may include dilated pupils, weak and rapid pulse, slow or rapid but shallow breathing, trembling hands, impaired reflexes, drowsiness, and fainting. Sedatives also can produce mood swings ranging from euphoria to confusion, disorientation, quarrelsomeness, depression, and apathy.
- **Overdose.** Sedative overdose can cause the user to progress through successive states of sedation, sleep, coma to death from respiratory arrest and cardiovascular complications.

Hallucinogens

Hallucinogens are psychotropic drugs that cause hallucinations by distorting the perception of objective reality. They include phencyclidine (PCP), the synthetic drug lysergic acid diethylamide (LSD), certain psychoactive mushrooms, and mescaline (present in the peyote cactus).

PCP

PCP was investigated in the 1950's as an anesthetic, but because of extreme side effects (including topic psychosis schizophrenia), it was discontinued for human use. In its pure form, PCP is a white crystalline powder that readily dissolves in water. Because of contaminants resulting from its illicit manufacture, street PCP color ranges from tan to brown; its consistency can vary from a powder to a gummy mass. PCP is frequently misrepresented as mescaline, LSD, or tetrahydrocannabinol (THC).

Although it is sold in tablets, pills, and gelatin capsules, PCP is most commonly found in powder and clear liquid form. It may be inhaled, injected, or ingested, and frequently is applied to dark brown cigarettes ("Shermans") or a leafy material (parsley, mint, oregano, or marijuana) and smoked. PCP is also readily absorbed through the skin. In its liquid form, PCP is packaged and stored in small vials or other small glass containers.

- **Street names.** PCP is known on the street by various names, including "angel dust," "crystal," "supergrass," "killer weed," "KJ," "shermes," "embalming fluid," "hog," and "rocket fuel."
- **Paraphernalia.** Paraphernalia associated with PCP abuse may include tablets, pills, or gelatine capsules; dark-colored cigarettes; paper or cellophane packets; and clear liquid in small glass vials.
- **Effects.** The effects of PCP are as variable as its appearance; it is one of the most unpredictable of all street drugs, scrambling stimuli within the brain and altering how the user perceives and deals with the environment. It can act as an anesthetic, stimulant, and/or hallucinogenic drug. Moderate amounts can produce a sense of drowsiness, detachment, and estrangement or isolation from surroundings. Additional reported effects include numbness, muscle rigidity, slurred speech or an

inability to speak coherently, loss of coordination, and feelings of extreme excitement and invulnerability. A blank stare, rapid and involuntary eye movements (nystagmus), and an exaggerated gait are among the more common observable effects. Some users may experience auditory hallucinations, double vision, image distortion (comparable to a funhouse mirror), a rise in blood pressure and heart rate, and profuse sweating. Severe mood disorders also may occur, producing in some users acute anxiety and a feeling of impending doom, in others paranoia and violent, aggressive behavior.

- **Overdose.** PCP overdose can result in psychosis (delusional disorder, mood disorder), fever, convulsions, coma (often prolonged, from 12 hours to days), and death from respiratory repression.

LSD

First synthesized in 1938, LSD is an odorless and colorless substance derived from the ergot fungus that grows on rye and from a chemical found in morning glory seeds.

Because LSD is so potent, the dosage can be incredibly small. A microscopic drop can be put on any absorbent material and swallowed. LSD is generally sold in tablet or capsule form or placed into thin squares of gelatin (called "window panes"), paper ("blotter acid"), sugar cubes, chewing gum, hard candy, or crackers.

- **Street names.** Street names include "acid," "blotter acid," "microdot," "cubes," "big D," "trips," "sugar," "purple haze," and "white lightning."
- **Paraphernalia.** Paraphernalia associated with LSD abuse may include small paper squares, vials, tablets or capsules in plastic bags, and multiple small pills (generally white in color) attached to pieces of paper like candy dots.
- **Effects.** The duration of the hallucinogenic effect is commonly called a "trip," and this high can last from 2 to 12 hours. Physical effects include dilated pupils; elevated body temperature; high blood pressure; hallucinations; and a disoriented sense of direction, distance, and time. "Bad trips" can result in panic, paranoia, anxiety, confusion, and psychosis.
- **Overdose.** Overdose can result in longer trip episodes, psychosis (delusional disorder, mood disorder, panic disorder), and potential death.

Psilocybin and Psilocyn (Mushrooms)

Mushrooms have been used for centuries in traditional North American Indian religious rites. When certain types of mushrooms are eaten, they affect mood and perception in a manner similar to that of LSD. The active ingredients, psilocybin and psilocyn, are chemically related to LSD. These mushrooms can be chewed, smoked, or infused in hot water to make tea.

- **Street names.** The mushrooms are often referred to as "magic mushrooms" or "shrooms."
- **Paraphernalia.** Paraphernalia associated with the abuse of mushrooms generally includes the dried mushrooms themselves, similar in appearance to the dried mushrooms one sees in a grocery store, or a brownish powder.

- **Effects.** The effects of mushroom ingestion may include dilated pupils, sweating, hyperventilation, rambling speech, hyperactivity, increased blood pressure, elevated temperature, vomiting, and tremors. Users may experience impaired memory or attention span, anxiety, paranoia, depression, panic, delusions, and hallucinations.
- **Overdose.** Overdose can result in longer trip episodes, psychosis, and potential death.

Mescaline (Peyote)

Mescaline, a hallucinogen, is the primary ingredient in the peyote cactus (*Lophophora williamsii*), and is present to a lesser degree in the San Pedro cactus (*Trichocereus pachanoi*). Derived from the dried or fresh flowering heads (mescal buttons or buttons) of the cactus, mescaline, like mushrooms, has been used from the earliest recorded time as part of traditional Indian religious rites. Typically, mescaline is a brown, disc-shaped cactus "button," but it also can be produced synthetically in the form of a capsule or pill the size of a large aspirin.

Usually ingested orally, peyote buttons may be chewed or ground into a powder and used to make tea. The average dose is 3 to 10 buttons. Mescaline, in crystalline form, also may be snorted, but it is rarely taken intravenously. Mescaline reportedly has an intensely bitter taste.

- **Street names.** One variety is called "STP," after the motor oil additive.
- **Paraphernalia.** Paraphernalia associated with mescaline abuse generally includes dried brown, disc-shaped cactus buttons, or aspirin-like pills or capsules.
- **Effects.** From 30 minutes to 1 hour after ingestion, the user may experience muscle tension, nausea, and vomiting. Mescaline also can cause dilated pupils, dizziness, chills, increased pulse rate, dry mouth, and profuse sweating. It also may induce distortions in sensory and time perception as well as euphoria, a sense of well-being, and hallucinations. Some users experience panic and intense headache. These effects can last for several hours.
- **Overdose.** Although injury or death from overdose is uncommon, high doses can cause respiratory depression, slow pulse, and low blood pressure.

Cannabis

Cannabis refers to the Indian hemp plant, *Cannabis sativa*. The ingredient responsible for its psychoactive effect (the high) is THC, which is concentrated in the resin of the plant. Most of the resin is found in the flowering tops, with less in the leaves, and almost none in the fibrous stalks. The amount of THC determines the potency of the drug. Both marijuana and hashish are produced from the hemp plant.

- **Street names.** Hashish is usually referred to as "hash." Common names for marijuana include "grass," "pot," "weed," "Acapulco gold," "Columbian," "ganja," and "smoke."
- **Paraphernalia.** Paraphernalia associated with cannabis use may include cigarette papers (e.g., "ZigZags"), small wooden or clay pipes, water-filled pipes (called "bongs"), plastic bags, "roach clips" (small clips that may be made from tweezers, electrical clips, or other items to hold a partial-

ly smoked marijuana cigarette), and decorative boxes ("stash boxes") designed to conceal and store the drug.

