PARENTAL SUBSTANCE ABUSE AND CHILD MALTREATMENT - CHARTING A COURSE FOR GUARDIAN AD LITEM ADVOCACY

A REFERENCE AND RESOURCE MANUAL

June 1994

Office of Guardian ad Litem Services
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Children cannot vote, they do not have the funds to influence society, they are impotent with regard to the control of their own destiny. The societal problem of drug abuse must be managed in new ways to save the children, lest they become overwhelming burdens on society during their childhood and far into their adult years.

[Levy and Rutter, 1992:128]

We must all become advocates of the children of drug abusers. They have no voice of their own; without us they and we as a society are truly lost for a long time to come.

[Levy and Rutter, 1992:165]

CONTENTS

ACKNOWLEDGMENTS

There are a multitude of persons to thank for their help, information, and providing access to the resources needed to produce this work. They are truly too numerous to mention individually, so please understand that this general thanks strongly echoes my individual thanks and appreciation expressed to each of you throughout the project. In the initial stages of the project, several federally funded clearinghouses were contacted to identify relevant projects and programs as well as literature on the topic of child maltreatment and substance abusing parents. This led to contacts throughout the contiguous United States and Hawaii. A similar process was used in North Carolina but, instead of clearinghouses, selected researchers, trainers, and practitioners were contacted for information about North Carolina projects and programs relevant to the topic. Again, through this snowballing technique of going from referral to referral, contacts were made throughout North Carolina and many useful programs, projects, and ideas were identified. Many of these state and national persons, programs, and projects are referred to in this work and in the bibliography accompanying this work. My thanks to all of these persons in North Carolina and throughout the country (including Hawaii) who supported this effort with their time and help.

The preceding paragraph refers to researchers, practitioners, and others in organizations other than Guardian ad Litem. The bulk of these persons represent social work agencies; public and private substance abuse services; public health programs; and community family services. Although there are allegations and sometimes spectacular examples of the lack of meshing of these many "system" elements, and indeed the "asystematic" nature of the so-called human services system, I encountered a singular desire to make the future of all children the best that it can be. It appears that the artificial boundaries set by human bureaucracies often create significant barriers for interagency wholistic implementation of the commonly shared hopes and desires of those who inhabit the human services system.

The Guardian ad Litem program data are presented separately from the above human service agencies because the GAL program is the focus of this study. However, they too share the above-mentioned desire to make the future of all children the best that it can be. They too are an important part of the human services system.

My thanks go to the many volunteer GALs around the state who took an hour or two to share their experiences and insights with me. Thanks also to the district administrators who took time from their busy schedules and paperwork to do my paperwork to select those volunteers who met several criteria that I had designated. My additional thanks to the district administrators and/or their support staff for taking the time to answer my lengthy questions about their program and their parental substance abuse cases. I learned a lot and I have developed a healthy respect for the important job that GAL volunteers and program staff are doing throughout North Carolina. I sincerely hope that this project product proves useful in a variety of ways for each of your programs.

This project was housed in the State Office in Raleigh. That's where I worked most of the time. I want to take this opportunity to thank everyone in the State Office for supporting my efforts and for creating an environment in which this work could be successfully completed.

My thanks to the regional administrators, Alma Brown, Cy Gurney, and Marilyn Stevens who facilitated my initial contacts with the various districts throughout the state.

When the first draft of this work was completed, several persons were instrumental in helping to "polish" it. They helped to make it a better document - although any shortfalls are not theirs but are my responsibility. Ilene Nelson, the Division Administrator, read it, made several useful suggestions, and despite its bulk, remained cheerful and encouraging. Cindy Bizzell, Assistant Administrator, read it, made many detailed comments, and gave the work its title. At the beginning of the project I asked Cindy to be my project monitor. My special thanks to Cindy for playing that important role. Cindy has been highly supportive and helpful throughout the project. The third reader, Rosemary Ritzman, Program Evaluator and the author of the phase one project report (this work is phase two), did extensive editing which vastly improved the readability of the report. Rosemary took the material which was chapter V (it's now Appendix B) and rewrote it as the current chapter V. This was, in my view, an onerous task which she accomplished with the greatest of skill. Finally, Linda Ward took the raw draft and crafted it with the word processor into a form which greatly enhances its content for the reader. Linda also assumed the very important responsibility for keeping track of the full work in its frequently dissembled (owing to its large size) form and of the various and sometimes seemingly whimsical changes that were made.

I am very grateful for the help and support of Ilene, Cindy, Rosemary and Linda. Their contributions have been especially significant. Thank you very much.

Again, my thanks and best wishes to the many persons that I had the privilege of getting to know and to talk with, if only for a short while.

Jay R. Williams, Ph.D.
Raleigh, North Carolina

I. INTRODUCTION

This report is the result of the second phase of a two phase project entitled, *Intensive Substance Abuse Case Advocacy Program.* Phase one was a statewide survey of Guardian ad Litem (GAL) volunteers to determine the number of cases in which parental or caretaker substance abuse was identified. The patterns found among a variety of variables for those cases are reported in *Intensive Substance Abuse Case Advocacy Program: The Survey* (1993). Phase two of the effort was mandated to "develop an advocacy model designed to prevent removal of the child and, in such cases where removal is necessary, facilitate family reunification by addressing child and family service needs." This is in concert with the stated mission of the Guardian ad Litem program as found in the policy manual.

Mission

> To provide trained advocates who represent the best interest of every abused, neglected or dependent child involved in the court system and work toward a comprehensive service system for children that enables them to reach their full potential in a safe environment.

This report provides GAL staff and volunteers with information on parental substance abuse and its relationship to child abuse and neglect. Based on this information GALs should be sensitized to the many facets of this issue and to various resources that are potentially helpful. Since many of those resources are not uniformly available across the state, volunteers will discover many alternatives for which they can appropriately advocate. Each GAL district program has its own unique set of conditions in which it must operate. Also, each GAL district program has notions of how those conditions can best be addressed. Thus, local programs will need to pick and choose which information and suggested resources are most likely to resolve their special needs. After reading this report GAL personnel (staff and volunteers) should be better able to target advocacy issues and take action on whatever is indicated for their locality. The report describes specific programs and identifies contact persons who have successfully implemented these programs. In addition, training needs of volunteers on issues of children in substance abusing families will become clearer, and a variety of training resources are provided.

II. SOURCES OF INFORMATION

Information about parental substance abuse and child maltreatment exists in many forms. There is an extensive literature on this topic which is sampled in the selected bibliography at the end of this work. There are a large number of organizations (governmental and private) devoted to general child protection issues which sponsor community programs and research relevant to parental substance abuse and child maltreatment. Appendix A lists some of those resources.

While the project is focused on the role of the GAL volunteer in child maltreatment cases where there is parental substance abuse, the GAL volunteer typically enters the picture after an array of professionals have intervened. To prepare for the interviews with the GAL district administrators and volunteers, information from other participants in the system was indicated. Chapter IV presents information from a variety of selected North Carolina practitioners in the field who have experience with these cases day in and day out. The viewpoints and information gleaned from these sources were invaluable for helping to sharpen the issues and thereby the focus of the GAL interviews that followed.

Turning to out-of-state programs, three particularly outstanding programs were identified and visited. [Additional information on these and other outstanding programs identified during the project is found in Chapter VII.] One of these programs, Michigan's Families First program, was visited before the GAL interviews began. During the visit to the Michigan program, approximately twenty staff persons from the Lansing office and the Detroit program were interviewed, and two home visits were made to substance abusing families in Detroit. These persons are not included in the count given in Chapter IV of pratictioners and others interviewed.

The other two visits were made to programs in Newport News (On-Target Program) and Hampton (Hampton Family Resource Project), Virginia. [See Chapter VII.] These two visits occurred at the end of the interviewing of the GAL district administrators and volunteers. Again, during these two visits approximately ten program staff persons were interviewed. These persons are also not included in the count in Chapter IV.

In preparation for the GAL field interviews, a memorandum was provided the regional administrators to elicit volunteers for the interviews. Thirty of the thirty-three districts with volunteers responded. Cases were requested which had the following attributes:

- GAL volunteers with moderate to extensive experience with substance abuse cases
- Alcohol is the major drug abused; drug other than alcohol is the major drug abused; polydrug abuse
- Case in beginning phase, middle phase, or final phase

The district administrator was contacted by telephone and asked for more detail on the case submitted. Interviews were selected based on type of case, availability of persons for interviewing, and location in the state. In the selection process efforts were made to obtain as much variability in cases as possible within the travel and time constraints existing. Twenty-one districts were visited yielding, on average, two interviews per district (on some occasions there was only one interview and on some occasions there were as many as three interviews completed). At most sites, the district administrator and/or a support staff person was interviewed. Selected questions from the interview guide developed for the GAL volunteer interviews [see Appendix C for the interview guide used] were used to get an overview of substance abuse cases handled by that district. The GAL volunteer was asked questions specific to the case that had been selected for the interview. In both cases, the questions were general guidelines for information. If the interview led in directions that were not covered by the guide but appeared to be productive, they were pursued. Cooperation was excellent throughout the interviewing process. The concern and caring about this issue highlighted the professional way in which these GAL staff and volunteers conducted themselves as well as punctuating the appropriateness of focusing on this difficult problem.

In addition to a literature search, visits to selected out-of-state programs, and interviews — departments of social services throughout the United States were sent a letter requesting a copy of their risk assessment form with special emphasis on substance abuse as a factor in risk assessment. Risk assessment provides insight into the factors considered by child protective service workers when they must decide if the child is safe in their current setting and if there is a risk of future harm to the child. Risk assessment instruments and material were received from eighteen states. Several states replied that they were in the process of developing risk assessment materials but had nothing available to share at that point in time.

The remainder of this report presents the findings of these multiple sources of information. Hopefully the reader will be able to find useful information throughout which will suggest advocacy strategies and enhance advocacy action. In Chapter III there is a review of the recent literature on the topic. Chapter IV reports the results of interviews with practitioners and others working in the areas of child maltreatment and/or substance abuse. Chapter V summarizes the finding of interviews with the GAL volunteers and staff (the full responses are found in Appendix B). Guidelines are presented in Chapter VI for working with substance abusing families. These guidelines are culled from a variety of current sources. Noteworthy programs of potential interest to GALs are described in Chapter VII. Finally, Chapter VIII suggests four areas in which GALs may profitably focus their advocacy efforts. The bibliography which follows provides a rich source of additional information that may be pursued by the interested reader. The three appendices provide information on relevant resources and resource organizations; a full version of GAL volunteer and staff interview responses; and a copy of the interview guide for those interested in knowing about the instrument's specifics.

III. BACKGROUND

Concerns about child abuse, neglect and dependency have heightened in recent years due, in large part, to issues of substance abuse among the mothers of those children. The FBI Uniform Crime Reports total arrest trends for the years 1983 to 1992 report an increase in drug abuse violations for males of 53 percent and an increase of 84.7 percent for females (Federal Bureau of Investigation, 1993:222). These data report arrests made by the police for the use, possession and/or trafficking of illegal substances. Although the data serve as only a rough indicator of the actual number of substance abusers, nevertheless, they show a dramatic increase of females involved with the police during this time period for drug violations.

The significance of this increase in female substance abuse for child abuse and neglect is described by Kinscherff and Kelley.

> Maternal use of drugs and alcohol during pregnancy and child rearing is one of the most significant contemporary problems facing professionals in the field of child maltreatment. Fetal alcohol exposure is the "leading cause of mental retardation in the Western world" (American Medical Association, 1989). The National Institute on Drug Abuse estimates that six million women of childbearing age use illegal drugs, with one million using cocaine (Office of Inspector General, 1990).
>
> (Kinscherff and Kelley, 1991:3)

The National Committee for Prevention of Child Abuse (1989) reports that nationally, 60 percent of confirmed cases of child abuse and neglect involve drug or alcohol abuse. And, the Children's Defense Fund notes that:

> Nationwide, the number of children reported abused or neglected almost tripled since 1980, increasing 40 percent between 1985 and 1991. *The three most prevalent problems among families reported for abuse and neglect are economic stress, difficulties in handling parental responsibilities, and substance abuse.*
>
> (Emphasis added)
> (Children's Defense Fund, 1992:62)

These "most prevalent problems" will be addressed later. The issue that this raises is the complex interaction of poverty, racism, sexism and substance abuse.

The estimates for cases in which there is child maltreatment and substance abuse in the family vary. McCullough (1991) writes that "Nationwide, it is estimated that between 30% and 90% of all confirmed child abuse cases and as high as three quarters of child abuse fatalities in some cities involve families where there is some degree of adult abuse of drugs and alcohol" (p.62). The Child Welfare League of America (1990)

in a review of "numerous, isolated studies" reports that estimates range from fifty percent to eighty percent. Blythe, Jiordano, and Kelly (1991) note that a review of protective services across the state of Michigan showed sixty to seventy percent of families had problems with substance abuse. The more recent and rigorous nationally representative study of Crosse, Kaye, and Ratnofsky (1994) puts the estimate at 41.6 percent. A state study done for North Carolina (Office of Guardian ad Litem Services, 1993) puts the estimate for North Carolina at 46 percent. Clearly, whatever the exact proportion is, there are a large number of child abuse and neglect cases in which caretaker substance abuse is implicated.

Both drug abuse and child abuse and neglect have increased in the last ten years (Children's Defense Fund, 1992; Federal Bureau of Investigation, 1993). Clearly more children are at risk and with them the whole of society. It is in the common interest to have each child reach their full potential in a safe environment. The role of the GAL volunteer advocate in achieving this end is a vital one. How to best advocate for the children of substance abusing families is the focus of this report.

The Child Welfare League of America in a volume entitled, *Crack and Other Addictions: Old Realities and New Challenges for Child Welfare* (1990) describes the problem of parental substance abuse and child abuse and neglect as follows:

> Children are the most innocent and vulnerable victims of the drug epidemic. As many as one-hundred alcohol- or drug-exposed babies are born each day, and thousands of older children live in homes where they compete with drugs and alcohol for their parent's attention and, at times, for their basic survival. The well-documented link between the abuse of alcohol and other drugs and family violence is not new. But what has changed with the advent of cocaine — and especially crack — is the number of chemically dependent women with children. Never before have children and families been so at risk from the effects of drugs. In many communities females now outnumber males in the abuse of cocaine.
>
> Reliable national data on the prevalence of child maltreatment among parents who abuse alcohol or other drugs is elusive because there is no systematic national child abuse data reporting system to collect that information. When one examines the numerous, isolated studies that have been done, however, the correlation between the use of illicit drugs, especially crack, and child abuse or child fatalities is alarming. Estimates are that, overall, 50% to 80% of all confirmed child abuse reports and almost three-quarters of fatalities involve some degree of parental abuse of drugs or alcohol.
>
> In 1989, 2.4 million reports of suspected child abuse or neglect were filed in the United States, a 9% increase. More than 900,000 reports were substantiated. In congressional testimony, and in hearings by the United States Advisory Board on Child Abuse and Neglect, alcohol and other drug abuse is the cause most frequently cited for the dramatic increase in child protective services referrals. In many cities, chemically exposed

> infants and children of chemically dependent parents make up the majority of child protective service caseloads. A study examining case records in Boston found that 64% of all substantiated child abuse and neglect cases involved parental alcohol or drug abuse; for children less than one year old, substance abuse was a factor in 89% of the cases.
>
> (Child Welfare League of America, 1990: 161-162)

The National Center on Child Abuse and Neglect has just released a study which presents nationally representative data on child maltreatment in alcohol abusing and illicit drug abusing families (Crosse, Kaye and Ratnofsky, 1994). In recognition of the "close correlation" between alcoholism, alcohol abuse, and illicit drug abuse these two types of substance abuse were included in data collection and separately analyzed in the study report. Caseworkers in a national sample of Child Protective Service (CPS) agencies were asked to provide information about suspected or known alcohol or drug abuse for each adult in a family in which child maltreatment was substantiated. Since polydrug use is common among substance abusers (Abadinsky, 1989; Duncan and Gold, 1982), the caseworkers were asked to indicate the "primary substance" (i.e., the substance which "causes the most harm or is used most frequently") that was being abused **prior to the maltreatment.** In this manner alcohol abusing families were identified (alcohol was the "primary" substance abused) and illicit drug abusing families (illicit substances or licit substances used illicitly were the "primary" substance abused) were identified independently. The report notes that "approximately 39.1 percent of the alcohol abusing adults in families of maltreated children also abused illicit drugs" (Crosse, Kaye and Ratnofsky, 1994:4-1). The authors use the term "substance abuse" to encompass alcohol abuse and/or illicit drug abuse.

For all maltreated children identified during the study period, 23.8 percent were found in alcohol abusing families and 17.8 percent were found in illicit drug abusing families. Hence, an estimated 41.6 percent of maltreated children (as substantiated by CPS) nationally are in substance abusing families. For a variety of reasons, the authors suggest that their figures may be slightly underestimated. As noted above, the National Committee for Prevention of Child Abuse estimates that nationally 60 percent of the child abuse and neglect cases involve drug or alcohol abuse while the Boston study cited by the Child Welfare League of America (see above) estimates a 64 percent involvement with substance abuse.

Some major findings of the study by Crosse, Kay and Ratnofsky are quoted below. Keep in mind that their study estimates are probably conservative. Also note that CPS workers did substantiate maltreatment of all the children in the study.

Maltreatment of Children in Alcohol Abusing Families

- For the representative sample of maltreated children studied, in alcohol abusing families, 65.3 per 1,000 children were maltreated. This rate was more than 3.6 time higher than the rate for children in non-alcohol abusing families (17.9 per 1,000 children). Maltreatment

included **physical**, **sexual**, and **emotional abuse**, as well as **physical**, **educational**, and **emotional neglect**.

- The incidence of **emotional neglect** (17 per 1,000 children) among maltreated children in alcohol abusing families was 10 times higher than for maltreated children not in alcohol abusing families.

- Among maltreated children in alcohol abusing families, the incidence of **physical abuse** was 12 per 1,000 children, a rate 2.8 times that for maltreated children in non-alcohol abusing families.

- Among maltreated children in alcohol abusing families, the incidence of **sexual abuse** was 2.9 times that for maltreated children in non-alcohol abusing families (5.2 per 1,000 compared with 1.8 per 1,000).

- Among maltreated children in alcohol abusing families, the incidence of **physical neglect** was 28 per 1,000, a rate 4.7 times that for maltreated children in non-alcohol abusing families.

Maltreatment of Children in Illicit Drug Abusing Families

- Among children whose maltreatment had been substantiated by a CPS agency, children in illicit drug abusing families were **more likely** to have experienced **physical neglect**, **inadequate supervision**, expulsion and **refusal to care for the child**, and to have been born with a **positive alcohol or drug toxicology** than were children in families without illicit drug abuse.

- Among children whose maltreatment had been substantiated by a CPS agency, children in illicit drug abusing families were **less likely** to have experienced **physical abuse** and **sexual abuse** than were children in families without illicit drug abuse.