- **Effects.** In low doses, cannabis can induce restlessness and a dreamy relaxed state; however, stronger doses can cause shifting sensory images, rapidly fluctuating emotions, and hallucinations or image distortions. Physical effects include red or bloodshot eyes, dryness of the mouth and throat, increased appetite, impaired muscular coordination, increased heart rate, and lowering of body temperature. Users may exhibit intensified concentration on their surroundings, reduced reactions, decreased ability to concentrate on tasks, an altered sense of time, impaired short-term memory, meaningless giggly conversation, anxiety, and psychological dependency.
- **Overdose.** Overdose can result in fatigue, paranoia, and possible psychosis/mental disorder (delusional disorder).

Marijuana

Marijuana consists of the leaves, flowers, stems, and seeds of the Indian hemp plant, which are dried and crushed or chopped into small pieces. Marijuana appears on the street as a greenish or brownish material that may be full of seeds or stems, or it may be cleaned and "manicured" (seeds and stems removed). Marijuana also can be found as sinsemilla, the potent flowering tops of the female plant. Marijuana usually is sold and stored in plastic bags, aluminum foil, or small hand-rolled cigarettes called "joints" or "reefers."

Generally smoked in cigarettes or in pipes, marijuana has a strong, pungent odor when ignited. However, it also can be blended into food and then cooked and eaten. The average period of intoxication following use of one marijuana cigarette is approximately 2 hours, although the residual chemicals may remain in the body for up to 1 month.

Hashish

Hashish and hashish oil are other forms of cannabis. Hashish is a compressed form of the resinous secretions of the flowering parts of the plant. It is a gummy substance ranging in color from light green to gold to dark brown to black in color, and may appear in ball, cake, or cookie-like sheet form. Hashish oil (hash oil) is produced by the repeated extraction of the resin through the use of alcohol and heat, and the resulting product is a viscous light to very dark brown liquid with the consistency of molasses.

Because hashish contains a higher concentration of THC than marijuana, hashish and hashish oil are more potent and are sold and used in smaller quantities. Hashish is most often packaged in aluminum foil, and hash oil is stored in small vials. As with marijuana, both hashish and hashish oil are smoked in pipes, but they also may be mixed with tobacco in cigarettes or pipes.

Inhalants

Inhalants are a diverse group of substances that normally may not be thought of as drugs. Most are legal substances found in everyday household products, and they are sniffed or inhaled. Fumes from aerosol sprays such as spray paint and cleaning fluid as well as hydrocarbons such as model airplane glue, gasoline, paint thinner, and dry cleaning solution may be abused. Some abusers also inhale the vapors from lighter fluid, hair spray, whipped cream canisters, typewriter correction fluid, paint, rubbing alcohol, and nail polish remover.

- **Street names.** Various types of inhalants and their street names include nitrous oxide (called "laughing gas" or "whippets"), amyl nitrite (poppers" or "snappers"), and butyl nitrite ("rush," "bolt," "locker room," "bullet," "climax").
- **Paraphernalia.** Paraphernalia associated with abuse of inhalants may include spray cans, glue containers, saturated cloths, or ampules.
- **Effects.** Effects of inhalant use include dilated pupils, runny nose, watery eyes, loss of coordination, slurred speech, stupor, and vomiting. Users may experience a buzzing sensation in the ears, dizziness, severe headache, double vision, drowsiness, lightheadedness, loss of memory, and weight loss.
- **Overdose.** Overdose can result in CNS system depression or cardiac arrhythmia.

The chart on the following pages lists each substance, commonly used paraphernalia, and observable effects.

Table 6
MAJOR SUBSTANCES OF ABUSE

Drug	Paraphernalia	Observable Effects of Use
Alcohol	bottles and cans	impaired coordination, staggered walk, bloodshot eyes, flushing, slurred speech
Cocaine	small glass vials; foil, cellophane, or paper packets; triple beam scales SNORTING: mirrors, razor blades, straws INJECTING: syringes, needles, spoons, cotton, tourniquets SMOKING: small glass or pottery vials, glass pipes, handrolled cigarettes	increased alertness and energy, dilated pupils, rapid speech, tremors, sweating, runny or irritated nose, decreased appetite, weight loss, depression
Amphetamines Methamphetamine	SWALLOWING: pill bottles, plastic bags, paper packets SNORTING: plastic or paper packets, plastic bags, razor blades, mirrors, straws INJECTING: plastic or paper packets, plastic bags, syringes, spoons, tourniquets, needles	increased alertness, decreased appetite, weight loss, increased respiration and heart rate, dilated pupils, sweating, rash, insomnia, depression
Heroin	foil or cellophane packets, rubber or plastic balloons folded into balls INJECTING: needles, cotton, matches, spoons or bottle caps, tourniquets SNORTING: razor blades, straws, pipes	needle marks, slurred speech, slow gait, sleepy appearance, constricted pupils, decreased pulse and respiration rate
Sedatives	pill bottles, plastic bags	impaired judgment, staggered gait, drowsiness, slurred speech, dilated pupils, shallow breathing, weak and rapid pulse
Phencyclidine (PCP)	tablets, pills, or gelatin capsules; dark-colored cigarettes, paper or cellophane packets, clear liquid in small glass vials	drowsiness, excitement, slurred speech, muscle rigidity, unusual eye movements, exaggerated gait, sweating
Lysergic acid diethylamide (LSD)	small paper squares, vials, tablets or capsules in plastic bags	dilated pupils, elevated body temperature, anxiety, confusion, disoriented sense of direction, distance, and time
Mushrooms	dried mushrooms, brownish powder	dilated pupils, sweating, hyperventilation, tremors, rambling speech, hyperactivity, depression
Peyote	brown disc-shaped dried cactus "buttons," brownish powder	muscle tension, vomiting, dilated pupils, dizziness, chills, increased pulse, sweating, hallucinations
Mescaline	aspirin-like pills or capsules	
Marijuana Hashish Hashish Oil	plastic bags, aluminum foil packets, "ZigZag" cigarette papers, handrolled cigarettes, wooden or clay pipes, waterfilled pipes, plastic bags, roach clips, decorative boxes, small vials	restlessness, relaxation, bloodshot eyes, increased appetite, impaired coordination
Inhalants	spray cans, glue containers, saturated cloths, ampules	dilated pupils, runny nose, watery eyes, impaired coordination, slurred speech, headache, weight loss

**Table 6 (cont.)
MAJOR SUBSTANCES OF ABUSE**

Drug Group	Drug	Street Names	Method of Use
Depressant	Alcohol	booze, liquor, juice, brew, beer, wine, product brand names	swallowed in liquid form
Stimulants	Cocaine	coke, blow, white, snow, snort, flake, nose candy, toot, white lady, cane crack, rock	snorted or injected smoked
	Amphetamines	uppers, pep pills, bennies, dexies, black beauties	swallowed in capsule, tablet, or pill form
	Methamphetamine	speed, meth, moth, crank, water, crystal, crystal meth, ice, ice cream, batu, shabu	snorted, injected, or smoked
Narcotics	Heroin	smack, junk, horse, China white, Mexican brown, mud, black tar	injected, snorted, or smoked
Sedatives	Barbituates, Methaqualone, Choral hydrate, Glutethimide, Benzodiazepines	barbs, downers, yellow jackets, yellows, red devils, blue devils, ludes, supers	swallowed in capsule, tablet, or pill form, injected
Hallucinogens	Phencyclidine (PCP)	angel dust, crystal, supergrass, killer weed, KJ, sherms, embalming fluid, hog, rocket fuel	snorted, injected, drunk, applied to leafy material and smoked, or swallowed in capsule, tablet, or pill form
	Lysergic acid diethylamide (LSD)	acid, blotter acid, microdot, cubes, purple haze, white lightning	swallowed in tablet or capsule form, or placed into thin squares of gelatin, paper, sugar cubes, gum, candy, or crackers
	Mushrooms (Psilocybin/Psilocyn)	magic mushrooms, shrooms	chewed, smoked, or ground and infused in hot water and drunk as tea
	Peyote (Mescaline)	STP	chewed, swallowed in capsule or pill form, ground and infused in hot water and drunk as tea
Cannabis	Marijuana	grass, pot, weed, Acapulco gold, Colombian, ganja, smoke, sinsemilla	smoked in handrolled cigarettes or pipes
	Hashish	hash	
	Hashish Oil	hash oil	
Inhalants	Nitrous Oxide	laughing gas, whippets	inhaled or sniffed, sometimes using a paper bag, rag, gauze, or ampules
	Amyl Nitrate	poppers, snappers	
	Butyl Nitrate	rush, bolt, locker room, bullet, climax	
	Airplane Glue, Aerosol Sprays, Gasoline, Paint Thinner		

Appendix II.

SAMPLE MEDICAL CENTER PROTOCOL

SUBJECT: SUSPECTED CHILD ABUSE AND/OR NEGLECT: DRUG/ALCOHOL RELATED SITUATIONS INVOLVING PERINATAL PATIENTS

PURPOSE

To specify the protocol for identifying potential child endangering drug/alcohol related situations involving perinatal patients. Efforts are directed at problem identification, counseling the parent(s), making appropriate referrals for treatment, and initiating protective service referrals when indicated.

POLICY

The capacity of the drug/alcohol dependent parent to provide a safe, nurturing environment necessary for a child to thrive must be assessed.

Infant drug/alcohol exposure evaluations are necessary to determine the need for services and referrals that promote a safe environment for the infant and appropriate help for the parents.

Information for evaluations is obtained by history, the observation of signs and symptoms in the mother and infant, and toxicologic examination. A multidisciplinary approach is used to respond to the medical, social, and legal needs of substance abusing parents and their infants.

RESPONSIBILITIES

- I. The responsibility for evaluating infants exposed to potentially harmful substances rests with all mandated reporters which includes, but is not limited to physicians, nurses, and social workers. (See Attachment I.)
- II. It shall be the responsibility of the health care team to evaluate each case and make the appropriate recommendations and referrals.
- III. When a child-endangering situation is being evaluated:
 - A. The health care team is responsible for providing a medical evaluation of mother and infant, a psychosocial assessment, support, and referrals to appropriate resources.
 - B. If the assessment reveals factors that indicate risk to a child, the SCAN Team On-Call Consultant will be notified.
 - C. When indicated, the physician, in collaboration with the clinical social worker (or, in the clinical social worker's absence, the head nurse or his/her designee) is responsible for:

1. Reporting to Child Protective Services (CPS) in the county where the mother resides.
 2. Completing the State's Suspected Child Abuse Report.
- D. The attending physician is responsible for reviewing and cosigning the State's Medical Report—Suspected Child Abuse.
- E. The SCAN Team will review each suspected child abuse case referred for consultation at the weekly SCAN Team meeting where recommendations are made for continued case management. Physicians and other hospital personnel are requested to present the cases in which they have been significantly involved.

PROCEDURES

I. During the Prenatal Period

- A. The objective of prenatal interventions with substance abusing patients is prevention, early problem identification, education, and treatment. Substance abuse may impair a patient's ability to obtain prenatal care. Extra effort should be made to facilitate prenatal care for patients whenever they come in contact with a health care provider.
- B. When a patient presents to the Medical Center with a current history of or signs or symptoms of drug/alcohol abuse: (See Attachment II.)
1. The history of or signs or symptoms of drug/alcohol abuse shall be documented in the patient's medical record.
 2. The health care team is responsible for initiating a multidisciplinary assessment. (See Attachment III.)
 3. Refer the patient to the clinical social worker assigned to the service so that the assessment process can be coordinated and referrals to services can be made.
 4. Efforts to educate and counsel the patient regarding the risks of drug/alcohol abuse to self and fetus shall be documented in the medical record by the health care providers.
 5. Refer the patient back to their health care provider or to the High Risk OB Clinic for ongoing prenatal care, continuing assessment, and toxicology screening.

II. During the Labor and Delivery Period

- A. The following steps shall be taken for all patients presenting with a history of drug/alcohol abuse:
1. The history shall be charted in the patient's medical record.
 2. Clinical Social Work shall be notified so that an assessment can be initiated.
- B. If the patient has signs or symptoms of drug/alcohol abuse (See Attachment II.) or other indicators of possible drug/alcohol abuse (See Attachment IV.), the following additional steps should be taken:

1. The signs or symptoms or indicators shall be charted in the patient's medical record.
2. The physician shall order a toxicology screen and shall discuss the results with the patient.
3. The physician, in collaboration with the delivery room nurses and the clinical social worker, shall notify the SCAN Team consultant. (See Attachment I.)

III. During the Postnatal Period

A. The health care team shall evaluate for all situations involving infants born with signs or symptoms suggestive of prenatal drug/alcohol exposure (See Attachment V.), or who are born to a mother with signs or symptoms or other indicators suggestive of drug/alcohol abuse. (See Attachments II. and IV.) In these situations:

1. The signs or symptoms or other indicators of drug/alcohol abuse in the mother shall be documented in the mother's medical record.
2. Signs or symptoms of drug/alcohol abuse in the infant shall be documented in the infant's medical record.
3. The physician shall order a toxicology screen for the infant and discuss the result with the parent(s).
4. The clinical social worker shall be notified in order to coordinate the multidisciplinary assessment prior to the discharge of the infant. (See Attachment III.)

When appropriate, the assessment shall include consultation with psychiatry, child development, and agencies such as the parent's drug or alcohol treatment program, CPS, Regional Center, public health, siblings' schools, and siblings' pediatricians.

5. The physician, in collaboration with nursing staff and the clinical social worker, shall notify the SCAN Team consultant. (See Attachment I.)

B. CPS shall be notified when:

1. The assessment of the multidisciplinary team leads to suspicion of endangerment due to the interaction of the particular infant, parent, and environmental variables present in the situation. (See Attachment VI.)
2. The health care team is unable to adequately assess risk for the following reasons:
 - a. A home visit is needed prior to discharge.
 - b. The parent cannot be located.
 - c. The parent withholds information crucial to the assessment or gives conflicting information.
 - d. The parent refuses consent to contact involved community agencies for information pertinent to the assessment.

C. The discharge plan developed by the health care team shall:

1. Be developed in conjunction with CPS, when notified.
2. Identify services needed by the infant/parent/family and specify referrals.
3. Shall include a newborn follow-up visit at the Medical Center to take place within 10 days of discharge for infants who reside locally.

ATTACHMENT I.

SCAN (SUSPECTED CHILD ABUSE AND NEGLECT) TEAM CONSULTATION

When child abuse or neglect is suspected, hospital personnel should immediately contact the SCAN Team consultant.

During business hours, the SCAN Team coordinator can be reached at _____ (insert telephone #) for consultation. For consultation after hours, on weekends, or holidays, hospital personnel should contact the SCAN Team on-call consultant through the hospital page operator _____ (insert telephone #).

The SCAN Team on-call consultant assists in the determination of suspected child abuse or neglect and provides guidance with reporting steps when indicated. The on-call consultant may also suggest case management options.

ATTACHMENT II.