- Nearly all of the primary caretakers suspected of illicit drug abuse were the **biological mothers** of the maltreated children. Among children whose maltreatment had been substantiated by a CPS agency, primary caretakers who were suspected of illicit drug abuse were more likely to be **under the age of 30** and **never married** than were primary caretakers who were not suspected of illicit drug abuse.

- Primary caretakers suspected of illicit drug abuse were much more likely to be the **perpetrators** of the maltreatment than those not suspected of illicit drug abuse (96 percent vs. 53 percent).

Demographic Characteristics Compared

- Among children whose maltreatment had been substantiated by a CPS agency, children in **alcohol abusing families** were more likely to be in families with **annual incomes under $10,000**, **White**, and **under five years old** than were children in families without alcohol abuse.

- Among children whose maltreatment had been substantiated by a CPS agency, children in **illicit drug abusing families** were more likely to be in families with **annual incomes under $10,000**, **Black**, and **under age one** than were children in families without illicit drug abuse.

Case Processing Compared

- Cases **without suspected familial alcohol abuse** were **more likely to be closed immediately** after CPS agency substantiation than were cases involving suspected alcohol abuse (33 percent vs. 20 percent).

- Cases **without suspected illicit drug abuse** were **more likely to be closed immediately** after substantiation than cases involving suspected illicit drug abuse (33 percent vs. 12 percent).

- Among children whose maltreatment had been substantiated by a CPS agency, the rate of **placement into foster care** during the 3 or 4 months after substantiation was 30 percent for children in **alcohol abusing families** compared with 17 percent for children not in alcohol abusing families.

- **Families suspected of illicit drug abuse** were more likely to have a child **placed in foster care** during the first 3 to 4 months after substantiation than were families without suspected illicit drug abuse (29 percent vs. 19 percent).

Substance Abuse As a Contributing Factor in Maltreatment

- Among maltreated children with **substance abusing perpetrators**, 65 percent of the children were maltreated while the **perpetrator was under the influence of alcohol or illicit drugs**.

- CPS caseworkers reported that **familial substance abuse either led to or contributed to** the maltreatment of 78 percent of the maltreated children **with substance abusing perpetrators**.

(Emphasis added)
(Crosse, Kaye, and Ratnofsky, 1994:xi-xiii)

This remarkable study gives significant insight into the relationship between substance abusing families (alcohol and/or illicit drugs) and child abuse and neglect. Kinscherff and Kelley (1991:3) comment, "Although to date no studies have established a cause and effect relationship between maternal substance abuse and child maltreatment, children in substance abusing families are clearly at increased risk for child abuse and neglect." Clearly, then, there is a relationship although it may not be causal.

It has been suggested by several authors (Child Welfare League of America, 1990; Kinscherff and Kelley, 1991; Child Welfare League of America, 1992; Levy and Rutter, 1992) that the relationship between substance abusing families and child abuse and neglect is strongly mediated by low income levels and the attendant fellow travelers of persistent poverty - inadequate and unstable housing, inadequate and inaccessible health care, unemployment, low self esteem, poor self concept, and poor parenting skills to mention a few. This view is strongly supported by Blythe, Jiorodano, and Kelly (1991) when they wrote about their experience with the Michigan Families First program:

> Although service providers have tended to focus on "the drug problem", Families First therapists found that drugs were much less of a problem than were systemic barriers. The lack of decent, affordable housing, poverty, inadequate social support networks, the limited education level and/or job skills of the parents, and racial and general biases of the treatment system all work together to make it difficult for parents to make changes.
>
> (Blythe, Jiordano, and Kelly, 1991:13)

Levy and Rutter, after arguing that the life-style of the substance abuser is an "impoverished life-style," summarize this best when they say "... addiction is not simply about drugs: It is also about poverty and desperation. It is also about sexism, racism, and classism. It is also about continuing threats to our children and the perpetuation of cycles of poverty and despair." (Levy and Rutter, 1992:19) Again, this is to suggest that lack of resources combined with substance abuse may be a large part of the critical formula for child abuse and neglect.

As was indicated in the Introduction, this report is the result of the second phase of a two phase effort. Phase one involved a study of GAL cases in the state of North Carolina. A purposive sample of twenty-one counties was drawn in which GAL programs were operative at that time. A comparison of sample characteristics with state characteristics on selected demographic variables indicated that the sample was reasonably representative of the state GAL programs as a whole. This study, *Intensive Substance Abuse Case Advocacy Program: The Survey* (Office of Guardian ad Litem Services, 1993), reports on the North Carolina situation where GAL volunteers are involved in cases where there is parental substance abuse and child maltreatment. Some of the findings of that study are reported below.

Eighty-nine percent of the caretakers in the North Carolina sample were natural parents with the other caretakers being step-parents, grandparents, boyfriends or

girlfriends, and others. Of all the caretakers identified, 67 percent were females and 33 percent were males. The mean number of children per family was 2.2; the mean age of oldest children in these families were 9.29 years. Forty-six percent of the caretakers were substance abusers (note that this closely matches the 41.6 percent figure in the Crosse, Kaye, and Ratnofsky (1994) national study discussed above). While the Crosse, Kaye, and Ratnofsky study ascertained the "primary" substance being abused in the household, the North Carolina study reports the singular use of alcohol or other drug and polydrug use. Nevertheless, the figures are quite similar. The North Carolina study reports 21.6 percent of caretakers are alcohol abusers compared to 23.8 percent reported by the Crosse, Kaye, and Ratnofsky national study. In North Carolina 5.9 percent were found to abuse other drugs, not including alcohol. In contrast Crosse, Kaye, and Ratnofsky reported 17.8 percent to be primary users of drugs other than alcohol; it is not clear what proportion of these also abused alcohol. However, 18.1 percent in North Carolina were reported to abuse both alcohol and other drugs. Clearly then alcohol is the more frequent drug of choice in these child maltreatment cases.

For drugs other than alcohol, the North Carolina study reports that marijuana (36.8 percent), cocaine (34.2 percent), and crack cocaine (12.1 percent) are the most frequently abused drugs in the families studied. The use of all other drugs (other than alcohol) ranges from one percent to three percent (with the exception of unspecified prescription drugs which are found 4.8 percent of the time).

Of the cases adjudicated in the North Carolina study, 28.9 percent were abuse cases and 55.2 percent were neglect cases.

When the GAL volunteer respondents to the survey were asked to identify the factors contributing to child maltreatment, they indicated alcohol abuse was a contributor 40.9 percent of the time and drug abuse (other than alcohol) 23.7 percent of the time. It should also be noted that other factors were identified as contributors that are consistent with the reports of other authors (Child Welfare League of America, 1990; Kinscherff and Kelley, 1991; Child Welfare League of America, 1992; Levy and Rutter, 1992) that the relationship between substance abusing families and child maltreatment is joined by factors than are indicative of an impoverished lifestyle. These factors include unstable living conditions (51.2 percent), insufficient income (39.9 percent), single parent (38.4 percent), low socioeconomic status (36.2 percent), unemployment (37.5 percent), inadequate housing (32.3 percent), social isolation (17.4 percent). In addition, lack of parenting skills (67.4 percent) was the number one identified factor contributing to child maltreatment. This too can be seen as a possible outcome of an impoverished lifestyle. One of the strongest statistical relationships reported in the North Carolina study was the relationship between a composite poverty indicator and substance abuse of parents or caretakers. Seventy-eight percent of the substance abusing families were in the poverty category.

The characteristics of the children who were maltreated in the North Carolina study further reflect the negative impact an impoverished lifestyle, parental substance abuse and a dysfunctional family may have on children. Children's characteristics were identified as follows: emotional behavioral problem (30.9 percent), physical and or mental handicap (17.6 percent), fetal alcohol syndrome (16.2 percent), and born a cocaine addict (11.6 percent). Unfortunately, the substance abusing family may have

heavily contributed to the children's developing these characteristics. In turn these characteristics put them at risk for abuse and/or neglect because the parent's social psychological makeup (the product of such things as poverty and substance abuse) cannot tolerate their children's conditions and related behavior.

Finally, in the North Carolina study (1993) the relationship between type of child maltreatment and type of substance abused by the child's caretaker corresponds to what Crosse, Kaye, and Ratnofsky (1994) report. In both these studies alcohol is more likely to be associated with abuse than are illicit drugs. Further, both studies report that other drugs are more likely to be associated with neglect than is alcohol. A similar pattern is reported by Littell and Kim (1990:6-4) in their study of substance abuse among clients of the Families First program in Illinois.

In 1980 Congress passed the Adoption Assistance and Child Welfare Act of 1980 (known as Public Law 96-272). This act has been called "the most important piece of child welfare legislation enacted in the past twenty years, a blueprint for a new combined effort on the part of the judicial, executive, and legislative branches to preserve families and, if necessary, to build new ones." (National Council of Juvenile and Family Court Judges *et al.*, nd) Shotton (1989-90) in a review of P.L. 96-272 ten years later outlines the history of the law.

> Before passing P.L. 96-272, Congress heard testimony over a five-year period about our country's treatment of abused and neglected children and their families. The most striking fact presented was the astonishing number of children who were being removed from their families and placed in foster care, many for the entire duration of their childhoods. . . . While lost in a system that could neither return them to their families nor place them with adoptive parents, these children often moved from foster home to foster home, becoming more and more disturbed with each move.
>
> (Shotton, 1989-90: 224)

Among the major provisions of P.L. 96-272 is the requirement that judges determine whether "reasonable efforts" have been made to keep children safely at home rather than moving them into foster care. If children have already been removed from the home the judge is required to see that "reasonable efforts" are made to reunite the children with their natural family. Underlying this mandate is a belief in the importance of attachment and bonding of the child and parents as well as the belief that separation of children from their parents has negative effects on the children (see for example, Krugman, 1971; Goldstein, Freud, and Solnit, 1973, 1979; Fahlberg, 1979; Barthel, 1991; Shillington, 1993). The tenets of these beliefs are succinctly summarized in the training curriculum of Michigan's Family First program. They are as follows:

- Children have a right to their family.
- The **family** is the focal point of child welfare services.

- Our first and greatest investment is to the care and treatment of children in their own homes.
- The family is the fundamental resource for the nurturing of children.
- Parents should be supported in their efforts to care for their children.
- It is in the best interest of the child for his or her family to remain intact in the absence of compelling evidence to the contrary.
- Families are diverse and have a right to be respected for the special cultural, racial, ethnic, and religious tradition [sic] that make families distinct.
- Children can be reared well in different kinds of families and one family form should not be discriminated against in favor of another.

(Michigan Department of Social Services, nd)

Concurrent with the congressional concern over children being removed from their homes and sent into foster care, a small number of programs around the country were "experimenting with new ways to work with families in crisis." (Shotton, 1989-90:224) One effort in particular was to become a highly influential model for preserving families. Bartel (1991) describes this somewhat serendipitous development.

> In 1974, two child psychologists in Tacoma, Washington — Jill Kinney and David Haapala — began the program that led to a national movement of family preservation services. At the time, they had hoped to improve the child welfare system by working on a network of "super foster homes, "where a foster family would receive intensive training, ample staff backup, and increased payments for taking on difficult children. When they applied to the National Institute of Mental Health for a grant, their liaison, Jack Bartleson, suggested they try working with a family *before* a child was removed, by having a social worker move in with a family. They agreed to try the in-home work first, even though some of their colleagues warned they'd need "bulletproof sleeping bags."
>
> "We found out right away that you didn't need to actually move in," Kinney recalls." If you did a good job of listening, people would calm down. Things would begin to look clearer, and emotions would subside. We had no idea what we were supposed to be doing, which was wonderful, because we weren't constrained by program guidelines. We were free to respond to the needs of each family; we could be creative and flexible,"

> After six months, when none of the families they'd worked with had children removed, it was considered mere coincidence. Pure luck. After another six months, when NIMH studied the data, the success rate was sustained.
>
> This pioneering family preservation program was called Homebuilders. By the late 1970s, family preservation services were being offered by a dozen private agencies, with a dozen different names across the country. In 1982, as the model continued to spread, Homebuilders set up its own parent organization, the Behavioral Sciences Institute, to handle training. Now family preservation is a national movement of carefully structured services designed to keep children and parents together safely, to provide an alternative to the automatic removal of a child from the home. Family preservation services are short-term, intensive, crisis-intervention programs used when children are "at imminent risk" of being taken from their families. This approach is remarkably different in practice and philosophy from the traditional social welfare method of helping families.
>
> (Barthel, 1991:14)

The timing for the family preservation program model's development and implementation could not have been better. Shotton (1989-90) notes that P.L. 96-272 unfortunately failed to precisely define the meaning of "reasonable efforts" which is mandated. The law provided no clear guidelines as to how "reasonable efforts" might be implemented or tested. Supreme Court Justice Potter Stewart writing in a concurring opinion on the issue of obscenity and pornography (Jacobellis v. Ohio) said, "But I know it when I see it." In like manner, "reasonable efforts" was left to community standards to be defined. Shotton remarks that to date "Only a few states have attempted to define 'reasonable efforts' in their statutes." (p. 225) Family preservation programs then became a viable solution for the "reasonable efforts" dilemma. Some Department of Social Services have adopted it as the "final reasonable effort." If the child is unsafe in the family and/or the family is unresponsive to the crisis intervention of the family preservation model, then the child will be removed. The child's safety is supposed to always be paramount (Shotton, 1989-90: 227). Barthel (1991:15) describes the goal as ". . . to remove the risk, not the child. To protect children while preserving families."

In the last decade family preservation programs have multiplied. However, many researchers and others are finding that these programs have not flourished in terms of their primary goal of keeping children from foster care (Wells and Biegel, 1991; Rossi, 1992; Schuerman, Rzepnicki, Littell, and Budde, 1992; Vobdjda, 1994). And it has been reported that children in these intensive intervention programs have not always been kept safe, as some children have been abused and/or killed (Vobdjda, 1994). The utility of the family preservation model will be explored later in this paper in a discussion of programs and program models to advocate for.

Some questions raised by these issues at this point are: What are reasonable efforts? What are reasonable efforts for substance abusing parents or caretakers? When is it in the best interests of the child to not keep the family intact? What

conditions (family, neighborhood, etc.) are safe and unsafe for the children of substance abusers? What interventions seem to be the most appropriate and successful for substance abusing families in which there is substantiated abuse and/or neglect? This background section is intended to give the reader an overview of the problem of abuse and neglect in substance abusing families - as much as we currently know. The discussion of P.L. 96-272 was intended to make the reader familiar with the constraints (however they may be defined) placed on decision-makers in these cases where the best interests of the child may be in conflict with preserving the family. Finally, family preservation models and the underlying belief that children will suffer from being removed from their birth family are important for understanding the decisions social service professionals make and the recommendations they make to the court.

The remainder of this paper will look at the experiences and opinions of GAL volunteer workers throughout the state with and about cases in which substance abuse was a factor in child abuse and/or neglect. Guidelines for working with substance abusing families will be offered based on the literature and materials that are relevant. And a review of current outstanding programs that were identified in this phase of the project will be presented. An "ideal" model for advocacy will be presented. Based on this "ideal" model each district GAL program and each GAL volunteer will need to assess the resources available in their program area or beyond. Then they will have a good basis on which to advocate for the use of certain resources or to advocate getting those resources for use.

IV. PERSPECTIVES FROM PRACTITIONERS AND OTHERS

There are various practitioners in the field who have experience with parental substance abuse and/or child maltreatment. Since these practitioners typically encounter child maltreatment cases prior to the involvement of the GAL volunteer, it was important to solicit information from them in preparation for the interviews with the GAL volunteers and staff. Using a snowball sampling approach, individuals and programs were identified in North Carolina. The following types of practitioners and researcher/trainers were interviewed. [Note that this list only refers to interviews done in North Carolina and does not include interviews done on visits to programs outside the state which are referred to in Chapter II.]

DSS (supervisors and workers) (Intake/Treatment and Foster Care)	-	25
Substance Abuse Services (SAS therapists and one residential treatment SAS program manager/therapist)	-	9
Public health	-	5
Former substance abusers (female)	-	4
Community family services program manager/therapist for children and parents	-	2
DSS attorney	-	2
GAL attorney	-	2
Social work researcher/trainer	-	2
Alcohol/drug researcher/trainer	-	1

INTERVIEWS WITH CHILD MALTREATMENT AND RELATED PROFESSIONALS

In preparation for interviewing the GAL staff and volunteer interviews, preliminary interviews were conducted with various professionals in the child maltreatment field and related fields. In addition, a small number of former substance abusing mothers were interviewed. The interview format was open-ended and exploratory. The basic approach to the interviewees was to explain that a research project was being done for the State GAL program. The project focused on parental substance abuse and its impact on child abuse and neglect. The interviewees were invited to comment on all facets of parental substance abuse and child maltreatment. Strategies of intervention with the family and advocacy for the child were also explored. From these interviews came a set of issues and questions which were compiled into an interview guide for the GAL interviews [this interview guide is found in Appendix C].

Following are findings from the interviews with professionals from child maltreatment and related fields as well as a small group of users. Data were organized into common themes that emerged from analysis of the interviews. This section begins with findings from the largest group interviewed, DSS personnel. Each theme or topic area is followed by a mixture of summary information and close paraphrasing of direct quotes. There is no attempt to discuss individual input at this point. A similar format for each additional group follows.

DSS Personnel

Drugs encountered: Alcohol is identified as the biggest drug problem. Alcohol and crack cocaine are the most frequently encountered drugs of abuse. Marijuana is also found (one person commented that unless the use of the marijuana is chronic, it may not be a serious concern). There is some abuse of prescription drugs such as Xanax (a mild tranquilizer). Heroin appears to be making a comeback on the streets. Finally there is the polydrug user who uses a variety of drugs. The main type of polydrug use mentioned is alcohol and crack cocaine.

Family composition: Most families encountered consist of single mothers who are in their mid-twenties. When they get involved with drugs, they begin to have children again. Another scenario is the young female (fifteen perhaps) who begins using drugs and then gets pregnant (often described as the child having a child).

Relationship of type of drug to type of maltreatment: Chronic neglect cases are the most common. The indicators are unpaid bills, leaving children with others (such as neighbors or friends), selling food stamps, no food in the house, and DWI arrests. The drug abusing parent is using their energy and resources for the drug and not to care for the child or children. When alcohol and/or crack cocaine are involved there may be domestic violence which the child may experience as a victim and/or as a witness (as in spouse abuse). Spin-off concerns are that the children

may get access to the drugs and use them or if the parent trafficks in drugs, the child may be the victim of sexual abuse or physical abuse by strangers.

***Substance abuse and its immediate effects on babies*:** Drug abuse by the mother may result in babies who are born addicted to the drug such as crack babies or babies suffering from the effects of maternal alcohol abuse - fetal alcohol syndrome. In addition, substance abusing mothers may give birth to babies who are HIV positive. In foster care there have been some behavior problems noted for children born addicted. Cocaine babies and those born with fetal alcohol syndrome may develop into vicious, violent children.