MATERNAL SIGNS AND SYMPTOMS OF ALCOHOL/DRUG ABUSE

- Positive drug screen(s) during pregnancy.
- Skin lesions such as abscesses or track marks consistent with IV drug abuse.
- Placental abruption in absence of other identifiable causes.
- Withdrawal symptoms.
- Intrauterine growth retardation in the absence of other identifiable causes.
- Current enrollment in a drug treatment program.
- Presence of drug paraphernalia in the mother's hospital room.
- Previous history of delivery of prenatally drug exposed infant(s).
- Altered mental status consistent with drug/alcohol intoxication.

ATTACHMENT III.

AREAS FOR ASSESSMENT

1. Parent's current drug/alcohol use history.
2. Parent's drug/alcohol treatment history.
3. Parent's use of health care systems.
4. Parent's physical, intellectual, and emotional status.
5. Parent's level of cooperation.
6. Parent's history of prior child abuse/neglect.
7. Strength of family support systems.
8. Drug/alcohol use in the home.
9. Sibling health, development, and school performance.
10. Environmental conditions within the home.
11. Infant's alcohol- and drug-related symptoms.
12. Infant's medical and/or physical problems.
13. Infant's special care needs.
14. Parent's awareness of the impact of drug/alcohol use on the fetus.
15. Parenting skills and responsiveness to infant.
16. Presence of alternate caregiver in the home.

ATTACHMENT IV.

MATERNAL INDICATORS OF POSSIBLE ALCOHOL/DRUG ABUSE FOR FURTHER EVALUATION

The following may be indications of drug/alcohol abuse, but are not diagnostic. It is the constellation of factors that need to be evaluated.

- Inconsistent or inadequate prenatal care (less than 3 visits).
- Sexually transmitted diseases.
- Violence and substance abuse in the home.
- Precipitous delivery.
- Poor maternal weight gain.
- Premature onset of labor.
- Unexplained changes in mental status.

ATTACHMENT V.

SIGNS AND SYMPTOMS OF POSSIBLE PRENATAL DRUG/ALCOHOL EXPOSURE IN THE NEONATE

The following may be indications of prenatal drug/alcohol exposure but are not diagnostic. Prenatal drug exposure should be considered when a constellation of factors is present and in the absence of other medical causes.

- Positive drug screen for unprescribed medications or drugs
- Excessive tremulousness
- Poor feeding
- High-pitched cry
- Seizures
- Lethargy
- Vomiting
- Watery stools
- Small gestational age
- Prematurity
- Diaphoresis
- Physical stigmata of fetal alcohol syndrome
- Stillbirth
- Frantic sucking

ATTACHMENT VI.

HIGH-RISK INDICATORS

The health care team should consider the following variables in making the determination to refer to CPS. The assessment of suspected endangerment is based upon the interaction of variables, rather than the presence of any single variable.

Infant

- Prematurity
- Equipment dependency (i.e., tracheostomy, oxygen dependency)
- Medically fragile status
- Irritability/hyperactivity/poor sleeping
- Lethargic (increases risk for neglect)
- Feeding difficulties
- Special medication needs

Parent

- Denial of drug/alcohol use in spite of indication of use
- Parent's belief that drugs/alcohol are not a problem for her/him in spite of indication to the contrary
- Non-compliance with substance abuse treatment program (poor attendance, positive toxicology screens, etc.)
- Entrance into drug/alcohol treatment within the third trimester
- No prenatal care or noncompliance with prenatal care
- Unwanted pregnancy
- Parental history of abuse during childhood
- Unrealistic expectations/perceptions of the child's behavior
- Severe intellectual limitations/developmental disability
- Serious medical problems
- History of mental health problems
- History of violent behavior
- Hostility toward child

ATTACHMENT VI., continued

HIGH-RISK INDICATORS

- Rejection of child
- Abandonment of infant in hospital
- Denial of infant's problems/symptoms
- Refusal to cooperate with health care team
- Lack of responsiveness to infant's needs (i.e., lack of attention to crying, poor eye contact, infrequent hospital visits)
- Previous allegation of child abuse/neglect
- Prior removal of a sibling from the parent's custody
- Poor skills in providing physical care of the infant

Environment

- Unstable living situation (homeless or resident in hotel or shelter)
- Safety or health hazards in the home
- Lack of preparations for infant
- History of family violence
- Presence of known drug user in the household
- Siblings with untreated health problems
- Siblings without current immunizations
- Siblings with untreated developmental delays or school problems

Appendix III.

SAMPLE INTERAGENCY AGREEMENT

JOINT SERVICE AGREEMENT AMONG
PUBLIC HEALTH SERVICE
DIVISION OF PUBLIC HEALTH NURSING,
DEPARTMENT OF SOCIAL SERVICES
CHILD PROTECTIVE SERVICES (CPS), AND
DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

The purpose of this interagency agreement is to provide comprehensive services to the increasing numbers of children exposed in utero to alcohol and drug abuse. These infants are at risk for serious medical, developmental, and psychological problems. As these children grow they may experience problems with balance, coordination, learning, or memory. Because they are difficult to care for, and because their parents often continue to abuse drugs, these children are at risk for child abuse and neglect.

The objectives of this agreement are that:

- a. All newborns who are at risk due to drug abuse by their mothers are referred to Public Health Nursing Services.
- b. All women with substance abuse problems are referred to the County Department of Alcohol and Drug Programs, Center for Drug Problems.
- c. The roles/functions of Children's Services, Public Health Nursing, and Alcohol and Drug Programs staff are clearly specified.
- d. Consistent actions are taken by Children's Services and Public Health Nursing to keep these children safe.

The following actions will insure that these objectives are met.

I. Children's Services Social Workers will:

- A. Refer cases by phone or in writing by completing an InterAgency Referral Form to the Supervising or Senior Public Health Nurse at the appropriate Public Health Center.
- B. Notify the Public Health Nurse of Emergency Response Team staffing.
- C. Provide the following information at the time of referral:
 1. name, address, and telephone number of client(s);
 2. number of children in the home;
 3. names and birth dates of the children;
 4. identification of the victim(s) and risk issues;
 5. any known or suspected history of violence at the time of or subsequent to the referral;

6. previous history of CPS involvement;
 7. specifically what services the Public Health Nurse is requested to do;
 8. the plan of action to be taken by Children's Services (e.g., close, voluntary, court, inhome, etc.);
 9. any request for a telephone or written report by Public Health to the Department of Social Services; and
 10. specifically what agencies/programs are involved in the case.
- D. Conduct joint visits with the Public Health Nurse if requested and appropriate.
 - E. Keep the Public Health Nurse informed of any change in status with regard to case disposition (e.g., subsequent removal of child to foster care, termination, etc.).
 - F. Give the Public Health Nurse a minimum of 10 working days' lead time on any request for written input for review hearings.
 - G. When available, provide a copy of the court order or voluntary agreement to the Public Health Nurse.
 - H. Keep the Public Health Nurse informed of any social worker change (e.g., transfer from intake to family maintenance).
 - I. Provide CPS as mandated by State and Federal regulations and within the County Public Social Services agency staffing and procedures.
- II. The Public Health Nurse representative will attend PSSA's Emergency Response Team staffing to contribute nursing/medical knowledge and obtain direct referrals.
 - III. Public Health Nurses in the field will provide initial and ongoing assessments, education, intervention, and referral in the following areas:
 - A. medical problems such as Fetal Alcohol Syndrome, congenital anomalies, AIDS, hepatitis B, hyperbilirubinemia, low birth weight, and seizure activity;
 - B. failure to thrive;
 - C. parenting skills and abilities, and feeding and teaching skills;
 - D. mother-infant attachment;
 - E. knowledge regarding child care;
 - F. infant growth and development; and
 - G. well-child care;

IV. Public Health Nurses will:

- A. Provide progress reports to the Department of Social Services as required for the juvenile court and/or case management.
- B. Based on a history of violence and the ability of Public Health Nursing to meet the objectives of the referral, the Supervising or Senior Public Health Nurse will determine whether or not to accept the referral or take appropriate steps to provide safety to the Public Health Nurse. The Supervising or Senior Public Health Nurse will notify the Department of Social Services by phone if the referral is rejected.
- C. Based on previous services provided by the Public Health Nurse and progress or lack of progress made, Public Health Nurses may request that a client self refer.
- D. Conduct joint visits with the Department of Social Services social worker when requested and if appropriate.
- E. Notify the Department of Social Services by phone or in writing in the event that a client declines Public Health Nursing services.
- F. Comply with legal reporting responsibility according to State law, Child Abuse Reporting.
- G. Make a telephone or written report to the Department of Social Services.