***Identifying substance abuse*:** The initial complaint is usually neglect. It is difficult to determine substance abuse on a first visit or an initial investigation. Thirty days to investigate is not enough time in drug cases. If DSS can't find the effects of the substance abuse, they can't do anything about it.

Looking around the house you may see that there is drug paraphernalia around the house, no food in the home, little or no furniture in the house, no toys for the children. There are unpaid bills. Food stamps are sold. Children are left with others such as neighbors, friends, or relatives. Otherwise caring mothers who use drugs often don't know where they left their children.

Parent is out cold on the couch. Parent wears long sleeved clothes all the time to cover track marks on arms. There is a lot of traffic going in and out of the house (drug dealing going on). In talking with young children they often make inadvertent comments about parental substance abuse. Up to age eight or nine children will talk about parent's substance abuse unless they have had prior experience with DSS and then they usually shut down.

Prime visitation times to establish drug use is on payday, Saturday night, and when welfare checks or food stamps arrive. This is when money received is used to buy drugs which are then used. However, these are also dangerous times to visit [some felt it was too dangerous to visit during these times particularly if substance abuse was occurring]. For example, for crack cocaine the user typically has a quick temper and can be violent when high. When the user is high on heroin they can not function. With alcohol it depends on the personality but the person can get "ugly or mellow." Coming off the drug the user is often irritable. On or off some drugs the user can be dangerous to the child. On some drugs the child is neglected.

Record checks can be made for criminal activity involving drugs - such as arrest for possession or sale or drugs or arrest for a DWI.

In small communities neighbors and friends may report the parent's substance abuse. In small black communities however, neighbors and friends often will not cooperate with white DSS workers. Neighbors, friends, and relatives are potential sources of information about parental substance abuse resulting in neglect or abuse of children as are the children themselves up to about age eight or nine.

***Assessing safety of child(ren) and risk to child(ren)*:** The child's age is important. Even more important is the maturity level of the child. The highest risk age category is birth to age six. Within that category birth to age three is the most vulnerable since they are non-verbal. Children ages three to six can take care of themselves to an extent. However, children in this age category (birth to six) are vulnerable in part because nobody has to see them (they are not in school and they may be confined to a particular dwelling unit - not seen by teachers, neighbors, etc.). Those at moderate risk are in the age category of six to twelve. In this age group the school can monitor the well-being of the child if they attend school regularly. The least vulnerable age group is twelve to eighteen. While they are also at risk, albeit of a different kind, they can usually care for themselves. In sum, the younger the child, the more risk there is, in general, for neglect and abuse.

Assessing the safety of and risk to the child is complex. Lots of questions need to be asked such as - What kind or kinds of substances are abused? Who is(are) the abuser(s)? Was everyone in the family talked to about the abuse? Are children present when drugs are used and/or sold? How are funds raised to support the substance abuse - use welfare check, sell food stamps, steal and fence, selling drugs, prostitution, or something else? Are the children involved in any of this fund-raising activity (as observers or participants)? What is the parent's ability to maintain a safe home? Is there lack of supervision of the children because of the parent's substance abuse activities? What networks are available for the child (older siblings, a sober parent, grandparents, other relatives, friends, neighbors, or others)? Are there alternative arrangements that can be made for child care? Is there domestic violence connected with the substance abuse? Does the child see the violence or is the child a victim of the violence? Is the mother (or substance abuser) "out of it"? Do the children have access (for their own use) to the substances being abused? Do any of the children have a serious medical need (HIV positive, asthma, etc.) that is not being met? Does the parent sell drugs from the home thereby exposing the children to stranger buyers and possible sexual abuse or physical abuse from them? Is the substance abusing parent unwilling to participate in substance abuse treatment?

Weighing substance abuse factors against other family strengths:

Are there other non-substance abusing caretakers in the home who can and will take responsibility for the children?

Is the parent willing to admit to the substance abuse and to give in to intervention (i.e., activities which support their getting clean)?

Is the parent able to agree to get the child into a place to keep the child safe (perhaps this means giving up the child temporarily)?

Does the substance abuser hold down a regular job?

Is the home stable - is there a lack of constant moving?

Is there a willingness to accept services from outside agencies?

Is there a willingness to accept in-home services?

Can the substance abusing parent focus on issues rather than blame their child and/or DSS? Can they take responsibility for themselves?

DSS beliefs about GAL: DSS deeply believes that children belong with their families unless they are at risk for physical harm. There is a literature on the trauma of separation [see, for example, Fahlberg, 1979] which must be considered in removing a child. DSS has a strong philosophical belief based on experience that children want to be with their birth family. Therefore, if placement is required, it should be made in the extended family whenever possible. Everyone (including DSS) deals with the "best interests of the child."

GAL overemphasizes social/psychological harm. So while there may be no risk of physical harm, the social/psychological environment may be seen as harmful and a reason to remove the child.

Safety vs. best interests - the GAL volunteers use the "white glove test." If the mother does something "immoral," that has a negative impact on the safety of the child in the view of the white glove test.
If one believes that the child belongs in the family, the tolerance for imperfection is broader than if one doesn't believe this.

DSS suggests that GAL volunteers be sensitized to this issue. They might ask themselves - What did their family do that under the microscope would look strange? No family is perfect - what imperfections are tolerable? What is "harmful"? How often is a "bad" or "dysfunctional" family predictive of a troubled child? How often not? How often is a "good" or "functional" family predictive of a non-troubled child? How often not?

Temporarily remove the child(ren): If no responsible caretaker is available for the children - as in the case of a single substance abusing parent; if the children, due to their ages, are especially vulnerable; if the children are in danger, remove the children from the home preferably to the home of a relative. DSS will err on the side of removing the child(ren).

Removal of children makes parent vulnerable: When DSS removes children all support is taken away from the parent - their housing support, AFDC, JOBS program, and public assistance. This makes the parent additionally vulnerable at a time when they are very vulnerable.

What the substance abusing parent must do: The substance abuse problem needs to be taken care of before anything else is done.

The problem with taking care of the substance abuse problem: Resources are not available. Often when the client is ready to go, there may not be a place. When a place is available, the client may not be ready. Counties don't have the resources to treat the substance abuse problem. Clients don't have transportation to treatment.

Prognosis for substance abusing parent: We have had some success with alcohol abuse. Substance abuse - I can't think of anyone that has stayed off drugs for more than six months. This seems to be an intergenerational phenomena - parents and other family members have had substance abuse problems sometimes going back several generations. The prognosis for substance abusers is very poor. However, the extended family usually steps in to take the children.

Return child(ren): In order to return the child to a home where there is or was substance abuse the substance abuser must have demonstrated that they followed the required treatment. There should be a recommendation from the treating counselor that the parent(s) can parent. If the substance abuse problem doesn't clear after three to six months of having the child(ren) removed, then remove the child(ren) permanently. [NOTE: This last position is controversial. Some see this time period as too short. Many are not certain when the children should be permanently removed.]

Relapse: This is part of recovery. One should not go off the deep end and overreact to the relapse. How to react depends on the age of the child. Older children can be trained to recognize the relapse and to ask for help for their parent.

Outcomes experienced: In this county approximately sixty-five percent of children are removed from their families because of drugs - very few of these children are returned and TPR (termination of parental rights) occurs.

***An ideal model for substance abuse treatment and child care*:** Ideally the family should be kept together. Remove the family [child(ren) and substance abusing parent] from their environment for six months minimum. Provide residential substance abuse treatment with the child(ren) present in the residential program. Provide the children with special care as needed and teach parenting skills along with other life skills to the parent. Put things (jobs, etc.) in place when the family leaves residential treatment and returns to a better (if possible) environment.

***Impact of family preservation*:** DSS's utilization of family preservation, an intensive in-home intervention will result in GALs seeing fewer cases in which there is a question of what needs to be done.

***Suggested joint training - DSS and GAL*:** DSS workers need to know more about substance abuse. This is a possible ground on which to do joint training.

***Suggested training - GAL*:** GAL volunteers could observe DSS workers in the field and see how they handle these cases. Arrange this with local DSS agency. This could promote better understanding between DSS and GAL.

Substance Abuse Services and Community Family Services

In this section two categories of interviews are combined thereby representing a total of ten interviews. Both these groups deal with substance abusers and/or their families. This ranges from individual therapy to residential treatment to community in-home family therapy. These then are their views of substance abuse and substance abusers who have responsibility for children. The reader is reminded that topic areas include mostly paraphrases of quotes from interviewees with a minimum of summarization.

***The most frequent case where children are involved*:** Single parent (female) substance abuser.

***Unsubstantiated allegations*:** We are frustrated when we know that children are being neglected or abused and report that to DSS. They investigate and everything looks "good." There is no DSS action. There was one case in which the substance abusing mother was "tricking" (to make money for drugs) in the back seat of a car with the child in the front seat.

***The need for training in substance abuse*:** DSS workers don't seem to understand addiction. They need more training. Social workers do some "enabling" for those who are addicted - but not intentionally. DSS sees drug use as symptomatic of other things. Women are transferred from one DSS worker to another and the workers don't keep up with the case.

90% of families are in denial (for all drugs). Without training, this is almost impossible to detect. However, children in the age range of two to four will tell about substance abuse.

There needs to be substance abuse training for DSS workers, GAL volunteers, and school teachers.

There should be an in-service training for GAL volunteers by a trainer with extensive experience with substance abusing families so the volunteers could learn about this type of case. Also, the volunteers would deal with cultural differences and issues (e.g., race, social class, age, and the like) in their in-service. The in-service should have a follow-up component to help insure the training is fully understood and utilized (this would also provide feedback to the trainer on the case needs of the volunteers). The GAL volunteers also need to be sensitized to the need for family treatment - the children need to receive support and care as well as the parent receiving treatment.

***Drugs encountered*:** The drug of choice is cocaine which is associated with violence.

- Narcotics, alcohol, cocaine, marijuana, and polydrug use.
- Marijuana, cocaine, alcohol and prescription drugs.
- Alcohol, PCP, amphetamines, cocaine, opiates.
- There has been an upsurge in hallucinogens (PCP, LSD, mushrooms) and inhalants (airplane glue, STP carburetor cleaner).
- Crack is the most dangerous.
- Alcohol is the most devastating drug related to dysfunctional parenting (i.e., parent(s) unable to cope in ways that meet the needs of the family).

***Type of drug and child maltreatment*:** Violence is associated with alcohol, PCP, amphetamines, and cocaine (this tends to engender more neglect than abuse). Persons in need of the drug get irritable and are potentially violent. Neglect is associated with the opiates and cocaine - the addictive drugs that totally absorb the person.

Crack is the most dangerous - the mother neglects her child(ren) and others may physically or sexually abuse the child(ren).

***Type of drug not the major focus of concern*:** I am more concerned with the lifestyle the drug engenders than the drug itself.

Don't look at what is being used but at what happens when the person uses.

Polydrug use is really not a big deal - it's a frequency issue. If the person uses everyday several times a day, that is a worst case scenario.

***Substance abuse and child maltreatment*:** If the mother is chemically dependent [this term is preferred over the term "substance abuse" by this interviewee] that is *prima facie* evidence of abuse and neglect and the child(ren) needs to be removed.

If someone is "addicted" (dependent as defined by DSMIII) to a drug, there will be some abuse or neglect.

Any substance abuse of a parent puts the child at high risk for neglect or sexual abuse unless there is another adult to intervene on behalf of the child.

Children's parent(s) turn the children on to drugs. Children's parent(s) have the children run drugs and deal drugs. Children's parent(s) prostitute the child for money and/or drugs.

Parental drug dealing may lead to violence in which the child(ren) becomes a victim.

Children in substance abusing families are short on love. Their parent(s) are not physically available. They experience a lack of routine - there is chaos and anarchy.

Age of child is critical. Infants to three years of age are most vulnerable to harm. Ages three to five they are less vulnerable and more mobile - at this age they have an innate sense of self preservation. When they are the age of being in school, they are more able to elicit outside help.

***Treat the drug dependency first*:** The drug dependency is the #1 consideration. Chemical dependency mimics every psychiatric symptom in the book - they need to be drug free first, then work on the other problems.

***Warning signals*:** The parent(s) never seem to have money. There are cigarette burns, etc. on the kids. What do the kids do with their free time? The parent(s) have a disheveled appearance. There is limited interaction in the family. The kids are playing adult roles.

***Getting the substance abuser into treatment - model currently being tested in Mecklenburg County called Substance Abuse Intervention in Families (SAIF)*:**

Level 1 - Have a meeting with everyone - family, neighbors, etc. to gather information on the chemically dependent person(s).

Level 2 - Call a meeting of all the people involved in Level 1 - talk about the problems of the family.

Level 3 - Focus on the substance abuse issue and confront the abuser(s) with the people from Level 2 plus a substance abuse professional.

Prior court agreement assures that if Level 3 doesn't work, then the child(ren) is removed from the home.

***The threat of removal or removal of children from parent(s) by DSS*:** If DSS says the parent(s) will lose their children unless they go into treatment, nine times out of ten they go into treatment.

Taking a child from the mother as a motivator for "cleaning up" has a 50/50 chance that the mother will shape up.

Sometimes the mother will comply to get her child(ren) back.

Some mothers are not interested in their child. They don't take advantage of visitation rights, for example. So, some mothers are not influenced to get treatment for their addiction by removing the child from the home and making the return of the child contingent on getting substance abuse treatment.

In some cases taking a child out of the home of a younger parent frees them up to party. They like their new found freedom and are not impressed with the loss of their child.

Some mothers, despite feelings of guilt, may not want their child. If the child is the product of rape or prostitution, they may be an unwanted child.

***Take child from the home*:** When the mother spends 90%+ of her energy pursuing drugs. If the child's care for being in a safe environment is compromised. And if the child's psychological/emotional health is being traumatized.

If the substance abuser is a single parent with no support system. They are isolated.

Things to look for - this is an art. Children dressed inappropriately. Children left alone. No food in the house. Sexual abuse of child(ren). Children are not going to school. There is medical neglect. Must provide a wide range of services to the family.

Whether to remove the child from the home is a clinical judgment unless it is a real black and white case.

***Removing child(ren) from the home and bonding*:** Critical levels for development which are impaired in substance abusing homes are: ages birth to three - child bonding; ages birth to six - problems in the home; ages six to twelve - developmental issues. Developmental impairment occurs in different ways at different ages.

As for the bonding issue - the crack addict mother is not bonding anyhow.

***Foster care*:** Foster care is abusive to the child. The child thinks they have done something wrong to warrant removal - they feel guilty and "act out."

Foster care does not work. Kids get abused. Try to place the child(ren) with their extended family - but not usually with grandparents [see extended family placement].

***Extended family placement*:** It's highly likely that substance abuse is an intergenerational disease. This does not mean that the grandparents, although they do not use substances themselves, are not still dysfunctional. Use of the extended family for placements must be cautious.

In the extended family there is a high risk for the same behavior (substance abuse, neglect, and/or sexual abuse). But they may have matured out of the problem behavior (usually this doesn't happen without

some kind of treatment but often, not even then). Therefore, don't give children to grandparents but to aunts, uncles, or older siblings. Grandparents - there is a possible risk for their own substance abuse and/or sexual abuse.

***Keep child in the home*:** When the substance abuser is doing something about it. When they are trying to change their behavior. This needs to be carefully monitored. When there are other adult family members who are competent providers. When there is order in the household - it's not chaotic.

For abuse concerns -if there is at least one responsible adult person in the home (i.e., one person who does not abuse substances) or for neglect concerns (not abuse) is there is an adult person who spends a substantial amount of time in the home.

***Child(ren) able to return or remain in home*:** There should be at least three months of sobriety or being clean or being drug free to consider keeping the children in the home.

Indicators of whether the drug dependency is under control: stability in employment; managing their finances; balance in life between rest and work; develops a support group; opens a circle of acquaintances - including the children; appropriately confronts problems; has some kind of spiritual life (belief in self); and abstinent from drug use.

***Optimal treatment model*:** The optimal treatment is to treat the whole family but there are barriers to this approach.

***DSS*:** Our caseloads are smaller than DSS so we can work more intensively and get children back at home.

From the client's point of view, DSS is the enemy. The DSS caseworker is never trusted. They cannot form a therapeutic alliance with the family. There is the DSS stigma. DSS can remove the child and that is the source of a client's lack of trust.

DSS's function should just be case management - they should coordinate the delivery of services. They try to provide treatment (the Treatment Unit) but they don't provide treatment. A treatment model is the family preservation model - doing intensive family intervention.

DSS caseworkers are overloaded - their caseload is too high and they are emotionally overloaded. Caseworkers overload families with things to do and set them up for failure. Caseworkers need more training in general and substance abuse training in particular. Caseworkers need more accountability by way of interagency cooperation. Caseworkers need ongoing work with a consultant to do group problem solving - an internal consultant-run support group.

Public Health

In this section persons working in a public health setting were interviewed. They are involved in a comprehensive program of clinical and support services for substance abusing mothers and their families. The port of entry to the program is when pregnant and postpartum women are identified in the public health clinic where they come for services. Once identified, they are encouraged to enter the program. If they agree, they sign a contract and begin the program. Follow-up from the program is provided for a period of eighteen months. Again, common themes are followed by paraphrasing of quotes and minimum summary information, and there is no attempt to comment on their content.

***Signs of substance abuse*:** Rent not paid; gas and/or electricity is off; drug paraphernalia (often this is not hidden but in plain view); trash can full of beer cans, reefer papers, etc.; very little furniture (this varies but the furniture may have been sold for drugs); how the children are fed - is food available for children, e.g., milk not available (food is sold for drugs and food stamps are reported stolen); the company they keep; lots of traffic in and out of the home while the worker is visiting.

When parents try to hide their habit from the worker, they take their children to family or a friend and disappear to a crack house or other place to use drugs. Women usually have someone else take care of children while they get high. In this sense, we usually don't see neglect cases.

Other behavioral signs of substance abuse - miss appointments; lie (need to cross-check with family members); stop going to treatment meetings; begin to minimize support (support group is no longer liked); give excuses for not doing what they should be doing.

***Household composition*:** This can vary widely and vary from day to day. Following are compositions experienced by the program - living with "someone"; living with friends; living with god parents; living with family; a single parent; an unmarried couple plus someone to help pay the rent.

***Household environment*:** The house is a "swamp" but usually the child's room is lighted and orderly compared to the rest of the house. The child's room is kept better than the rest of the house (this shows caring for the child(ren).

***Extended family*:** The extended family often enables the addiction. The extended family typically tries to get the children from the user. The family usually wants the children.

***Cultural awareness issues*:** Do not prejudge or judge the lifestyle of another cultural group. Focus on their needs and wants and assist them in behaving and functioning in a way that those needs can be met - teach skills, access services, provide support. Do not allow the client to become dependent. Empower them - teach them to take responsibility for themselves.

***Treatment success*:** Typically, the substance abuser is in treatment 18-20 times before success is experienced.

Former Substance Abusers (Females)

Three of the four females interviewed were mothers. They were substance abusers when their children were born and continued their substance abuse for several years after the birth of their children. The fourth female began her substance abuse in her teens. She had several substance abusing friends who had children and observed how her friends related to their children and families. Again, the information under the common themes mainly includes paraphrasing of quotes without comments by the interviewer.

***Drug using lifestyle*:** You want to get high! It's a drive! The user becomes totally self-absorbed when using drugs. They ask, "What can I do for me?" They like the high - they like checking where you can get the drugs - they like checking where you can get the money for the drugs.

First priority - take care of your habit. Everything else goes on hold until the habit is taken care of. You need lots of money to maintain the habit and you needs skills to "hustle."

Addiction is the disease, drugs are the symptoms.

***Parenting and substance abuse*:** Because of the focus on drugs, the caretaker role of the parent is drawn away from the focus on children and the ability to care for the children.

It will cost the child if you don't have someone backing you up. My grandmother backed me up.

When she was a baby I could take care of her physical needs and drug use was not a great problem [Note: The respondent's view was that a baby did not have emotional needs as she defined it.] When she was four I needed to take care of her emotional needs - she wanted to talk. Then drugs were a problem.

***Drugs and child maltreatment*:** The addictive use of drugs leads to neglect and possibly dependency. Alcohol, amphetamines, cocaine, and crack may lead to abuse.

Marijuana - spending money on the drug is the only problem. Amphetamines - I was on them in a serious way - you go crazy. Alcohol - not as dangerous. Downers plus alcohol - leads to fights. Cocaine - you get obsessed with it. Heroin - I nodded off - cigarettes catch things on fire when you nod off. Crack - the most dangerous drug. For crack users, that's all that means anything to them. For female crack users men are hanging around - the woman has a man to support her and protect her. Women selling drugs - especially crack - is dangerous because people try to rip them off and they may be violent. With these drugs there is the risk of neglect (from the mother), sexual abuse (from strangers, boyfriends, live-ins, and from the mother if she prostitutes her

child to obtain drugs), physical abuse (from mother or others around her), and other violence (a drive-by shooting, a fight between addicts, and the like) for the child.

Mothering suffers from substance abuse. Parenting skills are adversely affected. If the mother is addicted to sex there are men coming to the household all the time. And there are mothers who have kids they don't want. They use the kids to keep from going to jail. But someone else keeps the kids until they are needed to stay out of jail.

I was addicted to alcohol and my husband was addicted to cocaine. We didn't feed the children. My mom lived next door and was an enabler - she took care of things we should have but didn't.

***Safety of the child*:**

- Recreational user - even a recreational user is potentially dangerous to the child.
- Doing drugs - one usually doesn't do drugs alone - they "party" - there is a danger to the child from the other drug users.
- Dealer, not a user - the child might be in danger because the dealer can't always control what goes on (e.g., a shooting, etc.).
- Father is a drug user and mother is not - the mother cannot protect the child(ren) or perhaps even herself. Don't punish the child, remove the father!

***Remove the child*:** When parental substance abuse is identified, temporarily remove the child(ren). The parents should get a drug screen; parenting class; and drug treatment.

Take the child from the substance abusing parent before the child gets too old and can't change.

Unless the child(ren) can go into residential treatment with the mother they should be taken from the mother until she gets her addiction under control.

***Return the child*:** The child can go back when the parent is "clean." Abstinence is not using. Clean is not using plus working on issue of self - "quality clean time." You can see the person change in positive ways.

***Drug treatment*:** The "quick fix" doesn't solve the problem of chronic drug use. One needs a support system to help the drug user to recover fully - a support system which is social, economic, etc.

Attorneys

Both DSS and GAL attorneys were interviewed. Although these attorneys could be in a courtroom situation in which they were adversaries, this was not the case for the subject of these interviews. They all addressed the issue of parental substance abuse and child maltreatment. They were in accord on this issue.

Family configurations: Mostly we see single parent families in which the parent is a substance abuser. In two parent families both parents may abuse drugs or one or the other parent may abuse drugs. Most often in the two parent family, alcohol is abused. Most often in the one parent family cocaine is the drug of choice and around here sometimes it's heroin.

Risk to children in substance abuse household: Children are at risk for neglect by parent(s) and sexual abuse by others (such as a boyfriend).

The age of the children is critical. From infancy to age five they are at risk because the are isolated - not in the school system. From age six forward, the school can monitor the child(ren).

The age of the children is important. Younger and older children have different needs and vulnerabilities.

When the caretaker(s) is non-functional due to substance abuse, if there is no one to take up the slack, then the child is at risk.

There is less risk when there is a support system in place. Preferably a family support system with extended family.

Children are at less risk but still at some risk when the substance abuser is trying to get off drugs, in treatment, and not dealing drugs.

The person's track record - that is, the chronicity factor for their drug use determines whether the child is safe or not. The more chronic, the more risk.

Services to substance abusing parent: The substance abuse needs to be dealt with first since it could mask other problems. Other services that should be offered are housing, jobs, financial counseling, parenting services, and mental health counseling.

Children can stay: The mother can be dependent on alcohol or crack and the children can stay in the home if they are adequately cared for. However, if the abuser is a single parent with no support (i.e., they are isolated), then the children must be removed.

***Remove children*:** There are two sides to removing the children from the home. Removal provides an incentive for the parent(s) to "get their act together." The flip side is that the responsibility for the children has kept them on track. When the children are gone, they get comfortable with no responsibility and get deeper into substance abuse.

Removing the children from the home can send the parent on a downward spiral in their substance abuse (therefore, it's best to keep the mother and child together). Their attitude is "Everyone is against me - why try?" They firmly believe that their children are gone - even though they aren't necessarily. However, some mothers are successful in drug treatment despite this initial reaction.

Residual Group

The residual group contains the remaining three interviewees - three researcher /trainers. Since there is only one respondent in one category and two in another, they have been combined to preserve confidentiality and to allow reporting of the information gleaned from these interviews. The reader will recall that the purpose of the interviews in this section was to get a better understanding of how DSS and other agencies dealt with and perceived parental substance abuse cases in which children were involved. From this information the issues were sharpened and an interview guide for the GAL volunteers and staff was developed.

Viewpoint: To advocate for the child one has to advocate for the parent.

The cost of addiction: Alcohol is inexpensive. Illicit drugs are expensive and this expense leads to putting kids at risk (e.g., selling children or selling "things" - furniture, toys, food, etc.).

Programs for children of chemically dependent parents: A kids' "support group" is needed. There is a need for a group that educates and a group that provides treatment.

First intervention goal: First, clear the addiction. Then use an outpatient therapeutic community where skills are taught and the person is linked to community resources.

Residential treatment: Residential treatment for the parent will provide respite from the children. This would be followed by intensive outpatient treatment.

Treatment ideal - On the county level have a campus setting where substance abusing parents and their children would go for a period of six months to a year. There would be a parent's cottage and a children's cottage (protection is an issue even here). The parent(s) would be given substance abuse treatment, learn social skills, and parenting skills. A social worker would do a continual family assessment during this time.

Relapse: Relapse is part of the disease - allow for it. When children are returned home, have a mechanism for the child to report relapse - to go to a supporting adult and to deal with the parent's relapse.

Education needs: The GAL volunteers need to be educated about addiction.

V. GAL PROGRAM AND FIELD EXPERIENCE

by
Rosemary Ritzman
and
Jay R. Williams

The perceptions and experiences of the GAL volunteers and program staff throughout the state provide essential information in developing advocacy strategies for the GAL program statewide. The previous section reports an exploration of issues of substance abusing parents and child maltreatment with a large group of professional care providers and others who typically encounter substance abusing parents prior to GAL involvement. These issues set the stage, as it were, for individual cases. The GAL volunteer begins with what could be a massive amount of data from DSS involvement as well as from other community services offered the substance abuser. Their job becomes one of "getting up to speed' with the case and ferreting out those issues that may have been overlooked or partially addressed but which have direct bearing on advocating for the "best interests of the child." Their job is at once a singular one which somewhat paradoxically calls for collaboration.

An interview guide [see Appendix C] was developed based on information from the interviews reported in Chapter IV and from conversations with GAL staff. Next, arrangements were made to actually interview GAL volunteers and the staff who supervise them in the field. At each site selected for interviewing, the district administrator (or a support staff person if the administrator was unavailable) and a volunteer were interviewed. The volunteers were interviewed because they have the experience of investigating the case and preparing recommendations for the court. They typically focus on the very important but somewhat narrow view of their own particular cases. As a volunteer's case experience grows they begin to develop a broader view of the issue. The GAL staff provides oversight and quality control for the volunteers for each case. They, by definition, experience a broader vista of the problem and are, therefore, in a better position to see more general and repetitive patterns. For these reasons, it was important to interview both volunteers and staff.

A convenience sample of the state was constructed by contacting the district administrators statewide and asking them to participate in the data collection. Each district administrator was asked to recommend GAL volunteers and cases with the following attributes:

- GAL volunteers with moderate to extensive experience with substance cases.
- Type of substance: Where alcohol is the major drug abused; where the major drug abused is other than alcohol; polydrug abuse.
- A case in its beginning phase where substance abuse is suspected but not yet substantiated.
- A case in its middle phase where substance abuse is established and efforts are or have been underway to remedy that abuse.

- A case in its final phase where substance abuse has been established and efforts to remedy the abuse have failed.
  [NOTE: These are general guidelines. Cases that "generally" fit these categories were selected with no particular effort to perfectly match the conditions noted above.]

Thirty of the thirty-three GAL district programs with volunteers responded. Twenty-one of the thirty district programs were selected for interviews based on the general guidelines listed immediately above. The distribution of the selected districts on these three guideline variables is as follows:

[NOTE: In one district the selected volunteer became ill and was not available for an interview. The interviewer's time frame did not permit scheduling a substitute volunteer. In another district the volunteer was unable to meet with the interviewer on the date set. In this case a GAL attorney was substituted for the volunteer. The volunteer interview guide, however, was not used with the GAL attorney . As a result the totals are 19 rather than 21.]

Experience of volunteer

Very experienced	12	(63%)
Moderate experience	2	(11%)
Very little experience	5	(26%)

Type of substance in case

Alcohol	10	(53%)
Alcohol & marijuana	1	(5%)
Alcohol & cocaine	2	(11%)
Crack/cocaine	5	(26%)
Polydrug abuse	1	(5%)

Case phase

Beginning	2	(11%)
Middle	10	(53%)
Final	7	(36%)

As is easily seen, most of the volunteers (63%) interviewed were very experienced. Alcohol alone was involved in cases 53% of the time and alcohol combined with other substances appeared in cases 69% of the time. Cocaine ran a second place (26%) as the type of substance involved in a case, but cocaine appeared in 37% of the cases when the reported combination of alcohol and cocaine was counted. Although somewhat higher proportions appear here (probably due to the small sample size) than the proportion of substances reported in GAL 1993 statewide survey (see Table 7, Office of Guardian ad Litem Services, 1993:10) the general distribution pattern of substances associated with GAL cases is the same. This similar pattern is remarkable particularly in the light of persons familiar with the cases reporting that they are often unsure of just what drugs are actually involved in a particular case (the denial and

secretiveness of the abuser makes precise knowledge of the drugs abuse extremely difficult sometimes). However, the general consistency of these reports of proportional use should give the reader confidence in the overall pattern of use that repeatedly emerges.

Finally, most (53%) of the cases were in their middle phase with another 36% of the cases reported drawing to a close. Overall, very experienced volunteers were reporting on cases that were well underway so that they could comment on them with some confidence. Also, recall that the district supervisor or a support staff person was interviewed and often commented on the volunteer's case along with other cases that illustrated the general conclusions they drew in their interviews.

The distribution of the programs that participated in the interviews by section of the state is as follows:

Eastern region-	5 programs
Piedmont region -	8 programs
Western region -	8 programs

This represents a fairly balanced coverage of GAL programs throughout the state. There were some scheduling difficulties compounded by time and travel constraints which limited the interviewer from responding to all of the thirty programs that volunteered cases for the study.

Following are the reported responses from both GAL volunteers and GAL staff. GAL volunteers' responses to closed-ended questions are presented first, followed by responses to open-ended questions. Staff responses are for open-ended questions only.

A. *GAL Volunteers*

These are the responses for the nineteen GAL volunteers interviewed. The interview guide is found in Appendix C. Not every question from the guide will be summarized. The reader can refer to the guide to identify those questions which are not reported here. The first portion of the interviewing instrument asks about the characteristics of the household. For simplicity the data are summarized over all of the nineteen interview cases. There are too few cases to permit breaking the data into multiple sub-categories or cross-classifications. This summarization, as presented, will give the reader a sufficient overview of the type of cases seen by GAL volunteers that are substance abuse related.

Characteristics of the Household

Location of the household:

Rural	- 4
Small town	- 8
Big or medium city	- 6
Suburban	- 1

Neighborhood economic characteristics:

Wealthy	- 0
Middle class	- 4
Poor	- 15

Neighborhood physical characteristics:

[NOTE: Due to instrument revision there are two cases with missing data for this question.]

Orderly	- 9
Chaotic	- 6
Don't know	- 2

Clean	- 9
Dirty	- 7
Don't know	- 1

Neighborhood safety:

Very safe	- 1
Fairly safe	- 8
Unsafe	- 9
Don't know	- 1

Is substance abuse (buying, selling, using) a problem for this neighborhood?:

Yes	- 14
No	- 5

Cases reported are fairly evenly spread between rural, small town, and city (big or medium) areas. Small towns and cities are the predominant areas from which this sample of cases is taken. A majority of reported cases involve persons coming from neighborhoods judged to be poor. In three of the four instances in which the volunteer reported the neighborhood to be middle class, they qualified that response to "lower middle class." It will be recalled that these cases are highly filtered - they have gone through DSS and a variety of community agencies and programs and DSS has finally petitioned the court to take custody of the children. This does not necessarily imply that substance abuse and child maltreatment cases are strictly a lower class phenomena. Perhaps the resources of persons in other social classes permit them alternative solutions which do not put them at risk for intervention by the court and the GAL program. On the other hand, perhaps substance abuse creates a "drift" to a lower socioeconomic environment. What is known, however, is that the preponderance of GAL substance abusing child maltreatment cases reported in this sample consist of persons living in neighborhoods that are characterized by the GAL volunteers as being poor.

The 15 poor neighborhoods are seen as being orderly and clean about as often as they were seen as being chaotic and dirty. Also, neighborhoods were viewed as being fairly safe or very safe as often as they were viewed as being unsafe. Characteristics of order, cleanliness and safety were perceived to be evenly distributed in poor neighborhoods, and thereby fail to show a pattern for substance abuse-related child maltreatment cases. However, substance abuse was reported to be a problem in nearly two out of three neighborhoods. Not surprisingly, child maltreatment cases involving substance abuse appear to occur most often where substance abuse and its related activities (buying, selling, and/or using) are a problem for that neighborhood.

A sub-analysis of the neighborhood variables orderly/chaotic, clean/dirty, safe/unsafe, and drug problem/no problem was done to see if a particular pattern between these variables emerged. As the data below demonstrate, there is a compelling pattern.

			Drugs	
Orderly and Clean	8	Safe -	Yes - 2	No - 4
		Unsafe -	Yes - 2	No - 0
Chaotic and Dirty	6	Safe -	Yes - 0	No - 0
		Unsafe -	Yes - 6	No - 0
Orderly and Dirty	1	Safe -	Yes - 0	No - 1
		Unsafe -	Yes - 0	No - 0

Missing data cases - 4 [NOTE: If a case was incomplete for any of the four variables above, it was ruled a missing data case]

When the neighborhood is considered chaotic and dirty it is also seen as unsafe and having a drug problem. Three-quarters of the neighborhoods described as orderly and clean are seen as safe although it is reported that one-third of these "safe" neighborhoods have a drug problem. One-fourth of the neighborhoods reported as orderly and clean are viewed as unsafe with a drug problem.

It is interesting to note that all of the middle or lower middle class neighborhoods are viewed as orderly and clean as well as safe. Only one of those orderly, clean, and safe middle class neighborhoods was reported to have a drug problem. However, in general, if a neighborhood has a substance abuse problem (buying, selling, and/or using), it is seen as an unsafe environment.

The household composition of the cases reported had an average of 3.7 persons (this excluded one atypical household in which ten persons were listed in the household - the number of persons listed in the other households ranged from six to two). Dividing the total number of persons (again, excluding the atypical household) by the total number of reported bedrooms produced a 1.65 persons per bedroom. In those cases where there was information on the sleeping arrangements, children most often had their own bedroom or shared a bedroom with a sibling. There were two cases, however, in which the sleeping arrangements were unusual. In one case a nine-year old female slept with her mother and father and sexual abuse was alleged. In the other case a thirteen year old female slept with her father in a one bedroom camper. Sexual abuse was also an issue in this case.

Persons in household:

Mother alone	- 8
Mother and boyfriend	- 5
Mother and father	- 2
Mother and stepfather	- 1
Mother and parents	- 1
Father alone	- 1
Father and stepmother	- 1

Single mothers are the most frequently occurring category. Mothers with live-in boyfriends are the second most frequently occurring category. Often the stability of the relationship with the boyfriend is unsteady and the children experience multiple, serial boyfriends living with the mother. In all but two cases, the mother is in the picture for the children. In the other two cases the father is the parent with the responsibility for the children. Approximately two thirds of the parents in these cases are in their thirties. The other third consists of two mothers with boyfriends in their early twenties and one in her early forties; and two single mothers are in their mid-forties while one is in her late twenties.

The following table shows additional characteristics for each category of household composition. These characteristics are number of children, race, job stability, education, who abuses drugs and which drugs are abused

HOUSEHOLD COMPOSITION
Comparisons of Characteristics

	Household Composition:	Mother Alone	Mother w/ Boyfriend	Mother w/ Parents	Mother & Father (or stepparent)	Father Alone
Characteristics	**Category of Characteristic**					
Number of Children	One	4		1	1	1
	Two	1	1		2	
	Three	3	1			
	Four		3			
	Six				1	
Race	Black	2	4			
	White	5	1	1	4	1
	Native American	1				
Job Stability	Stable	3	1		4	1
	Unstable	4	4	1		
	Don't Know	1				
Education: Grade Completed	6th Grade			1		
	8th Grade	1				
	10th Grade	3	3		1	
	11th Grade		1		1	
	12th Grade	2	1		1	
	Don't Know	2			1	1
Persons Abusing Drugs	Mother	8	2			
	Father				1	1
	Mother & Father				3	
	Mother & Boyfriend		3			
	Mother & Mother's Father			1		
Types of Drugs:	Alcohol	5			1	
	Cocaine				1	
	Crack		2			
	Prescription drugs				1	
	Alcohol & Cocaine		1	1		
	Alcohol & Crack	1				
	Alcohol & Marijuana	1			1	1
	Alcohol, Coc., & Marij.		1			
	Alcohol, Coc., Crack & Marij.		1			
	Alcohol, Crack, Heroin, Coc. & Marij.	1				

The reader is cautioned at this point to not use these small non-random sample distributions to make generalizations. The distributions are presented as information for the reader to get a sense of the characteristics of the families involved in the cases which were selected for their substance abuse traits for this phase of the study. These data, in large part, support and are supported by the results of the statewide survey (Office of Guardian ad Litem Services, 1993). However, these data also may suggest to GAL policymakers a need for further exploration and verification of patterns of interest observed in these data.