V. Department of Alcohol and Drug Programs staff will:

- A. Provide hospital outreach services through referrals from the County Medical Center social worker. A counselor will see any prenatal or postpartum women in the hospital to offer substance abuse treatment services if the woman desires this contact.
- B. Provide substance abuse treatment and referral for any chemically dependent women. Treatment services include assessment, substance abuse counseling on an outpatient basis, and referral to residential treatment if needed.
- C. Coordinate with the Department of Social Services and Public Health Services regarding services provided to these women and their children, while maintaining confidentiality in full accordance with regulations governing "Confidentiality of Alcohol and Drug Abuse Patient Records." Information regarding clients' attendance and general progress can be released to Social Services and Public Health if clients have signed the appropriate Release of Information forms.
- D. Comply with legal reporting responsibility according to State law, Child Abuse Reporting.

VI. This Joint Service Agreement in no way interferes with the Department of Social Services' working relationship with other resources in the community.

VII. This Joint Service Agreement in no way interferes with the resources in the community.

VIII. This Joint Services Agreement may be amended or terminated by written consent of all parties. All amendments shall be attached to the Agreement and made a part thereof.

NOTES

1. Child Welfare League of America, *Highlights of Questions from the Working Paper on Chemical Dependency* (Washington, DC: Child Welfare League of America, 1989).
2. U.S. General Accounting Office, June 1990.
3. E.L. Abel and R. J. Sokol, "Incidence of Fetal Alcohol Syndrome and Economic Impact of FAS-Related Anomalies," *Drug and Alcohol Dependency* 19(1987):51-70.
4. UCLA Medical Center, "Suspected Child Abuse and/or Neglect: Drug /Alcohol Related Situations Involving Perinatal Patients," UCLA Medical Center Policy No. 0020, February 13, 1991.
5. C.L. Jones and R.E. Lopez, "Component Report on Drug Abuse: Direct and Indirect Effects on the Infant of Maternal Drug Abuse," in G. Hill, ed., *Public Health Service Report on the Content of Prenatal Care*, Vol.II (Washington, DC: Department of Health and Human Services, in press), 12.
6. L.P. Finnegan, "Neonatal Abstinence Syndrome: Assessment and Pharmacotherapy," in F.F. Rubaltelli and B. Granati, eds., *Neonatal Therapy Update* (New York: Excerpta Medica, 1986), 122-146.
7. A.R. Rudolph, J.I.E. Hoffman, and C.D. Rudolph, *Rudolph's Pediatrics*, 19th ed. (San Mateo, CA: Appleton and Lange, 1991), 156-164.
8. S. Dixon and R. Bejar, "Echoencephalographic Findings in Neonates Associated with Maternal Cocaine and Methamphetamine Use: Incidence and Clinical Correlates," *Journal of Pediatrics* 5(November 1989):770.
9. I.J. Chasnoff, et al., "Perinatal Cerebral Infarction and Maternal Cocaine Use," *Journal of Pediatrics* 3(March 1986):456.
10. A.C. Duhaime, et al., "Head Injury in Very Young Children: Mechanisms, Injury Types, and Ophthalmologic Findings in 100 Hospitalized Patients Younger Than 2 Years of Age," *Pediatrics* 2(August 1992):179.
11. J. Caffey, "The Whiplash Shaken Infant Syndrome: Manual Shaking by the Extremities with Whiplash-Induced Intracranial and Intraocular Bleedings, Linked with Residual Permanent Brain Damage and Mental Retardation," *Pediatrics* 54(1974):196.
12. New Jersey Statutes, *annot. Section 30:4C-11*.
13. D.J. Besharov, "Mandatory Reporting of Child Abuse and Research on the Effects of Drug Exposure." Paper presented at the National Institute on Drug Abuse Technical Review Meeting on Methodological Issues in Epidemiological, Prevention, and Treatment Research, Baltimore, MD, July 25, 1990.

14. G.L. Zellman, "Child Abuse Reporting and Failure to Report Among Mandated Reporters—Prevalence, Incidence and Reasons," *Journal of Interpersonal Violence* 1(March 1990):3–22.
15. J. Bays, "Substance Abuse and Child Abuse: Impact of Addiction on the Child," *Pediatric Clinics of North America* 4(August 1990):881–904.
16. Center for Substance Abuse Treatment, *Screening and Assessment of Alcohol and Other Drug (AOD)-Abusing Adolescents. The Recommendations of a Consensus Panel* draft copy (Rockville, MD: Center for Substance Abuse Treatment 1993).
17. *Ibid.*
18. R.E. Griffen, "Assessing the Drug-Involved Client," *Families in Society: The Journal of Contemporary Human Services* (February 1991):90.
19. S. Block, chairperson, Tables developed by a subcommittee and approved by the Interagency Council on Child Abuse and Neglect, Los Angeles County, November 4, 1987.
20. J. Belsky, "Child Maltreatment: An Ecological Integration," *American Psychologist* 4(April 1980):320.
21. M.S. Wald and M. Woolverton, "Risk Assessment: The Emperor's New Clothes?" *Child Welfare* 6(November/December 1990):484.
22. P.G. Tjaden and N. Thoennes, "Predictors of Legal Intervention in Child Maltreatment Cases," *Child Abuse and Neglect* 16(1992):807–821.
23. P. Boland and J.L. Henning, "Decision-Making Protocols for Drug-Related Dependency Cases," memorandum from the Juvenile Department, Superior Court, Los Angeles, CA, January 12, 1990.
24. *Ibid.*
25. C.W. Williams, "Dispositional Alternatives Examining the Options for Permanence." Paper presented at the Children Need Permanent Families Conference, Administrative Office of the Court, Raleigh, NC, March 1985.
26. L. Feig, "Drug-Exposed Infants and Children: Service Needs and Policy Questions," Executive Summary. (Washington, DC: U.S. Department of Health and Human Services, Office of the Secretary for Planning and Evaluation, Division of Children and Youth Policy, January 1990).
27. D. Weston, B. Ivins, B. Zuckerman et al., "Drug-Exposed Babies: Research and Clinical Issues," *Zero to Three* 5(June 1989):6.
28. M. McNulty, "Pregnancy Police: Implications of Criminalizing Fetal Abuse," *Youth Law News* 1(1990):35.
29. A. Watahara and T. Lobdell, "Providing 'Reasonable Efforts' to Prevent Removal of Children from Their Homes," *The Children Nobody Knows: California's Foster Care-Dependency System* (San Francisco, CA: California Tomorrow, 1990), 45.