In the next section of the interview the GAL volunteers were asked how they would characterize the household on six criteria. This is followed by questions about the family's support network or lack thereof.

Household Characteristics:

Orderly	12	Sufficient food	12
Chaotic	5	Little or no food	5
Clean	13	Sufficient furniture	14
Dirty	4	Little or no furniture	3
Safe physical environment	13	Toys for children	11
Unsafe physical environment	4	Few or no toys	6

[NOTE: There were two don't know responses for this question series. Therefore, the total number of responses is 17 rather than 19.]

The distribution depicted above indicates that most households in this group of cases were orderly, clean, safe, and had food, furniture, and toys. Of the five cases that were characterized as chaotic, four of the five also had other negatives - dirty, unsafe, little or no food, little or no furniture, and few or no toys. Two of the chaotic cases were negative on five and six factors while two cases were negative on two factors. What these four cases have in common is that cocaine or crack cocaine was the substance being abused. The fifth case, involving alcohol and marijuana, was seen as chaotic but the other five factors were all positive.

Twelve cases were seen as having orderly households. Of these, seven involved alcohol as the drug of choice. Only one of the seven even had one negative - an unsafe physical environment in which the father abused the children and the stepmother when using alcohol. In all other cases where alcohol was the substance abused, the households were positive on all six factors. The household in which prescription drugs were abused was also positive on all six factors. This accounts for eight of the twelve cases.

The remaining four cases of the twelve cases that had orderly households showed another pattern. These four cases involved cocaine or crack cocaine (three of the four had cocaine and alcohol combined). In three of these four "orderly" households containing a cocaine or crack abusing mother and/or boyfriend, at least one of the other five factors was negative. Only the remaining fourth case had all six factors positive and in this case the mother and boyfriend abused cocaine, alcohol, and marijuana.

The pattern that emerges from these seventeen cases is one of cocaine or crack cocaine being more disruptive than alcohol to the family and household as measured by the six factors above. In general, alcohol alone does not appear to compromise the household on these six factors. But alcohol in combination with cocaine or crack cocaine does appear to produce negatives for the six factors. The main effect appears to be the use of cocaine or crack cocaine. As DSS investigators indicated, food, furniture, and toys are often sold to support this very addictive drug habit. The focus on obtaining the drug can easily lead to neglect of the children and the household - hence the chaotic, dirty, and unsafe environment.

Characteristics of Family Supports Networks by Types of Substance Abuse

	Abuse of:	Alcohol	Alcohol/ Marijuana	Alcohol/ Cocaine	Prescription Drugs	Cocaine/ Crack	Cocaine/ Crack/ Marijauna/ Alcohol
Strength of Support Network	Strong	1				1	2
	Moderate	2	1			2	
	Weak	3		4	1		
	None-isolated		2				
Who is in Support Network	Extended Family	4	1	3	1	3	2
	Friends	3	1	1		1	1
	Neighbors	1	1	1		1	
	Others	2		2	1	2	

[NOTE: For the question, "Who is the support network?" respondents gave multiple responses so that the total number of responses may exceed the number of cases. In the support network "others" category, DSS and the GAL volunteer had four mentions; church and therapist/group or therapy/mental health had three mentions.]

Case Information

Ten of the nineteen cases involve cocaine or crack cocaine (three of these nine have combined alcohol and cocaine or crack cocaine abuse) substance abuse. Nine of these ten cases are neglect cases (four of the nine are neglect and dependency cases). The tenth case involves neglect, dependency, and sexual abuse.

An additional eight of the nineteen cases involve alcohol abuse, and another involves prescription drug abuse. These account for the nine remaining cases. Four of the eight alcohol abuse cases are neglect cases and a fifth alcohol abuse case is neglect and dependency. The remaining four cases (three alcohol abuse cases and one prescription drug abuse case) are abuse cases - three sexual abuse cases and a physical abuse case (specifically, one physical abuse, one sexual abuse (the prescription drug case), one sexual abuse and neglect, and one sexual abuse, neglect, and dependency case).

It would appear, based on these nineteen cases, that cocaine principally results in neglect while alcohol abuse (and perhaps prescription drug abuse) has a higher likelihood of resulting in sexual and/or physical abuse. Again, the numbers are small and caution must be exercised in interpretation of the data. However, to the extent that these data are accurate reports of the type of child maltreatment, the above pattern is reasonably strong. Several volunteers indicated that when sexual abuse cannot be substantiated and neglect can, the case is often pressed forward on the neglect issue.

How did this (abuse, neglect, dependency) come to the attention of DSS? Who filed a complaint?

Family
- Father 3
- Stepmother 1
- Grandmother 1
- Cousin 1

School
- Counselor 2
- Truancy 2

Police
- Violence in home 1
- Investigation ouside home 1

DSS Monitoring 2

Other
- Boyfriend 1
- Neighbor 1
- Anonymous 1

Don't know 2

***Has this family had any prior complaints filed?*:**

Yes - 14
No - 5

***How many prior complaints?*:**

One - 1
Two - 2
Three - 1
Six - 3
Many - 2
Don't know - 5

Seventy-four percent of the nineteen cases had prior complaints about child maltreatment. The GAL volunteers were uncertain about how many prior complaints there were in five of the fourteen cases where there were prior complaints. For the remainder, the number of priors ranged from one to many prior complaints.

The major source of complaints came from family members (or quasi-family members such as boyfriends) and the school. The police also made complaints as the result of investigations and being summoned to a crime committed in the home (a mother stabbed a "guy" in her home). DSS in carrying out their normal monitoring function discovered situations that warranted action being taken. The reported sources are rounded out by a neighbor reporting and an anonymous report being made.

It appears then that the children are best protected if they are not in isolation but can be monitored by family and extended family and by the school. Children who are isolated, very young, and/or not in school are more at risk for having no one to advocate for them when they are the recipients of maltreatment. It also appears that troublesome families are not a secret to DSS and other community agencies. It would seem that with the many prior complaints made to DSS about many of these families, that being able to substantiate the complaints is a major barrier to positive action to protect or remove the child from harm.

GAL Volunteers' Responses to Open-ended Questions

From this point forward the interview instrument utilizes predominantly open-ended questions. Questions are organized in the following categories: dealing with substance abuse cases; the best interests of the child; substance abuse cases and DSS; substance abuse and child maltreatment; community resources; and ideal solutions. Following are summarized responses from volunteers. The section that follows this one has the same format and summarizes responses from GAL staff. In reading these summaries keep in mind that, because some volunteer and staff gave more than one answer to some questions, the number of responses does not necessarily equal the number of respondents.

Responses to each question have been roughly organized into categories. Where response counts are included in the summarizations, they are used to denote the importance of that category relative to others, or to indicate respondents' consensus on some question. In other words, the response counts give the reader a sense of the general weightings of responses to a question. If they wish, readers may explore the full, complete data found in Appendix B to make more detailed response counts on issues of particular concern to them. Detailed reponses from both volunteers and district administrators are reported in that appendix.

Dealing With Substance Abuse Cases

A. ***How do substance abuse cases differ from non-substance abuse cases you see?***

Overall, responses indicated that substance abuse cases are (a) more difficult cases than others, (b) carry a greater risk of violence, (c) are more likely to be associated with physical and/or sexual abuse and (d) are more likely to be associated with neglect.

Fifteen responses indicated that substance abuse cases are extremely difficult, with less likelihood that the parents will make the necessary lasting changes. Lack of motivation and denial are mentioned as major problems. One respondent did point out that once in the system, the system holds the substance abusers much more accountable than it does other parents.

- Five responses indicated that there is a greater risk of violence with substance abusers. Three named alcohol and cocaine as carrying special risk, although a fourth specifically excluded alcohol as especially dangerous. One noted danger to GAL's when a parent is under the influence.

Two responses noted more physical and sexual abuse with substance abusers, while another two cited neglect as the major problem. One did say that there was more abuse with alcohol, more neglect with other drugs. This is in keeping with findings from the literature review and from the GAL North Carolina Survey (Office of Guardian ad Litem Services, 1993).

B. ***When you get a "new" substance abuse case, what is the first thing you do because it is a substance abuse case?***

The responses split 60/40 with most persons saying that they did the same for substance abuse cases as they do for non-substance abuse cases. But even some of those who said they did the same for all cases had suggestions about how substance abuse cases might be addressed.

Three responses indicated the types of data-gathering specific to their substance-abuse cases: assessing parent's desire for treatment and motivation to get the children back, history of previous treatment, availability of treatment, and looking for other sources of information (one included consulting a recovering alcoholic for insights into these problems). One noted that since substance abuse records are not open, GALs need to talk with DSS about their assessments. One expressed concern for GAL's safety in visiting these homes.

Two responses advocated looking for drug problems in every maltreatment case, and one of these went so far as to suggest drug testing in all cases. It is interesting that only two of the eight responses to this question addressed the children's needs directly: one stated that the child should be removed immediately (except where there was use, not abuse, of marijuana or alcohol); and another emphasized the child's need for evaluation and treatment.

C. ***What is the first issue you address? Is it the immediate safety of the child(ren), the risk of future abuse or neglect, or something else? Why that first? How do you do that?***

This question series had seventeen of the nineteen respondents saying that they addressed the immediate safety of the child. Two respondents said they addressed the risk of future abuse or neglect first because they either assumed the social workers have seen to the safety of the child and/or the child is out of the home and therefore assumed to be safe. They assessed the risk of future abuse or neglect by interviewing professionals connected with the case and others connected with the case (e.g., family), made home visits, and checked various records (criminal, hospital, and substance abuse records when possible).

In response to the question of how they address the safety of the child a decided majority indicated that making visits to the child's environment is very important. One respondent advocated random visits to the child in school. If the child is in placement (foster care, with a relative, or elsewhere) it is still important to visit the child to check on their safety and to gather information from the child about their home situation. The family of the substance abusing parent may have their own substance abuse problems. Foster care placements may have their own hazards leading to child maltreatment. One advocated looking for stability in the home before reunification.

In addition to visiting, it is also important to gather information from a large number of persons involved in the case from professionals (DSS workers, day care staff or teachers, mental health workers, probation officers, medical personnel, etc.) to relatives, friends, and neighbors.

The Best Interests of the Child

A. *What does "in the best interests of the child" mean to you?*

When asked what the 'best interests of the child" means to them, volunteers responded with two major themes. One group emphasized a safe, nurturing environment. These responses mentioned being nourished and loved along with issues of basic safety. Another group was more future oriented, emphasizing an environment in which the child could become a healthy and productive adult. This latter group did not mention the safety issue, perhaps because they saw safety as a given when the issue is a child's best interest.

A few volunteers mentioned the reunification issue which has as its basic premise that children are best served by being in their biological families, which could include extended family. They were careful to note, however, that the family unit (whether parental for extended) needed to provide a healthy environment in order for the child's best interests to be served by placement with family.

Finally, volunteers commented that what the child wanted was not necessarily in their best interests. The volunteers were not in the business of making the child happy in the short-range if it had long range-negative implications for their well-being.

B. *Under what conditions is it in the "best interests of the child" to keep the family together when there is substance abuse in that family?*

The two main themes in these responses were treatment for the parent and risk to the child. One response included both these elements. The responses in the first theme emphasized parents' cooperating and making progress in substance abuse treatment. One mentioned making progress "according ... to the drug counselor." One indicated that children should be with the parent in treatment. One said the child shouldn't be in the home if there is substance abuse.

Responses in the second theme, risk to child, suggest that parental substance abuse alone is not enough to prove that the child is in danger. Some of these responses indicated that children can live with alcoholic parents. The important issue here is whether the family has resources, such as a support network and makes arrangements for the children to be cared for when the parent isn't able to function. Another volunteer cited the parent's ability to work as an important factor. One pointed out that substance abuse is not as dangerous to the child as sexual and physical abuse.

B. ***Under what conditions is it in the "best interests of the child" to keep the family together when there is substance abuse in that family? [continued]***

One volunteer thought the age of the child was an important factor if there is neglect only; if the children are 15 or older this volunteer thought it would be safe to leave them in the home; if there is abuse, remove them regardless of age. This volunteer, however, thought an exception should be made if there is a non-substance abusing parent in the home who protects the child.

C. ***Under what conditions is it in the "best interests of the child" not to keep the family together when there is substance abuse in that family?***

There were two main categories of responses to this question: one category related to the parent(s)'s failure to deal adequately with the substance abuse problem; the other responses addressed the child's continued risk of neglect and/or abuse.

A major theme in the first category is the parent's rejection of help; there is a distinct flavor of frustration on the part of these volunteers who speak of many attempts to make help available to parents who will either not agree to get treatment or who agree and then fail to follow through -- they don't try. Volunteers cited examples of arrests after being released from prison, inability to maintain sobriety, and not taking responsibility.

The second category emphasized the child being at risk from a parent who is out of control with no one in a support network to care for the child. These respondents reported that the critical issue was the parent's ability to function as a parent, to protect and care for children and to provide for "normal" family activities. The main concerns in this category ranged from poor parental decision-making resulting in failure to protect the children and other forms of neglect to increased danger of violence either directed toward the children or taking place in their presence.

Substance Abuse Cases and DSS

A. In substance abuse cases, do you usually agree or disagree with DSS's assessment of the situation?

Thirteen of the nineteen respondents said they usually agreed with DSS's assessment of the situation. One volunteer commented, "There is no optimum solution." Although overall most volunteers agreed in general, many of them had specific points of disagreement. Often these points of disagreement are couched in a recognition of DSS limitations - They have limited county financial resources which sometimes do not allow them (DSS) to act in the best interest of the child. The lack of resources directs DSS behavior. These points of disagreement are usually about reunification, placement or permanency planning.

Four of the six responses about reunification indicated that DSS wants to place children back in their homes too soon. As one volunteer put it, "we are more cautious." One, however, thought that DSS had demands that were unreasonably high for parents, expecting them to be "squeaky clean." Another said DSS wants to return children either too soon or not soon enough.

One volunteer said that DSS looks for the most expeditious placement rather than for the best placement. Three others talked about disagreeing on appropriateness of placement and about DSS failing to remove children soon enough. Two of these put these disagreements within the context of having so few foster families in the county. One thought that an ideal solution to this would be a residential group home for foster care and treatment.

Two others disagreed with the amount of time children are left in foster care and with multiple placements for children. One respondent answered with a question, "When is enough, enough?" The message here is that GALs want to move to permanency earlier than DSS.

Other responses indicated dissatisfaction with DSS services not provided. One indicated that sometimes DSS doesn't do thorough research, and another specifically stated frequent disagreement with DSS's assessments of child's safety.

Substance Abuse and Child Maltreatment

A. ***What drug or drugs are most often associated with a child being physically abused? Why is that?***

Thirteen respondents indicated that alcohol is most associated with physical abuse. Three of these volunteers said they didn't know why alcohol had this effect. Several cited the tendency to go out of control and become violent. They blamed this on either the direct effects of alcohol in producing anger and/or violence or on a indirect effect of lowering inhibitions and allowing the violence to come out.

Four responses indicated that cocaine and crack cocaine were most associated with physical abuse. Two said they didn't know why. One of the other two suggested that when the parents are high and the child bothers them, they get violent. The other expressed the opinion that when they're up all night using, they want to sleep all day and they get nasty.

One respondent cited the combination of alcohol and cocaine. This comment stated that people are more irrational when on cocaine, and when alcohol is involved, parents shoot at each other.

One volunteer's cases of physical abuse were not associated with drugs.

B. ***What drug or drugs are most often associated with a child being sexually abused? Why is that?***

Four respondents said they didn't know, and two said no drug was involved. Of the thirteen remaining, ten cited alcohol alone, one said alcohol and marijuana and another identified alcohol and crack. Three of these twelve gave no reasons. Seven mentioned that the substances release inhibitions. One of these, the one that cited the combination with crack, specifically stated that the drugs increase sexual drive and lowers inhibitions. One said that while the parent is drinking the child is neglected. Another cited an example of a father prostituting his daughter for alcohol.

C. ***What drug or drugs are most often associated with a child being neglected? Why is that?***

Twelve responses included cocaine, eight with cocaine or crack alone, 1 with heroin, and 3 with alcohol. The responses to "why" were similar for these categories. One of the cocaine/crack cocaine responses made the general observation that with this drug other loyalties and commitments are not in place -- crack is master. Six responses included concerns that parents use money to buy drugs that should be used for necessities, including selling things for drug money. Four respondents cited the self-absorbed focus of the substance-abusing parents to the exclusion of attention to the children.

C. ***What drug or drugs are most often associated with a child being neglected? Why is that? (continued)***

Three additional respondents identified alcohol alone as being most associated with neglect. Two specifically mentioned that these parents are not able to function. Two other volunteers said all drugs were associated with neglect.

D. ***What drug or drugs are most often associated with a child being unsafe? Why is that?***

Six respondents said all drugs were negatively associated with child safety; five specifically mentioned cocaine or crack cocaine, three said alcohol and one each mentioned heroin or cocaine, alcohol and cocaine and a combination of alcohol, cocaine, marijuana and prescription drugs.

The threats to children's safety fell into two general categories. The first had to do with failing to protect the child from harm and the other cites direct harm to the child. In the first category respondents talked about either leaving children alone in dangerous environments or taking the children with them into danger. One example of the latter is driving drunk with children in the car. One respondent, however, said that it's the parents on heroin or cocaine who take the children with them, rather than the ones on alcohol. One respondent summed it up with "It takes some sense to keep someone safe."

Two of the three responses in the second category were general, that is, cocaine is associated with violence and alcohol abuse leads to loss of control. A third response in relation to cocaine abuse more specifically states that the abuser will hit or kill the children or sell them sexually for money."

E. ***How do each of the following factors relate to how you view and work with a substance abuse case?***

E1. Age of the children in the family

Most volunteers indicated that younger children were most at risk. The general comments were that the younger the child, the more unsafe, the more they need to be protected. Older children are seen as having better defenses, being better able to take care of themselves, to understand what is happening, to run away and/or to get help. One said, "the older the child the more I consider their viewpoint."

Five volunteers mentioned preverbal and preschoolers as being isolated and particularly vulnerable, more in need of closer monitoring. One noted that you can't interview very small children, but have to rely on observations. Another pointed out that parents may train little children what to say, whereas school children are more verbal. One volunteer offered the guideline, if neglect, take children under fifteen out of the home; if abuse, take the child out regardless of age.

E2. Availability or non-availability of caretakers other than the substance abusing caretaker

Fourteen respondents indicated that family support is important. One pointed out that a single person with no support system is the worst possible case, because the children need someone to give them protection. Twelve mentioned the importance of an appropriate, responsible and/or stable caregiver in the home to protect the child. One of these specifically stated this caregiver should be strong enough to "not let the substance abuser run over them."