30. M. Ford and J. Kroll, "Challenges to Child Welfare: Countering the Call for a Return to Orphanages," Research Brief No. 1 (St. Paul, MN: North American Council on Adoptable Children, November 1990),17.
31. M. Granger, et al., "Transitional Group Homes for Children with HIV: Support for Children, Families, and Foster Parents," *Zero to Three* 3(February 1989):14.
32. R. Kobler, Personal communication from a foster parent, February 28, 1988.
33. V. Kropenske, "Infants Prenatally Exposed to Phencyclidine: A Descriptive Study of Infant Characteristics and Foster Parents' Caregiving," Master's Thesis, California State University, Los Angeles, December 1989, 92.
34. D. Martin, "Now the Work That's Never Done is Grandmother," *The New York Times*, May 12, 1991, 6.
35. Kropenske, "Infants Prenatally Exposed to Phencyclidine: A Descriptive Study of Infant Characteristics and Foster Parents' Caregiving," 85.
36. S. Chira, "Crack Babies Turn Five and Schools Brace," *The New York Times*, May 25, 1990, 35.
37. Alcoholics Anonymous, *One Day at a Time in Al-Anon* (New York: Al-Anon Family Group, 1985), 1.
38. L. Stein and V. Mistiaen, "Pregnant in Prison," *The Progressive* (February 1988):18-21.
39. Cocaine Babies Project Community Services Department, *A Challenge for All: Recommendation for a Community-Wide Response to Drug-Involved Infants and Mothers* (St. Petersburg, FL: Cocaine Babies Project Community Services Department, Juvenile Welfare Board of Pinellas County February 1990),1.
40. National Association of Public Child Welfare Administrators, *Guiding Principals for Working with Substance-Abusing Families and Drug-Exposed Children: The Child Welfare Response* (Washington, DC: American Public Welfare Association, 1991), 3.
41. R. Horowitz, "Parental Substance Abuse: Legal Issues for Child Protection Investigation," *Protecting Children* 4(Winter 1989/1990):22.
42. A list of **Other Resources** is provided in this manual for readers seeking specific information on model programs and interagency approaches. For example, the CSAP National Resource Center acts as the Nation's focal point for policy, research, information/referral, training, service design, technical assistance, and evaluation findings of programs targeting substance-abusing pregnant and post-partum women and their children. The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) develops and disseminates Treatment Improvement Protocol Statements (TIPS)—one on substance-abusing pregnant women and another on drug-affected infants. TIPS are designed to assist policy makers, administrators, and practitioners dealing with substance abuse at State and community levels. CSAT is also involved in a collaborative effort with Head Start Centers to provide training to child welfare caseworkers, refer families to drug treatment centers, and enhance family access to needed drug treatment and social services. Head Start has also initiated a national effort to develop a program component that helps staff identify

families that have substance abuse problems and refer them to community agencies for appropriate services and treatment. In addition, the Emergency Child Abuse Prevention Service Grant Program within the National Center on Child Abuse and Neglect focuses on the coexisting problems of substance abuse and child abuse.

GLOSSARY OF TERMS

The reader is referred to Appendix I. for a summary discussion of common substances of abuse, including terminology and commonly used paraphernalia.

Child Protective Services (CPS) - the designated social service agency (in most States) to receive, investigate, and provide rehabilitation services to children and families with problems of child maltreatment. Frequently, this agency is located within larger public social service agencies, such as Departments of Social Services or Human Services.

Cognition - an individual's awareness of objects, thoughts, or perceptions.

Confidentiality - a provision in all State child abuse and neglect reporting laws that protects the privacy of children and families by not permitting information about the finding of the child maltreatment report to be released to other agencies without permission of the family. In some States, members of multidisciplinary teams may receive information without a release from the family.

Etiology - the cause or origin of a disease.

Family Assessment - the stage of the child protection process when the CPS caseworker, community treatment providers, and the family reach a mutual understanding regarding the most critical treatment needs the must be addressed and the strengths on which to build.

Family Preservation/Reunification - established in law and policy and based on the philosophical belief of social services agencies that the child(ren) and family(ies) should be maintained together as long as the safety of the child can be ensured.

Good Faith - the standard used to determine if a reporter has a reason to "suspect" that child abuse or neglect has occurred. In general, good faith applies if any reasonable person, given the same information, would draw a conclusion that a child "may have been abused or neglected."

Guardian Ad Litem - legal counsel assigned to represent the best interest of the child in juvenile and family court proceedings.

Immunity - established in all child abuse laws to protect reporters from civil lawsuits and criminal prosecution resulting from filing a report of child abuse and neglect. This immunity is provided as long as the report is made in "good faith."

Mandated Reporter - one who in his/her professional capacity is required by State law to report "suspected" cases of child maltreated to the designated State agency. Some States clearly spell out that teachers, principals, nurses, and counselors are included, while other States designate all school personnel.

Multidisciplinary Team - established between agencies and professionals within the child protection system to mutually discuss cases of child abuse and neglect and to aid decisions at various stages of the child

protection system case process. These teams may also be designated by different names, including child protection teams, interdisciplinary teams, or case consultation teams.

Multiservice Intervention - the delivery of a broad range of community services available from a multiple providers combined with individual counseling, individual and group parenting education, and family therapy.

Parent/Caretaker - person responsible for the care of the child.

Penalty for Failure to Report - all State child abuse reporting laws stipulate penalties for failing to report suspected instances of child abuse to the designated State authority. The penalty usually consists of a charge of a misdemeanor, which can result in a fine or jail term.

Polysubstance Abuse - the use of multiple drugs or the use of a combination of drugs, alcohol, and nicotine.

Post-traumatic Stress Disorder - the development of specific symptoms following a psychologically distressing event that is outside the range of common human experiences such as bereavement, illness, business failure or chronic financial worries, or marital conflict.

Protocol - an interagency agreement between CPS and other social service agencies and/or professionals that delineates joint roles and responsibilities and establishes criteria and procedures for working together on cases of child abuse and neglect.

Reasonable Efforts - as required by State law, the State welfare agency must make reasonable efforts to keep the family together, or if the child has already been removed, to reunify the family. Before a State may receive Federal financial support for the costs resulting from a child's removal from home in out-of-home care, a judge must determine that reasonable efforts have been made to keep the family together. Similarly, placement may not be continued with Federal support without a finding by the judge that such efforts have been made to reunite the family.

Relapse - the return of some of the symptoms of a disease or condition after treatment has ceased.

Reporting Policies/Procedures - written referral procedures that designate how to initiate a suspected child maltreatment report and to whom that report should be made. These procedures were established by professional agencies with mandated responsibility to report suspected child abuse and neglect cases.

Resistance - in psychoanalytic theory, the opposition to conscious awareness of repressed material.

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

Risk Assessment - an assessment and measurement of the likelihood that a child will be maltreated in the future, usually conducted using checklists, matrices, scales, and/or other methods of measurement.

Substantiated - a finding made by CPS after investigating a child abuse or neglect report indicating that credible evidence exists that child maltreatment did occur. The criteria used to substantiate a report differ among States. Other terms used by some States include "founded," "supported," or "indicated."

Termination of Parental Rights - a legal proceeding to free a child from a parent's legal custody so that the child can be adopted by others. The legal basis for termination of rights differs from State to State, but

most consider the failure of the parent to support or communicate with the child for a specified period of time, parental failure to improve home conditions, extreme or repeated neglect or abuse, parental incapacity to care for the child, or extreme deterioration of the parent-child relationship as grounds of termination of parental rights.

Treatment - the stage of the child protection case process when specific treatment and services are provided by CPS and other service professionals geared toward the reduction of the risk of maltreatment.

Unsubstantiated - a finding made by CPS after investigating a child abuse or neglect report indicating that there was insufficient evidence to support that child maltreatment occurred. In some States, the term, "unfounded" is used.

SELECTED BIBLIOGRAPHY

GENERAL OVERVIEWS

- Bays, J. "Substance Abuse and Child Maltreatment." *Violence Update* 2(February 1992):3, 6, 11.
- Bavolek, S.J. *A Handbook for Understanding Child Abuse and Neglect*. 2d ed. Eau Claire, WI: Family Development Resources, 1985.
- Besharov, D. J. "The Children of Crack: Will We Protect Them?" *Public Welfare* (Fall 1989): 6-11.
- Child Welfare League of America. *Children At the Front. A Different View of the War on Drugs*. Washington, DC: Child Welfare League of America, 1992.
- Crime Prevention Center, California Attorney General's Office Drugs and Youth. *An Information Guide for Parents and Educators*. Rancho Cordova, CA: Cal Image Marketing, 1990.
- Edwards, H.G.; Ridlen, W.; and Asamoah, Y. "The Relationship of Child Abuse and Parental Alcohol and Drug Abuse to Adult Social Functioning: Research Findings and Program Implications." In *New Directions in Child and Family Research: Shaping Head Start in the 90's*, edited by F.L. Parker, R. Robinson, S. Sambrano, C. Piotrkowski, et al. Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 1992.
- Elkin, M. *Families Under the Influence*. New York: W.W. Norton and Company, 1984.
- Gelles, R. J., and Lancaster, J.B. *Child Abuse and Neglect: Biosocial Dimensions*. New York: Aldine de Gruyter, 1987.
- Los Angeles Unified School District Division of Special Education, Prenatally Exposed to Drugs (PED) Program. *Today's Challenge: Teaching Strategies for Working with Young Children Prenatally Exposed to Drugs*. Los Angeles, CA: LAUSD, 1989.
- Mitchel, L., and Savage, C. *The Relationship Between Substance Abuse and Child Abuse*. Chicago: National Committee for Prevention of Child Abuse, 1991.
- Rodning, C., Beckwith, L., and Howard, J. "Characteristics of Attachment Organization and Play Organization in Prenatally Drug-Exposed Toddlers." *Development and Psychopathology* 1 (1989): 277-89.
- Schmidt, M.G. "Problems of Child Abuse with Adolescents in Chemically Dependent Families." *Journal of Adolescent Chemical Dependency* 1(1991):9-24.
- Thomas, J.N. "Drug Abuse and Child Maltreatment: A Clear and Present Danger." *Protecting Children* 6(1989-1990):4-8,11.

U.S. Department of Health and Human Services. National Center on Child Abuse and Neglect. *Perspectives on Child Maltreatment in the Mid'80s*. (OHDS)84 Washington, DC: Government Printing Office, 1984.

U.S. Department of Health and Human Services. National Center on Child Abuse and Neglect. *Study Findings: Study of National Incidence and Prevalence of Child Abuse and Neglect: 1988*. Washington, DC: Government Printing Office, 1988.

Yoast, R.A. and McIntyre, K. *Alcohol, Other Drug Abuse and Child Abuse and Neglect. Children At Risk Series*. Madison, WI: Wisconsin Clearinghouse, 1991.

Youth Law News XI:1, Special Issue on Drug-Exposed Infants (1990).

INTERVENTION STRATEGIES/APPROACHES

Anisfeld, E., and Cunningham, N. *A Comprehensive Intervention with Cocaine-Abusing Women and Their Infants*. Final Report. New York: Columbia University, College of Physicians and Surgeons, 1992.

DeLeon, G., and Jainchill, N. "Residential Therapeutic Communities for Female Substance Abusers." *Bulletin of the New York Academy of Medicine*. 67(1991):277-290.

Dixon, S. D., Bresnahan, K., and Zuckerman, B. "Cocaine Babies: Meeting the Challenge of Management." *Contemporary Pediatrics* (June 1990): 70-92.

Edelstein, S., Kropenske, V., and Howard, J. "Project T.E.A.M.S." *Social Work* 35:4 (July 1990): 313-318.

Fein, E., and Staff, I. "Implementing Reunification Services." *Families in Society* 72 (June 1991):335-343.

Howard, J.; Beckwith, L.; Rodning, C.; and Kropenske, V. "The Development of Young Children of Substance-Abusing Parents: Insights from Seven Years of Intervention and Research." *Zero to Three* 9(June 1989):8-12.

Jones, V.; Hutchins, E.; and Grason, H.A. "Meeting the Needs of Addicted Mothers and Their Children." *Counselor*. November-December(1990): 13-16,37.

Kumpfer, K.L. "Treatment Programs for Drug-Abusing Women." *The Future of Children*. 1(1991):50-60.

Select Committee on Children, Youth and Families. *Getting Straight: Overcoming Treatment Barriers for Addicted Women and Their Children*. Washington, DC: Government Printing Office, 1990.

Straussner, S.L.A. "Intervention with Maltreating Parents Who Are Drug and Alcohol Abusers." In *Clinical Social Work with Maltreated Children and Their Families. An Introduction to Practice*, edited by E.G. Goldstein, L. Goodman, and J. Seinfeld. New York: New York University Press, 1989.

Tracy, C.; Talbert, D.; and Steinschneider, J. *Women, Babies, and Drugs: Family-Centered Treatment Options*. Denver: National Conference of State Legislatures, 1990.

CHEMICALLY INVOLVED PARENTS

- Azimov, B. "Regulation of Maternal Behavior: An Attempt to Punish Pregnant Women Who Use Drugs or Alcohol." *Journal of Juvenile Law* 12(1991):1-15.
- Bailey, D. A. "Maternal Substance Abuse: Does Ohio Have an Answer?" *University of Dayton Law Review* 17(Spring 1992):1019-1053.
- Barry, W.; White, D.R.; and Yoast, R.A. *Parenting Styles of Substance Abusers*. Madison, WI: Wisconsin Clearinghouse, 1992.
- Bays, J. "Substance Abuse and Child Abuse. Impact of Addiction on the Child." *Pediatric Clinics of North America* 37(August 1990):881-903.
- Bijur, P.E.; Kurzon, M.; Overpeck, M.D.; and Scheidt, P.C. "Parental Alcohol Use, Problem Drinking, and Children's Injuries." *Journal of the American Medical Association* 267(June 17, 1992):3166-3171.
- Black, M., and Schuler, M. "Prenatal Exposure to Cocaine: Neurobehavioral Outcome and Parent-Infant Interaction." In *New Direction in Child and Family Research: Shaping Head Start in the 90's*, edited by F.L. Parker, R. Robinson, S. Sambrano, C. Piotrkowski, et al. Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 1992.
- Burns, W.J., and Burns, K.A. "Parenting Dysfunction in Chemically Dependent Women." In *Drugs, Alcohol, Pregnancy and Parenting*, edited by I.J. Chasnoff. Lancaster, UK: Kluwer Academic Publishers, 1988.
- California State Health and Welfare Agency. *Options for Recovery. Services for Alcohol and Drug Abusing Pregnant and Parenting Women and Their Infants*. Sacramento: California State Health and Welfare Agency, Interagency Task Force on Perinatal Substance Abuse, 1991.
- Chasnoff, I. J., ed. *Drug Use in Pregnancy: Mother and Child*. Norwell, MA: MTP Press, 1986.
- Children's Services Division. *Task Force Report on Alcohol and Drug Abuse Among Pregnant Women and Mothers with Young Children*. Salem, OR: Children's Services Division, 1990.
- Famularo, R.; Kinscherff, R.; and Fenton, T. "Parental Substance Abuse and the Nature of Child Maltreatment." *Child Abuse and Neglect* 16(1992):475-483.
- Finnegan, L. P., and O'Brien Fehr, K. "The Effects of Opiates, Sedative Hypnotics, Amphetamines, Cannabis, and Other Psychoactive Drugs on the Fetus and Newborn." In *Research Advances in Alcohol and Drug Problems*, Vol. 5, ed. O. Kalant. New York: Plenum Publishing Company, 1980, 653-723.
- Griffen, R. E. "Assessing the Drug Involved Client." *Families in Society: The Journal of Contemporary Human Services* (February 1991): 87-94.
- Gustavsson, N.S. "Drug Exposed Infants and Their Mothers: Facts, Myths, and Needs." *Social Work in Health Care* 16(1992):87-100.