Two volunteers indicated that other caretakers don't make that much difference. One said it's rare for another parent to take up the slack, so caretakers from outside are still needed.

E3. Type of substance being abused

Six respondents said that any drug is a problem. Seven cited the combination of alcohol and cocaine and/or crack cocaine, and another three mentioned cocaine/crack cocaine alone. Another mentioned alcohol alone, noting that it causes the most abuse of any kind of drug. One noted that alcohol varies, but "we are scared of all other drug use." Another remarked that with crack or alcohol the parent shouldn't be allowed near the child until they've been sober for six months.

There were several different opinions as to comparisons between cocaine and alcohol. One noted that alcohol is about as bad as cocaine, and another said, "Drugs or alcohol, it doesn't matter." However, three respondents indicated that crack is worse, i.e., that more intensive effort needs to be made with crack than with other drugs and there is little or no hope. Another said flatly that if crack is involved, get the children out of the house. One remarked, "coke produces violence and alcohol produces verbal abuse." In contrast, another felt that a parent on alcohol is more volatile and dangerous to the child, whereas cocaine leads to neglect. One volunteer stated that alcohol causes the most abuse of any kind of drug.

E4. Type of drug-related activity: user; seller

Three respondents said it made no difference whether the substance abusing parent was selling or using. As one put it, "none of these people should be around the child." A fourth said that children are more threatened by users because of the things they do to get the drug. These four respondents were in the minority, however.

Eleven volunteers felt that sellers were more dangerous to children. Seven of their responses expressed concern about the trade attracting the "wrong kind of people," exposing the children to danger. Two others pointed out criminal behavior on the part of parents who are dealing: they may also steal, and they may sell themselves and/or the children for drugs. One said that if the parent is selling, get the parent or the child out of the house.

E5. Particular family strengths/resources

The strengths and resources these volunteers mentioned were presence of a support system, the parent-child relationship, stability, willingness to change and compliance with judges' orders. One volunteer noted that part of the job is to assess whether there are "enough strengths." Another cautioned that sometimes the strengths can seduce the volunteer into thinking that substance abusers stand a better chance than they really do. A third said that there aren't any strengths when the parents are using drugs. These responses were in the minority, however.

Ten volunteers spoke of the importance of a support system, usually extended family, to help care for the child. These responses indicated that supportive family members who are committed to working together and to caring for the child can make a real difference in working with a substance abuse case. Two volunteers specifically mentioned placing children with relatives. Another mention in-home services while the parent was in treatment as a particular strength.

Five volunteers cited the parent's relationship with the child as a crucial factor. Particular issues they cited have to do with parent's ability to persevere, whether the child fits in the parent's priorities, and whether love and concern are part of the relationship. One volunteer indicated that a good indicator is whether the child is afraid of the parent.

One volunteer said, "We're looking for some kind of stability." There were four responses that alluded to stable job, stable home and a stable income source as particularly important factors.

The other strengths cited, willingness to change and compliance with judges orders, relate to some extent to the parent-child relationship. That is, admitting the substance abuse, seeking treatment, and complying with orders may be indicators of the parent's commitment to the child.

F. Can a child stay in a family in which there is substance abuse or must the child be removed?

There were only seventeen respondents for this question; it was not included in the early version of the interview guide. Twelve respondents said yes, but with qualifiers; five said no.

One of the "no" responses noted that the children want to stay, but it is best to remove them. Two others indicated that the children are in danger if they are left in the home. Two others took a somewhat more lenient view, that although the children should be removed, they could be returned when the substance abuser demonstrated progress. To one of these volunteers progress means at least six months of sobriety.

F. Can a child stay in a family in which there is substance abuse or must the child be removed? [continued]

Of the "yes" answers, one was a very skeptical, "Sometimes they can stay but that is probably rare." Another stated that children should be removed only if they are neglected or abused. This volunteer noted that "substance abuse takes place in the middle or upper class families and their children aren't taken." Another agreed that children could stay with safeguards in place.

The remaining nine "yes" answers mentioned more specific conditions. Willingness to accept help and presence of a support system were important factors in this group of responses. Four respondents specifically identified other responsible caregivers as an important determinant of whether the child stays in the home. Two others said that if there is close supervision and there is ongoing or completed successful treatment for the substance abuse the children might be safe in the home.

G. Can a child be reunited with their family if the parent is not drug-free or must the parent be drug-free before they are reunited?

Fifteen respondents said the parent must be drug-free for reunification to take place. Eight of these specified drug-free periods ranging from three months to a year. Two of these noted that treatment should continue. Another seven mentioned no particular time, just that the parent should be drug-free. One remarked that, "If you take the child out of the home for safety reasons, then stay with the game plan. Don't return the child until the parent is drug-free." Another noted that legally it is hard to reunite if the parent continues the substance abuse.

Four volunteers dissented. These responses indicated that if a parent shows positive steps, has adequate supervision and is functional, reunification should take place. One volunteer qualified that response by adding that if the substance abuser is functional in the family with no potential for violence, e.g., selling drugs, reunification could occur. Another said that it depended how much the parent drank and what happens when they drink.

Community Resources

A. What kinds of resources are available for working with substance abusing cases?

Each respondent listed several resources. A simple tally of how often a particular resource was mentioned is listed here. More resources than were mentioned may be available, but these were the ones that were reported during the interviews.

AA - 10
Mental health - 9
Mental health (substance abuse services) - 8
Residential drug treatment - 8
Substance abuse counseling - 7
NA (Narcotics Anonymous) -5
Parenting classes - 5
DSS - 5
In-patient drug treatment - 4
In-Home Family Preservation Program - 3
Al-Anon - 2
TASC (Treatment Alternatives to Street Crime) -2
Alcohol counseling - 1
Infant - Child Development Services -1
Family Services - 1
Health Department - 1
Detox Center - 1

[Note that while most of these suggestions are for services specifically related to substance abuse, there are quite a few that address different needs or a broader scope of services. Mental health, for example is mentioned 17 times, only eight of which are specifically for substance abuse services. In-home Family Preservation, TASC, DSS, family services and the health department may certainly address substance abuse problems, but would also deal with other important issues for the well-being of children.]

B. What kinds of rescurces are not available that are needed to work with substance abuse cases?

Most responses to this question named treatment approaches and direct services that are needed by substance-abusing parents and/or their children. Some volunteers, however, mentioned other kinds of concerns, one of which was a need for facilities for battered women and their children.

B. ***What kinds of resources are not available that are needed to work with substance abuse cases? [continued]***

Five responses called for better knowledge of and closer cooperation with other agencies in the community that deal with these families and for more community education about child abuse. One volunteer wants more sharing of information with DSS and mental health, while another expressed a need for higher quality mental health counseling. One volunteer wants a list of services available with a description of what they do and for whom. One response suggested continuing education for GAL volunteers about substance abuse.

Eleven responses mentioned direct substance abuse services. Seven of these recommended treatment programs for parents and their children together, three of which specified residential treatment. Another recommended an in-patient program where the parent could go to work during the day. Still another pointed out that locating treatment centers in housing projects would decrease transportation and child care problems. One wanted a 28-day treatment program locally.

Three volunteers specifically recommended resources for children: a residential group home for treatment and a Big Brother/Big Sister-like program for <u>all</u> GAL children were two suggestions. The third noted that children in substance abuser homes have no one to help them with homework.

Two volunteers recommended drug testing, noting that in their counties mental health takes clients' word for whether they've been taking drugs.

Ideal Solutions

A. ***In your opinion, what kind of program would be an "ideal" program to address the issue of a substance abusing parent/caretaker***

Eight of the sixteen responses had the common theme of the need for integrated services. Five recommended residential treatment facilities that include mothers with their children; and two of these noted that parenting skills and vocational training should be offered in these facilities in addition to substance abuse treatment. Two others recommended day treatment programs for women with preschool children. Another didn't specify time of day, but did suggest multiple services at the same facility.

Two other responses expressed concerns for the length and availability of treatment. One felt that 28 days is not enough, and another said that more money for treatment is needed so that there can be treatment on demand -- i.e., so that people wouldn't have to be on waiting lists.

There were three more specific suggestions about approaches. A "reality approach" was recommended for alcoholics. Support groups were recommended for children and parents, but it was also pointed out that the substance abuser needs to be kept away from their environment and their substance abusing friends.

Three volunteers believed that no one program is sufficient; it takes a lot of different components. Another five said they didn't know what would be ideal.

B. ***In your opinion, how can the GAL program best advocate for the children of a substance abusing parent or caretaker?***

Several volunteers took a hard-nosed approach. The priority here was protecting the children. Three responses indicated that substance abusers needs to understand that their children may never come back if they don't clean up their act. Two others were less harsh but just as definite about keeping the children from these harmful environments.

Three responses stressed GAL involvement and intensive monitoring and information-gathering. One of these suggested observing a parent in a substance abuse program. Another noted that frequent visits, especially on weekends, were needed.

Five responses dealt with availability of programs, i.e., more programs and proper programs for substance abusers and their families. One cited the need for safety nets to be in place. One pointed out that we need to recommend something reasonable and practical. In addition to treatment programs two other responses indicated a need for more resources for the GAL program: more volunteers and support groups for volunteers. Still another suggested

B. In your opinion, how can the GAL program best advocate for the children of a substance abusing parent or caretaker? [continued]

advocating on a broader political level for more resources. In addition to political advocacy, two other responses suggest creating more public awareness of substance abuse, child abuse and fetal alcohol syndrome.

One volunteer thought that no special advocacy is needed, that all cases should be treated the same. Another summed it up: "Do what we do already. Ask over and over, what is in the best interest of the child?"

B. GAL District Administrators

The preceding section detailed the responses of the GAL volunteers who were interviewed about specific substance abuse/child maltreatment cases and the general issues involved in such cases. In this section interviews with district administrators are summarized (in two cases, a support staff person was interviewed in lieu of a district administrator). Interviews with the district administrators also utilized the interview guide developed for the GAL volunteer interviews. The first section on case-specific information was skipped and the interview began with the generic questions about substance abuse/child maltreatment issues (see Appendix C for the instrument - questioning began with the last question on page four of the instrument). Since the district administrators have knowledge of all their cases, their views and experience are expected to be more broad and comprehensive than the those of individual volunteers. These interviews were intended to tap their overall experience with substance abuse/child maltreatment cases within given districts.

It was noted in the beginning of this chapter that twenty-one district programs were selected for interviewing. Volunteer interviews were missing in two districts so that a total of nineteen interviews were reported. In this section the two missing districts are returned to the total since interviews were done with the district administrators in those programs. However, three districts will not be represented from the total twenty-one for the district administrator interviews. In two districts the administrator/support staff person was the GAL advocate. That is, the district administrator or support staff took on cases as would a volunteer. These interviews were counted as volunteer interviews. In another case, the district administrator and the support staff person acting as the GAL advocate were interviewed together and their collective interview was assigned to the volunteer section. Therefore, the total number of interviews considered in the district administrator interviews is eighteen. Following are the summary responses of those eighteen GAL district administrator interviews.

Dealing With Substance Abuse Cases

A. *How do substance abuse cases differ from non-substance cases you see?*

Like the volunteers the majority (13) of GAL staff who were interviewed believe that substance abuse cases are more difficult than others. They named many of the same kinds of problems, but in more detail. Five specifically cited more problems with parents, that is, the parents are more resistant to change, often in denial of their problems, and the drugs cloud their reason and judgment and make them irritable. Two mentioned the difficulty of knowing when there is resolution to the point that the children can be safely returned home. The main point here is that in non-substance abuse cases it is easier to measure progress and success. One response notes that treatment is not always available. Another pointed out that without intervention drug cases don't get better, whereas in non-drug cases, things can get better on their own.

Like the volunteer group, staff members specifically noted the connection between drug use and neglect -- all-consuming efforts to get drugs, leaving children alone for long periods of time, lack of "motherly instinct."

The most common difficulties cited by staff relate to the multiple family and systemic problems associated with these cases. One staff member talked about "a whole other level of problems and issues to deal with: What do you attack first?" Two spoke of the financial problems, including unemployment or irregular employment. Two also talked about the difficulties of coordinating diverse services from different agencies. One of these described the "Catch-22" situation in which public housing is denied to people without dependents (includes parents whose children have been removed from the home), people who abuse drugs and people with criminal records. If they don't have their children, they can't get AFDC and may not qualify for Medicaid, which may be their only way of paying for the substance abuse treatment. This staff member pointed out that sometimes DSS will leave children in their homes just so the parent can get the substance abuse treatment. This concern was echoed in another response that indicated the need to do something "for the children and the substance abuse at once."

In addition to the increased level of difficulty another four respondents expressed concern about safety of children and volunteers. Like the volunteers staff noted the risk for children of being prostituted by a parent who will do anything to get money for drugs and the risk of physical and/or sexual abuse by a drug/alcohol impaired parent. One cited the more general risk associated with living in a "drug/crime infested neighborhood." The risk for profound neglect is cited in the description of house in which "the children are filthy and not fed. There is no food in the house, no electricity, the children need medical treatment..." and "Crack cocaine users trade food stamps and AFDC money for drugs."

A. How do substance abuse cases differ from non-substance cases you see? [continued]

Another pointed out that the drugs make for volatile situations in which the drug user is unpredictable with a tendency to be violent. Some parents may kidnap their children and/or threaten GAL volunteers and DSS workers. One respondent said that relatives and friends often protect drug-using mothers, making them hard to find.

The Best Interests of the Child

A. *What does "in the best interests of the child" mean to you?*

Nine responses to this question cited the child's needs, with several specifying physical, psychological, educational, emotional, mental and/or security needs along with warmth and nurturing. Three stated that these needs must be considered ahead of the parents' needs. Two of these nine cited these needs in connection with children's potential for the future.

One response mentioned the child's need for permanence, a sense of belonging. Two others said that a child needs to be with family, but there were qualifiers. One recognized that staying with parents is not in the child's best interest in all cases, but that DSS should empower families to solve their problems so as to stay intact. The other also noted that the child should be removed if the family can't provide parenting; this respondent noted that taking the child out may not be what the child wants.

Four responses primarily addressed safety issues, and two of these placed safety within the context of permanence and nurturing. One stated the caveat that the child doesn't have to be happy. Another also addressed the development issue: "advocate for services for the child to be the best human being they can be."

One respondent was more vague, but summed up the ambiguity of the best interest issue. That is, GALs need to consider how to damage the child the least: "It's a difficult issue -- theory and reality are at odds."

B. *Under what conditions is it in the "best i nterests of the child" to keep the family together when there is substance abuse in that family?*

These responses centered around the substance abuser getting treatment, the child being safe and well-cared-for by some responsible adult in the family, and the age of the child.

Six of these responses centered around the need for a responsible adult care-giver in the household. In other words the children can stay if there is another adult who provides parenting. One suggested that if the responsible adult works, put the child in day-care; another suggested trying to find another family member to come in and care for the children.

Three responses included age of the child as a factor to be considered. Older children who could take care of themselves to some extent would be a lower risk than the very young. One of these three also noted that the parent's level of involvement in drugs should be discovered.

Seven other responses focused on the safety and well-being of the child. These GAL staff felt that if the children were safe, with no severe risk, and they

are fed and well-cared-for, they could be left at home. Three of these did add the condition that the substance abuser seek and follow through with a treatment plan, and another stated this as the only condition. Another two felt that using drugs alone is not so important if the child is well cared for, that in such cases removing the children would do them more harm.

There was one dissenter who said that under no conditions is it in a child's best interest to be left in a home where there is substance abuse: "It sets children up to get into the cycle of substance abuse. It takes the child's childhood when they take the parenting role for their dysfunctional parent."

C. ***Under what conditions is it in the "best interests of the child" not to keep the family together when there is substance abuse in that family?***

The two major categories of responses here had to do with the parent's continued substance abuse and with risks to the child. Seven responses indicated that if the parent denies the problem, does not seek treatment, does not remain drug-free even with treatment or is not committed to continue treatment, the family should not be kept together. One of these in advocating removal of the child, added, if there is no support network.

Nine responses expressed concern with the child's safety. Essentially, these respondents said to take the child if there is a high risk level, if there is fighting and violence, if there is chronic neglect, if the family puts the child in danger and doesn't provide for child's needs.

Substance Abuse Cases and DSS

A. In substance abuse cases, do you usually agree or disagree with DSS's assessment of the situation?

Two respondents said they usually agree, and did not comment further.

A majority of responses (10) said they agree with DSS most of the time but tend to disagree on certain issues. The issues mentioned here were treatment for substance abusers, placement of children and timing of reunification and implementation of permanency planning. Another four who said they usually disagree, and the issues these four mentioned were about placements and reunification.

The issue mentioned most frequently was the timing of reunification. Most of those who mentioned this said that DSS wants to return the children too soon. One, however, said that GAL wants to return children sooner, but that it's easier for DSS to leave them in foster care. Another gave a somewhat ambiguous answer: "DSS will give the parents more leeway than GAL. Substance abuse takes a long time to deal with, but not several years as DSS does." Another spoke to the related issue of permanency: "We have a sense of urgency for a permanent plan but DSS moves too slowly. It is in the best interest of the child to resolve this problem quickly."

The second most frequently mentioned issue was placement, and these answers often went with concerns about reunification. A point of disagreement is the use of foster care placement. One said that DSS is too quick to place children in foster care without exploring alternative placements that would keep the children in the family. Another agreed that DSS doesn't look hard enough for extended family placements. Another dissented, saying that DSS doesn't place children in foster care soon enough. Three expressed concerns about placements with other relatives: two said that DSS placed the children with extended family who shouldn't have them, and another said DSS placed children in foster care who should go to extended family and didn't use foster placement for those who needed it. One who was concerned about reunification stated that if foster care isn't "going well," DSS wants to return the child to the home, but if foster care is working they want to leave the child there. Another pointed out that DSS wants to reunite at all costs, they advocate for the parent and family, not for the child.

One respondent raised the issue of the number of chances parents should have, saying that DSS gives parents too many. This is partly related to the issue of treatment. One administrator said that GAL advocates residential treatment whereas DSS wants once per week sessions.

Several of these responses placed disagreements with DSS in context with limitations the GALs perceive as imposed on the departments. That is, when DSS wants to return children too soon or doesn't want to remove them it all, it is often because there is no suitable foster home for placement. Another pointed out that when DSS recommends placement with extended family who are "worse off than the child's family," it is sometimes because GALs have access to information that social workers don't have.