- Howard, J. "Chronic Drug Users as Parents." *Hastings Law Journal* 43(March 1992):645-660.
- Kelley, S.J. "Parenting Stress and Child Maltreatment in Drug-Exposed Children." *Child Abuse and Neglect* 16(1992):317-328.
- National Center on Child Abuse and Neglect. *Programs for Substance Abusing Women and Their Families*. Washington, DC: National Center on Child Abuse and Neglect, 1991.
- Rosen, T. S., and Johnson, H. L. "Children of Methadone Maintained Mothers: Follow-Up to 18 Months of Age." *Journal of Pediatrics* 101:2 (August 1982): 192-6.
- U.S. Department of Health and Human Services. *Maternal Drug Abuse and Drug Exposed Children: Understanding the Problem*. Rockville, MD: U.S. Department of Health and Human Services, 1992.
- U.S. Department of Health and Human Services. *Maternal Drug Abuse and Drug Exposed Children: A Compendium of HHS Activities*. Rockville, MD: U.S. Department of Health and Human Services, 1992.
- Wilson, G. S., McCreary, R., Kean, J., and Baxter, J. C. "The Development of Preschool Children of Heroin-Addicted Mothers: A Controlled Study." *Pediatrics* 63:1 (January 1979):135-41.

COURT INVOLVEMENT

- Bross, D. "Medical Diagnosis as a Gateway to the Child Welfare System: A Legal Review for Physicians, Lawyers, and Social Workers." *Denver University Law Review* 65(1988): 213-52.
- Dinsmore, J. *Pregnant Drug Users: The Debate Over Prosecution*. Alexandria VA: American Prosecutors Research Institute, 1992.
- Dolgin, J.L. "The Law's Response to Parental Alcohol and "Crack" Abuse." *Brooklyn Law Review* 56(1991):1213-1268.
- Eddy, W. A. "Motivating Substance Abusing Parents in Dependency Court." *Juvenile and Family Court Journal* 43(1992):11-19.
- Flannery, M.T. "Court-Ordered Prenatal Intervention: A Final Means to the End of Gestational Substance Abuse." *Journal of Family Law* 30(1991-92):519-604.
- Horowitz, R. "Parental Substance Abuse: Legal Issues for Child Protection Intervention," *Protecting Children* 6(Winter 1989/1990): 21-3.
- Garcia, S.A., and Segalman, R. "The Control of Perinatal Drug Abuse: Legal, Psychological, and Social Imperatives." *Law and Psychology Review* 15(Spring 1991):19-64.
- Grimm, B. "Drug-Exposed Infants Pose New Problems for Juvenile Courts." *Youth Law News*. 11(1990):9-14.
- Logli, P.A. "The Prosecutor's Role in Solving the Problems of Prenatal Drug Use and Substance Abused Children." *Hastings Law Journal*. 43(1992):559-567.

Lombardo, C. "Mothers' Prenatal Drug Use: Sufficient Grounds for Juvenile Court Jurisdiction." *Journal of Juvenile Law*. 12(1991):116-119.

Roper, M.E. "Reaching the Babies Through the Mothers: The Effects of Prosecution on Pregnant Substance Abusers." *Law and Psychology Review* 16(1992):171-188.

Rubenstein, L. "Prosecuting Maternal Substance Abusers: An Unjustified and Ineffective Policy." *Yale Law and Policy Review* 9(1991):130-160.

REPORTING ISSUES

Atkins, E. "Reporting Fetal Abuse Through California's Child Abuse and Neglect Reporting Law." *Southwestern University Law Review* 21(1992):105-123.

Bross, D.C.; Michaels, L.F.; and Hyden, P. "Suggested Guidelines for Management and Reporting of Suspected Endangerment of Children Through Perinatal Drug Exposure." In *Selected Readings in Child Abuse and Neglect*, compiled by M.L. Lenherr and P. Welch Denver, CO: C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, 1990.

Chasnoff, I.J. "Suggested Protocol for Reporting and Management of Suspect Drug and Alcohol-Related Child Abuse and Neglect." In *Drugs, Alcohol, Pregnancy and Parenting*, edited by I.J. Chasnoff Hingham, MA: Kluwer Academic Publishers, 1988.

McCurdy, K. *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1992 Annual Fifty State Survey*. Chicago, IL: National Committee for the Prevention of Child Abuse, 1993.

Roach, W.H., Jr. and Cosgrove, M.J. "Substance Abuse Record Confidentiality and Child Abuse Reporting Requirements." *Topics in Health Record Management* (1981):81-84.

OTHER RESOURCES

ACTION for Child Protection
4724 Park Road
Unit C
Charlotte, NC 28203
(704) 529-1080

American Professional Society on the Abuse of Children (APSAC)
University of Chicago
School of Social Service
Administration
969 East 60th Street
Chicago, IL 60637
(312) 702-9419

Association for Sexual Abuse Prevention (ASAP)
P.O. Box 421
Kalamazoo, MI 49005
(616) 349-9072
(216) 221-6818

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
University of Colorado Health Services Center
Department of Pediatrics
1205 Oneida Street
Denver, CO 80220
(303) 321-3963

Child Welfare League of America (CWLA)
440 First Street, N.E.
Suite 310
Washington, DC 20001
(202) 638-2952

Childhelp USA
6463 Independence Avenue
Woodland Hills, CA 91367
(800)4-A-CHILD or
(800)422-4453

Clearinghouse on Child Abuse and Neglect Information
P.O. Box 1182
Washington, DC 20013
(703) 385-7565

Community Leadership to End Abuse of Children (CLEAC)
2211 Riverside Drive
Suite 14
Ottawa, Ontario, Canada
K1H 7X5
(613) 738-0200

Military Family Resource Center (MFRC)
Ballston Centre Tower Three
4015 Wilson Boulevard
Ninth Floor
Arlington, VA 22203
(703) 385-7567

National Center for the Prosecution of Child Abuse
1033 North Fairfax Street
Suite 200
Alexandria, VA 22314
(703) 739-0321

National Center on Child Abuse and Neglect (NCCAN)
Administration on Children, Youth and Families
Administration for Children and Families
Department of Health and Human Services
P.O. Box 1182
Washington, DC 20013
(703) 385-7565

National Child Abuse Coalition
733 15th Street, N.W.
Suite 938
Washington, DC 20005
(202) 347-3666

National Children's Advocacy Center
106 Lincoln Street
Huntsville, AL 35801
(205) 532-3460

**National Committee for Prevention of
Child Abuse and Family Violence**
332 South Michigan Avenue
Suite 1600
Chicago, IL 60604
(312) 663-3520

**National Council on Child Abuse and
Family Violence**
6033 West Century Boulevard
Suite 400
Los Angeles, CA 90045
(818) 505-3422
(800) 222-2000

**National Resource Center on Child Abuse
and Neglect**
American Humane Association
63 Inverness Drive, East
Englewood, CO 80122
(800) 227-5242
(303) 695-0811