Substance Abuse and Child Maltreatment

A. ***The following table depicts responses to the series of questions about which drugs or combinations of drugs are most often associated with four forms of child maltreatment: physical abuse, sexual abuse, neglect and unsafe.***

Drugs Associated with Child Maltreatment

Mentions of Types of Drugs	Physical Abuse	Sexual Abuse	Neglect	Unsafe
Alcohol alone	10	11	2	2
Alcohol and cocaine	4	3		
Cocaine	1			
Crack			4	
Cocaine and crack				3
Alcohol, cocaine & crack			10	3
Crack, Alcohol, Pres. Drugs	1			6
No drugs		1		
Don't know	1	2	1	
Missing data				3

B. ***How do each of the following factors relate to how you view and work with a substance abuse case?***

B1. Age of the children in the family

In general these answers agree with those of volunteers, that younger children are at greater risk. There are three main issues related to age in addition to the obvious point that older children can fend for themselves and avoid injury better than younger ones. One of these additional issues is that infants and preschoolers are more isolated, whereas older children have contacts at school. A second point pertains to the differences in developmental needs, with safety/ physical risks predominant in infants and small children, and emotional needs more important for older children. The third point relates to children as sources of information: preverbal children can't speak for themselves, but four or five year-olds can provide a lot of information; as one administrator put it, this is the "honesty age." One respondent noted that, "When alcohol is involved the kids are older and they can do more to survive longer; when cocaine is involved the kids are younger and at risk."

B. How do each of the following factors relate to how you view and work with a substance abuse case? [continued]

B2. Availability or non-availability of caretakers other than substance abusing caretaker

Eleven responses indicated that the presence of another caretaker is critical, one of which stated that a non-substance abusing caretaker can mean the difference in the removal of the child. Three specifically mentioned grandparents as good resources, but one of these cautioned that the substance abuser must be taken out of the home — "...they create chaos." Two others recommended day care if the other caretaker works during the day.

One skeptic pointed out, however, that another caretaker in the home usually can't protect the children, "or there wouldn't have been a petition."

B3. Type of substance being abused

Six responses mentioned differences between alcohol and cocaine/crack cocaine. One noted that crack users disappear, leaving children alone, whereas alcohol is usually consumed at home. Another respondent made the curious comparison that crack cocaine users have the criminal element around them, but that with alcohol there is a higher risk factor. In contrast another thought there is milder neglect with alcohol. Another point of contrast according to one respondent, "You can reason with the alcoholic . . . with other drugs. . . the users need to leave their environment and the craving is easily triggered."

Four administrators, however, said the type doesn't matter. "All drugs are troublesome," said one. Another summed it up, "It's not the type of substance . . . it's how it is used and with what result."

B4. Type of drug-related activity: user; seller

Three administrators said they hadn't had any cases involving dealers. Seven made general remarks indicating that selling is dangerous and exposes the children to greater risk. Three of these mentioned that selling exposes the children to dangerous people, either because parents take the children out to where dealing is done, or users come to the house."

Three other reponses specified violence as the main risk. Another stated, "If there is drug selling remove the children from the home."

B. How do each of the following factors relate to how you view and work with a substance abuse case? [continued]

B5. Particular family strengths/resources

The major themes in these responses are extended family and other resources. Six administrators advocated looking first to extended family for support and to care for the children. The general message here is that there is often strength among relatives, particularly grandparents, that can be used so that family life does not have to be interrupted. One of these pointed out the basic assumption is that children do best in their biological families. A seventh response recommended observing family interactions to determine the motivation to work on the problem. Another respondent pointed out that sufficient care resources for the children can offset substance abuse problems.

Another administrator recommended looking to outside resources and consider how long the parent has been on drugs, and what level of commitment there is to getting off drugs. One said, "Look to empower parents to take care of themselves and their children."

Three respondents didn't answer this question.

C. Can a child stay in a family in which there is substance abuse or must the child be removed?

Most of the district administrators reported that children can stay under certain circumstances. The circumstances mentioned are: the child is safe; there is a responsible adult in the household who sees that the child's needs are met; and/or the parent is willing to get help for the substance abuse.

Five respondents emphasized safety as the main consideration. Ten of the responses, including two that addressed the safety issue, indicated that having a responsible adult in the household is the most important factor. The point here is that there is someone who protects the children and sees that their needs are met, i.e., "take up the slack." One noted that "Fine families who have alcoholics raise children -- the spouse covers it up." In contrast, four other administrators added the parent's help-seeking and cooperative behavior to the factors of keeping children safe and meeting their needs.

One administrator quoted the DSS concept tht the child can stay in the family if they meet a "minimum sufficient level." Another was more cautious: "The child doesn't necessarily have to be removed when there is substance abuse, but substance abuse is dysfunctional and if there isn't physical harm there may be emotional harm or neglect."

One dissenter just said, "If a parent is a substance abuser -- take the child out of the home!"

D. Can a child be reunited with their family if the parent is not drug-free or must the parent be drug-free before they are reunited?

Nine responses expressed a fairly hard-nosed attitude, that children should not be returned to parents who are not drug-free. Two specifically advocated periodic testing. Lengths of time for parent to be drug-free varied from three months to a year. One of these added the provision to make certain the home is safe for the child's return, implying that the parent's abstinence alone might not assure safety. Another response said that if DSS's "minimum sufficient level" is not met, do not reunite.

Others were less definite. Two noted that the issue is whether the substance abuse if harmful to the children; if not, reunite. A third said the parent "should have a commitment to not use substances," but didn't specifically say be drug-free."

Two more skeptical responses noted that these parents are held to a higher standard than exists before a petition is filed and higher than is necessary. A third skeptic said, "Drug-free? What's that? The last five urines are clear?" This one went on to say to reunite the family, but "the substance abuser must complete the treatment plan."

Community Resources

A. What kinds of resources are not available that are needed to work with substance abusing cases?

A majority of these responses relate to types of treatment. Four spoke to the need for residential treatment for parent and child together. The rationale provided by one respondent is that mothers would be less hesitant to go into treatment since they would not have to make the choice to place their children in foster care during treatment. A fifth recommendation was for a half-way house for parent and child. Akin to the idea of residential treatment is that of family therapy mentioned by four respondents. One of these recommended a one-stop facility for parents and children. Another suggestion was for an "emergency home -- quick response to situations and short term stay."

Eight responses indicated that more substance abuse treatment needs to be available. Three of these specified in-patient programs. Another advocated more intensive out-patient treatment, including more frequent drug screens. Four others were less specific, just identifying a need for more treatment facilities. One explained that more availability would mean fewer delays for treatment. A ninth response advocated "more drug assessment."

Two responses focused on inadequacy of Medicaid, with one advocating for funding for longer time periods and the other for therapists for specialized cases (such as those involving sex abuse) who will accept Medicaid. A third was more general: "more money for better services . . . you get what you pay for and that's a problem."

Follow-up treatment resources were also mentioned. One respondent advocated a half-way house and two others spoke to the need for support systems. One of these elaborated on the support issue with the idea of a "recovery mentor who could also provide respite care." The respondent who mentioned more out-patient facilities also specified longer-term follow-up treatment.

In addition to substance abuse treatment approaches for parents or parents and children together there were other responses about other kinds of treatment. Two mentioned therapy for sex abuse. Still another recommended battered spouse treatment.

One response was that therapists should go to children for sex abuse evaluation instead of sending children to them. This district administrator also said there should be a "Child Center -- a decorated center for all evaluation services for children." A more general comment was that there should not be a waiting list for children at mental health. Three recommendations were for programs and facilities for children.

Some respondents spoke about more general kinds of services. Four addressed the need for more foster homes. One of these four recommended foster homes for families, so that siblings would not have to be separated; another wanted therapeutic foster homes. In addition to the concerns with foster care, two other responses recommended more DSS workers and facilities for visitation at DSS that would be more pleasant for the children. Another two spoke of the need for transportation for parents and children to treatment and/or to visitations. One respondent said there should be more in-home services like Family Preservation.

Three responses recommended parenting classes, with one district administrator noting the need for a way to monitor effectiveness of these classes.

Ideal Solutions

A. ***In your opinion, what kind of program would be an "ideal" program to address the issue of a substance abusing parent/caretaker?***

Responses to this questions were mostly directed toward treatment approaches and the accessibility and coordination of programs and facilities. Eight responses stressed the importance of dealing with families as units, not with substance abusers alone. Four specifically recommended comprehensive family interventions. Two others mentioned residential treatment for parents and children together. One of these two specified a 28-day program for substance abusers followed by a halfway house where parent and child would both receive services. Services mentioned for parents included parenting skills, job training, help with employment and housing in addition to drug treatment. Still another response advocated intensive intervention in general and specified Family Preservation as such an intensive service. The eighth response noted the need for programs that "fit the needs of the family instead of vice-versa."

Fitting the needs of the family was the theme of several responses pertaining to accessibility and coordination. One district administrator mentioned in-home family preservation as a service that meets this need. She commented that services are not always accessible when families need them: "The system is not user friendly . . . shuts down on weekends -- you can't transport children for visitation on Saturday or Sunday. The bureaucracy stands in the way of treatment . . ." Two other responses noted the need for local treatment centers where treatment is coordinated in one place, ". . . so folks don't run from hither to yon." Another advocated for in-patient treatment at local hospitals. A slightly different concern about accessibility was voiced by the district administrator who said there needs to be gender equality for treatment: ". . . women get Medicaid and men get nothing and stay addicted."

There were two additional recommendations for follow-up care, with one specifying a halfway house as a place to go after residential drug treatment. The other commented that the follow-up was needed to provide motivation to continue to stay clean.

There were also recommendations that pertained to visitations rather than directly to substance abuse treatment. One thought that visitations could be made more productive where parenting instruction was included along with close in-home supervision. The other noted the need for better visitation facilities that are "child friendly and parent friendly."

One response advocated more generally for a multi-faceted approach: ". . . put money on the front end to stop the 'cause' of substance abuse."

B. ***In your opinion, how can the GAL program best advocate for the children of a substance abusing parent(s) or caretaker(s)?:***

Most of the responses to this question were at the case or family level, although there were some that spoke of advocacy within the court system and at the community level. Two responses emphasized seeing that the children are safe in their environments.

Five responses indicated that the best thing for children is to help the parents improve abilities to care for them. Two of these said to provide the services and help that parents need to become better able to care for the children. A third commented that the best way is to get the parent's cooperation and help, but noted that many parents don't want to help. Two others mentioned maintaining the parent-child bond when possible: one suggested visitations, the other cautioned against indiscriminately removing children from their families.

Two responses stressed objectivity. One emphasized the need to know the facts and come to conclusions based on facts. Another cautioned, "Don't let middle class, white values and attitudes about substances get in the way of advocating for the child." Two others advocated for early assessment and intervention. One of these said to advocate by assessing the severity of the problem early on and addressing the family's needs. The other said to advocated for support services and noted the need for availability of professionals when needed, not just when convenient for the professionals.

Two district administrators felt that best advocacy involved the court. One said to educate judges better about substance abuse. The other said to make the court recognize the need to address the child's issues as well as "getting the substance abuser squared away."

Three recommended broader based advocacy. One said that GALs should "become part of a coalition (community service providers or the general public) to do something about the drug problem." The other two specifically recommended the political path. "Don't be so politically isolated," said one. "Advocate with the legislature and have it filter down to local programs." The other also advocated legislative action and community service, but also noted, "but we are limited by our mandate from GAL."

C. *GAL Volunteers and Administrators - Selected Comparisons and Contrasts*

In this chapter a large amount of information is presented from field interviews with GAL volunteers and staff. Attitudes, views, perceptions, and experiences of GAL volunteers are reported for cases in which the substance abuse of a parent or parents was an issue in the case. Each GAL volunteer commented on a selected substance abuse child maltreatment case. While they drew on their experience with other substance abuse cases they handled, they used their specific cases as a basis for many of their answers. The GAL staff responded in a more general way by utilizing their experience with the collective substance abuse cases in their district. Together they present an overview of substance abuse child maltreatment cases and their implications for the GAL program.

In this section selected questions common to the volunteers and the administrators will be briefly discussed. The reader is encouraged to pursue comparisons and contrasts on those issues about which they are interested and for which there are data that are not discussed in this section. The data from these interviews contain a wealth of information about child maltreatment substance abuse cases and the role of GAL in dealing with those cases. (See Appendix B)

When asked how substance abuse cases differ from other cases that they see, both volunteers and administrators agreed that those cases involving substance abuse were extremely difficult, frustrating, and time consuming. Both noted that there was a risk of violence to the child either directly or indirectly in households where there was unchecked substance abuse. Both groups (although administrators seemed more concerned than the volunteers) reported their concern that the GAL volunteer could possibly fall victim to that unpredictable violence of the substance abuser while working on the case.

When volunteers were asked what the first issue was that they addressed in substance abuse cases, they all indicated the immediate safety of the child was a primary concern. This was echoed in later answers to various questions by both volunteers and staff. The volunteers indicated that visiting the child was a very necessary way to assess whether their immediate safety was at risk. In addition, talking with a variety of information sources such as extended family, friends, neighbors, and school personnel (when the child was school age) was very valuable. Of course, the DSS worker assigned to the case, provided they had been with the case for a sufficient amount of time, was a basic and invaluable source of information.

In interviews with DSS personnel, factors that might put the child at risk for abuse and/or neglect in substance abusing families were suggested. These factors were incorporated into the interview guide for the volunteers and administrators. These are some of the factors the volunteer may take into account in determining whether the child is safe in their environment. When asked about the significance of the age of the child, volunteers and administrators noted that the younger the child, the more vulnerable. Preverbal children are at greatest risk because they cannot communicate

their difficulties. Preschool children are at risk particularly if they are isolated from others (such as extended family or neighbors) and cannot be informally monitored. School children, while at risk, can be monitored by the school if teachers are sensitive to presenting symptoms. It was noted that while children may be instructed by their parent(s) to conceal certain information, four and five year olds are reported to easily "spill the beans" about family "secrets."

The availability of a responsible non-substance abusing adult in the household is another factor to take into account for protecting the child from harm. It was pointed out by both volunteers and administrators that in middle or upper class families in which there are resources to provide a responsible caretaker for the children, that a substance abusing parent (usually an alcoholic) could safely physically coexist with their children. The major concern of everyone is the parent who is isolated and, when under the influence of a substance, can offer no protection for their children. Sometimes grandparents will volunteer to take on the responsible caretaker role. While this is normally desirable, the GAL volunteer must make certain that the grandparent(s) is not an extension of the substance abuse problem - i.e., that they are not substance abusers themselves or that they do not have history of child maltreatment with their children. For many families intergenerational child maltreatment and/or substance abuse is unfortunately the rule rather than the exception.

The relationship between the type of drug and type of child maltreatment, as reported by the volunteers and the administrators, shows some clear patterns. Although there are some variants reported, overall, alcohol is predominately related to physical and sexual abuse while cocaine and crack cocaine are reported to be predominately related to neglect. These are also the relationships reported in a recent national study by Crosse, Kaye, and Ratnofsky (1994).

This is not to say that alcoholics do not neglect their children, especially very young ones, when they pass out for great lengths of time. Nor is it to say that cocaine and crack may not result in violence and/or sexual abuse. Both the volunteers and the administrators report that being involved in selling drugs is quite dangerous for the child due to the potential for violence during the sale and because a variety of strangers have access to the home and the child. The use of the drug is also dangerous for the child if the parent "parties" in the home - a variety of strangers have access to the child and may sexually abuse the child. Another dangerous downside for the child of parental use of cocaine or crack is the irritability of the user as the drug begins to wear off. These and other relationships between psychoactive substances and violence are well chronicled in a recent article by J.A. Roth (1994).

The last question in this section asked about the kinds of family strengths and resources one should look for in substance abusing cases? Both the volunteers and the administrators mentioned the family support system which usually involves the extended family. The family network can be supportive of both the substance abusing parent and the children. Placements of children in the extended family are generally viewed as highly desirable. Support systems may also include others outside the extended family. If there is no support system and the substance abusing parent is isolated, this makes them and especially their children exceedingly vulnerable.

Another family strength noted by both volunteers and administrators is the relationship of the parent(s) to the child - is there love and concern for the child?; is the parent motivated to persevere as a parent?; are there sufficient resources to care for the child? Some parents may not want their children. This is a key family strength that needs accurate assessment.

In addition to seeing support systems in place and a good relationship to the child as essential family strengths, the volunteers mentioned stability and willingness to change. A strength of the substance abusing parent that is desirable is stability in their life - work, income, and a place to live. The willingness of the substance abusing parent to admit that they have a drug addiction and their willingness to work on changing that is a paramount strength. Without sincere commitment to work on their problem and to change, the child is put at great risk.

When the volunteers and the administrators were asked, "What does 'in the best interests of the child' mean to you?" they both identified three major factors - safety, nurturing, and being with family. The frequency of mentions, however, were different. The volunteers most often mentioned the safety of the child as a primary concern for "best interests." The administrators most often mentioned meeting the child's needs and nurturing the child. The second most frequently mentioned factor reversed this. Volunteers mentioned needs and nurturing and administrators mentioned the safety of the child. This pattern perhaps reflects the pragmatism of the volunteers and the ideology of the administrators - both of which are operating at their appropriate levels. The third most frequently mentioned factor, by both volunteers and administrators, is the importance of keeping or returning the child to their family whenever possible.

Burning questions for everyone involved in child maltreatment cases are, can the child remain in the home with their family or do they need to be removed temporarily (when can they return?) or permanently? With the compounding factor of substance abuse, these questions become even more thorny. In answer to these difficult questions, the volunteers and administrators suggest the following. If the child is safe, if there is a responsible adult caregiver in the household, and if the parent gets treatment and is making an effort to recover then the child may be able to stay with their family. The volunteers noted that alcohol abuse may be different from other substances in that a lot of children live in alcoholic families and are safe. This is principally because the family has resources to care for the children and the children are protected and not neglected.

When should the child be removed from the substance abusing family? Essentially when any or all of the three conditions above do not occur. The child's safety is threatened, the parent continues to use drugs, the parent refuses drug treatment, and there is no adult in the household or a support network in place that will be responsible for protecting the child and meeting their minimal needs. A worst case scenario is a single parent who is isolated, has an infant to care for, and continues to use a highly addictive substance.

How the treatment progress of the substance abusing parent can be determined is an issue on which there are varying opinions. Some would require three months sobriety, some six months, and others one year sobriety punctuated by regular random

drug screens to substantiate the sobriety. Although substance abuse counselors assert that with the more addictive substances relapse is inevitable, the relapse itself would, for some, be reason to remove the child or to not reunite the child. It has been suggested that the children be educated to recognize parental relapse and to call for help when that occurs.

When asked what kind of program would be an ideal program for addressing the issue of substance abusing parents, the volunteers and administrators produced slightly different, but compatible, lists. The administrators focused more on the form of ideal programs (overall approaches, quality of services, availability of services, etc.) while the volunteers focused on the content of ideal programs (type of programs, treatment modalities, etc.). Together they draw a comprehensive picture of and ideal program system. It is one that takes a family approach. It serves the needs of the children as well as of the substance abusing parent.

An often suggested model is one of residential treatment for the mothers (fathers were not mentioned probably since single mothers are most implicated in substance abuse related cases) in which their children can accompany them. This would lessen the mother's reluctance to seek treatment if she would not be separated from her children. This would also offer an optimal opportunity to teach the mother appropriate parenting skills and to observe how well those skills are implemented. Also in this setting, the children can be provided treatment if they require it.

After the residential treatment (or after a 28-day treatment program) the mother and her children would go into a halfway house for post-treatment and reintegration into the community. A DSS worker would be on staff at the halfway house and aid the parent in accessing services in the community. It was suggested that these services be more accessible or "user friendly."

Following reintegration with the community, the parent and children would become members of a support group to provide support for maintaining sobriety, for dealing with everyday problems, for maintaining and improving parenting skills, for respite care, and the like.

For those not electing residential treatment, day treatment for mother and children too young for school was suggested. Again, a family approach is appropriate. In addition to substance abuse treatment there would be work with a family therapist and, perhaps, in-home intervention (following a Family Preservation model).

One respondent noted that no one program would suffice as an ideal program. The preceding suggestions serve to delineate the many facets of an ideal system of programs. These facets would be even more "ideal" if they could be integrated in some meaningful way to make the program components accessible to the substance abusing families and to effectively monitor each family's progress through the system of programs.

How can the GAL program best advocate for the children of a substance abusing parent? Again, the volunteers and administrators had overlapping as well as slightly differing emphases. They both addressed the need to deal with cases as thoroughly as

possible. They both emphasized seeing that the child is safe and getting the parents into drug treatment , "cleaned up" and back on track. The volunteers mentioned monitoring substance abuse cases more closely. The administrators mentioned being objective in dealing with substance abuse child maltreatment cases.

The volunteers remarked that creating awareness in schools and among the general public about substance abuse and child maltreatment would be good advocacy. The administrators looked to creating awareness in the court by educating judges about substance abuse and by placing a focus for the court on the child's needs, not just the substance abusing parent's needs. A few volunteers and administrators suggested a political path to advocacy by making legislators aware of substance abuse and child maltreatment issues.

A volunteer suggested that a support group consisting of volunteers would be very useful. Another volunteer said that more volunteers are needed and that would help to provide the needed advocacy. Finally, an administrator globally suggested that finding a way to address the drug problem (perhaps by becoming part of a coalition) would advocate well for the children of substance abusers.

VI. GUIDELINES FOR WORKING WITH SUBSTANCE ABUSING FAMILIES

This chapter suggests some minimal guidelines for working with substance abusing families. Along with these guidelines are a variety of resources which the reader may find useful. It is hoped that the information given here will pique the interest of readers to the extent that they will pursue further reading and relevant training.

The GAL volunteer is, in some measure, in an awkward situation. DSS and other agencies have been involved - often to a great extent - with the child and their family prior to the child being assigned to the GAL volunteer. One might assume that much has been done through services for the family and securing the safety of the child. For a variety of reasons, however, that assumption may not necessarily be correct. It is the task of the GAL volunteer to gently but firmly review all that has been done and put it all in the GAL focused context of the "best interests of the child." In some instances this may challenge the efforts of DSS and other professionals. To the extent that the GAL volunteer is informed about issues and options relevant to their case, these "challenges" are, in reality, sincere efforts to mend the fabric that is intended to provide a comprehensive interagency cover for the family and the child. Professionals should welcome this rather than resent it. The GAL volunteer becomes part of a team addressing familial and child needs (it is an underlying assumption that it is in the best interests of the child to have a family that is "working," albeit at a minimal level, so that that child may remain in or be reunited with that family). The GAL volunteer, under optimal conditions, will benefit greatly from the team approach. But, if conditions are not optimal, the GAL volunteer must still address the most difficult issue of substance abusing parents and the "best interests of the child."

Shotton, Beyer, and Acoca (1993) support the preceding point but with a more narrow focus on mental health and substance abuse professionals.

> Given the widespread nature of substance abuse and the high correlation of child neglect/abuse with substance abuse, mental health professionals must integrate the most effective techniques from both fields. This requires overcoming formidable philosophical and professional turf barriers between the mental health and substance abuse fields in order to support the family in meeting the child's needs.
>
> [Shotton, Beyer, and Acoca, 1993:28]

While the GAL volunteer may fall prey to these and other turf barriers, that is not a necessary outcome. In recognition of these difficulties, the GAL volunteer may advocate and indeed facilitate the blending of agency services. The synergy of this approach is beginning to be recognized more fully. As Shotton, Beyer, and Acoca (1993:28) note, "Many mental health, substance abuse, social work and health professionals have come to agree on a unified approach to working with multi-problem families where alcohol and other drug abuse is a core issue."

Deal With the Substance Abuse First

Acoca and Barr (1989) in their work, *Substance Abuse: A Training Manual for Working With Families*, review various conceptual models for understanding addiction. The model they favor is the psychological model which they describe as follows:

> The traditional psychoanalytic view has been that addiction is a symptom of an underlying character disorder. Until fairly recently, it was assumed that alcoholics and addicts were "self medicating" to avoid pain or anxiety caused by unconscious problems. The modality for treating addiction was individual and group psychotherapy with a focus on developing insight into the causes of the addiction. This approach has undergone a transformation since the mid-1970s, largely because it has proven ineffective.
>
> A more current psychological perspective is that addiction is a *primary* rather than a *secondary* problem that covers and profoundly alters personality function. According to this view, it is imperative that the dependency be dealt with *first*. Only then, when the person is free of dependency, can appropriate psychological and practical interventions be made.
>
> This viewpoint is noteworthy because it integrates behavioral, cognitive, environmental and systems approaches. . . . This is the conceptual model that offers therapists and clients the greatest advantages.
>
> [Acoca and Barr, 1989:26]

This perspective was echoed by a substance abuse counselor in the interviews reported in chapter IV. They said, "The drug dependency is the number one consideration. Chemical dependency mimics every psychiatric symptom in the book - they (the drug abuser) need to be drug-free first, then work on the other problems." Whether the child stays in the home or is to be reunited, a first priority is to address the substance abusing parent's addiction.

Family-Centered Approach

Substance abuse affects the entire family, not just the substance abuser. This happens in a variety of ways but the web it weaves virtually entraps the entire family.

> When a mood altering substance controls someone in the family, life for that family cannot be normal. Dependence on a drug makes users behave in ways that hurt the very people they are closest to. It dominates their thoughts and priorities, occupies their time and attention, depletes finances, and skews their values and behavior. The effects of these changes ripple through the family, often causing the nonusers to

> develop their own physical, psychological and emotional problems as they struggle to adapt. In this way, the entire family becomes co-dependent, falling under the controlling influence of the addiction.
>
> [Acoca and Barr, 1989:138]

This logically implies that not only does the substance abuser need treatment but that the family unit and the individuals in it will benefit from treatment that addresses the family co-dependency issues. Children in the family, depending on their ages, will benefit from treatment that deals with a variety of issues related to the substance abuse of their parents and its impact on them. In addition to their own developmental needs, children may learn about the signs and symptoms of relapse. When their parent inevitably relapses, they will recognize the signs and be able to get help for their parent and for themselves - in this way, their safety and their parent's renewed treatment is more certain.

Levy and Rutter (1992) argue for family-centered treatment. They describe residential treatment settings in which substance abusing parents and their children would be evaluated and treated.

> Programs should develop therapeutic nurseries where newborns and infants can be evaluated and treated. Both parents and children should be medically, psychologically, and developmentally evaluated. Individualized treatment plans that take the needs of parents and their children into consideration must be developed. Programs can be developed with educators on the premises who can work together with substance-abuse counselors and child care personnel. In other words, instead of separating out the adults and placing the children in foster care, the elements of joint care could be developed in a single setting. Such facilities would not be cheap. But it is foolish to conceive of "treatment on demand" when we insist that parents (mostly mothers) must automatically be separated from their children in order to receive treatment. Most federal and state agencies involved in the funding of drug-abuse treatment have historically been mandated to work with individuals addicts, thereby deemphasizing family-oriented treatment approaches.
>
> If we could assure women the kind of treatment options listed below, would they not come to treatment in greater numbers and be more likely to stay? What if we promised drug-addicted mothers that they could:
>
> - Remain with their children
> - Be assured of the physical, emotional, and spiritual health of their children as well as themselves
> - Learn more effective parenting skills while simultaneously receiving treatment for their addiction
> - Learn how to integrate a healthier family life with the prevention of relapse to drug use
> - Be trained for today's job market

> . . . one of the greatest barriers to treatment for women is the requirement that they be separated from their children. Hence, our call for a meaningful increase in the number of residential programs for women and their children with age appropriate programming for children of different ages. An unknown number of addicts, especially those who smoke cocaine, find their lives so debilitated that they can not hope to gain abstinence without some period of stabilization in a residential program. For impoverished minority women this problem becomes even more critical. How can they resist addiction in the emotional and physical climate of inner-city ghettos? How can they hope to properly nurture their children when so few of them have ever been properly nurtured? We must create settings where the parent and the child receive the nurturing, support, and basics for life they require. With a solid beginning — free of the pull of the street — and the mastery of basic coping skills we can not expect these people to adopt long-term, drug-free life-styles.
>
> [Levy and Rutter, 1992:129-131]

Levy and Rutter additionally describe a comprehensive multiservice center (a "soup-to-nuts" delivery system) for women and children. A part of the multiservice center would be a residential component which, although they do not describe it as such, could be the family-centered treatment facility. The rationale for the comprehensive multiservice center is as follows:

> *When addictive behavior becomes the driving force in a person's life it must be prioritized into the first target behavior to be addressed by any service agency.* [Emphasis mine] But it should not be the *only* need to be met. By breaking up service components into different bureaucratic strata we create too many false dichotomies for women and we create too many hurdles for them to climb over. . . . Addiction itself is a metaphor for many things in our society at all socioeconomic levels. But nowhere is it as devastating as it [sic] to the women who are already facing a melange of social, medical, psychological, nutritional, domicile, educational, and vocational problems. While we must admit that some of these problems are the usual outcome of an addictive life-style, they can also serve as the causes for the addictive behavior.
>
> Centers can be developed to focus on evaluation of a women's functioning in all these areas. Needs can then be prioritized and treated. This approach can cut through the wasteful squandering of valuable resources. For example, providing food, clothing, and temporary shelter to an active addict only prolongs his or her active drug use. Thus, we should make reception of other services contingent upon active participation in drug-abuse treatment. Such a system can work if it is set up so that the current interagency lack of communication is eradicated from the outset. If a woman takes advantage of the multiple resources presented at the proposed multiservice center as an outpatient, then she may indeed be on the road to true independent living. If she can not, and continues to use drugs, then she can be referred for more intensive care,

through a day treatment, evening treatment, or inpatient program. The staff of the center can help her and her children during the transition and make sure that treatment for mother and children happens as a joint experience, wherever that may be.

Furthermore, if there is a need to separate mother and children for a period, the mother's frequent visitation and awareness of adequate child care will help her to concentrate on addiction treatment. Too many women lose their ability to focus because they are worried about their children. The center will see to it that both parties' needs are being addressed. No longer will children be lost in the shuffle of "adult only" concerns.

[Levy and Rutter, 1992:132-133]

In summary, the emphasis needs to be on addressing the substance abuse of the parent so that the interests of the child will be served. But, this cannot occur in isolation - the family unit is, one way or another, influenced by the substance abuser's activities. For this reason, family-centered treatment needs to be initiated. Residential treatment for substance abusing mothers and their children will encourage more mothers to enter treatment since they will not have to be separated from their children. This will also afford the opportunity to observe and improve the parenting skills of the mother while providing essential services to the children. Finally, the notion of a multiservice center was introduced. The purpose of such a center is to reduce the barriers a substance abusing parent may encounter in seeking services. Treatment would be a requirement for the receipt of services. The ability of the substance abuser to keep one service provider in the dark about other service providers (thereby "working the system") would be greatly diminished.

By discussing services for the substance abusing parent, the story has leaped far ahead of itself. If substance abuse is suspected it must be substantiated. Only then can the services described be provided. However, establishing that a parent is a substance abuser is sometimes difficult. We now turn to ways in which the substance abuser can be unmasked.

DSS and Substance Abuse Services (SAS)

In many cases DSS substantiates substance abuse and arranges for the substance abusing parent to get treatment. In fact, DSS is turning more frequently to family preservation intensive, in-home, short-term intervention (see, for example, Barthel, 1992; Blythe, Jiordano, and Kelly, 1991; Edna McConnell Clark Foundation, 1985). Michigan's Family First program uses this approach successfully with substance abusing parents (Blythe, Jiordano, and Kelly, 1991). Other states, such as North Carolina, are using this intervention as the last of a series of interventions to establish reasonable efforts. With the in-home visitation and other services provided with this intervention, it is unlikely that the substance abuser will escape detection.

Acoca and Barr note that both child abuse and substance abuse are typically shrouded in secrecy.

> This secrecy is the result of an active attempt on the part of all family members to hide the abuse from outsiders, and indeed to hide it from themselves through denial. In both addictive and abusive families the tendency is for members to convince themselves that the problem is not a problem, either because it doesn't exist, its prevalence is exaggerated, or because it doesn't really cause as much damage as people claim.
>
> [Acoca and Barr, 1989:97-98]

Because of this denial and secrecy the DSS worker may only suspect the substance abuse but be unable to substantiate it. Therefore, the GAL volunteer should obtain the case files of DSS as well as discuss the case with the worker who is active on the case. If a family preservation team was involved with the family, they also should be interviewed.

North Carolina DSS workers have received training in the use of a Family Risk Assessment instrument. Every caseworker is encouraged to use the instrument, if for no other reason than to provide complete documentation of a case. Twenty-two factors are considered which are organized by four major factor groups - Precipitating Incident Factors, Child Assessment Factors, Caretaker Assessment Factors, and Family Assessment Factors. This assessment guide is used on the initial assessment and at six month, twelve month, and annual reviews. A twenty-third factor progress of the child/family in treatment is a narrative form which responds to five questions about the progress of the case. This factor is considered in follow-up assessments using the initial assessment as a baseline for comparison. Factor fifteen is the caretaker's substance/alcohol misuse.

If the Family Risk Assessment is not included in the DSS files reviewed, the GAL volunteer should ask for it. It too will be helpful in getting a picture of the family in question and some assessment of the level of substance abusing behavior of the parent or parents. It is also recommended that, when possible, the GAL volunteer attend training sessions for the Family Risk Assessment in order to understand how the instrument is intended to work. This training will serve a dual purpose - it will familiarize the volunteer with DSS casework issues as well as with the particulars of using the Family Risk Assessment format.

Substance abuse services may also have information on the substance abuser if they have been involved in treatment. However, "federal law protects clients in alcohol and other drug-abuse treatment programs from any disclosures without their written consent." (Levy and Rutter, 1992:139) They go on to say:

> . . . Violation of this law makes the offender vulnerable to stiff fines and possible imprisonment. Drug-abuse clinicians and administrators have been known to staunchly defend this law and protect patient rights at all costs. This attitude has led to a serious problem regarding the protection of the rights of the children of drug abusers. When child welfare, child

mental health, social service, family court, medical care, probation, or other workers representing the interest of the children seek information from a treatment agency, the client can simply refuse to grant permission and the staff are powerless to release any information about their client.

[Levy and Rutter, 1992: 139]

Levy and Rutter take the following position on this issue.

> . . . While we have no desire to violate the rights of addicts, this present emphasis on addict rights must be changed. The rights of addicts' children must also be met. Very often the rights of both parties clash head on and the burden of resolving the dilemma must fall squarely upon the shoulders of legislators and agency policymakers.
>
> . . . if the child protective authorities, child welfare authorities, and the substance abuse treatment agencies work together, children will be far better protected. It is just this kind of cooperative venture — one that would help both parent and child(ren) — that is impeded by narrowly focused laws concerning client confidentiality. How can addiction be successfully treated and the vicious cycle of abuse, maltreatment, and neglect be interrupted when they are not viewed as mutually compatible goals in the eyes of the law? Again we need to emphasize the importance of family-oriented treatment. Treatment that focuses solely on the individual often means the maintenance of child abuse and neglect!
>
> We believe that the issue of client confidentiality versus the issue of the rights of the addict's child(ren) can be solved by linking both to the issue of client motivation. The motivated client should willingly waive confidentiality for the benefit of her/his child(ren).
>
> [Levy and Rutter, 1992:138-139,145-146]

Levy and Rutter end their discussion of this issue by suggesting several ways to overcome the confidentiality problem.

- Addiction treatment programs should be more willing to communicate with other care-giving and service agencies.
- Treatment programs should insist that clients sign releases when the information will serve to aid their children.
- When family courts and others need to monitor client progress in treatment, particularly when issues of child placement and visitation arise, treatment staff should work together with these agencies to establish honest treatment progress and outcome reports.

- Treatment workers (particularly those involved with addicts in outpatient programs) can not safely assume that children are well cared for. Assessments of child welfare and family resources should be part of the initial treatment assessment and plan.
- Treatment programs should follow guidelines for reporting ongoing or potential abuse and neglect of children. Treatment of addiction should *never* be identified with failure to protect the rights and roles of children.
- Client motivation can be assessed, behaviorally, by their relative willingness to comply with the signing of releases that relate to child care (and other life-style issues). Motivation can also be assessed in terms of ongoing compliance with child care agency plans for both parent and child. Treatment staff need to become knowledgeable about these child welfare agencies and stop perceiving them as part of an adversarial relationship.
- Treatment programs must develop rational criteria for client progress. This must include urine surveillance, one of the few objective methods available. Family courts, foster care and adoption agencies, among others, need to make rulings regarding children that are based on realistic recovery criteria measured over time and reported in a timely fashion by treatment personnel.
- Treatment programs must move away from an exclusively client-based approach to a more family-based one.

[Levy and Rutter, 1992:146-147]

Clearly this is a wish list based on the realities of today's confidentiality issues. It is also very clear that the bests interests of the child would be better served by adopting these recommendations of Levy and Rutter. The GAL volunteer should contact SAS and request information. Has an evaluation been done? What is SAS's opinion about the substance abusing parent? SAS should, when they are legally able, provide valuable information for the GAL volunteer to more accurately assess the safety of the child and the needs of the child. When this valuable information is not available, the GAL volunteer should advocate for its availability.

Doing a Home Visit

Armed with information from DSS and SAS (if feasible), the GAL volunteer needs to visit the child and, if the child is not in the home, they need to visit the home and the parent(s). The home visit may be uncomfortable for the volunteer but the rewards are usually great. Levy and Rutter (1992) discuss home visits from the perspective of a therapist or a clinician. While the role of the volunteer is not the same as a therapist, the observations of Levy and Rutter are, nevertheless, instructive for the GAL volunteer.

> . . . Home visiting enables the therapist to make his/her own assessment of the child's environment (for historical and current understanding). A visual assessment adds to the therapist's knowledge of the child's background.

. . . The parent(s) are more relaxed in their own home and can present problems they do not feel free to share in a clinic setting. For adults and children who have difficulty with expressive language, familiar surroundings create a sense of security and emotional comfort, and may lead to more openness. The clinician can obtain a "closer look" at the reality of the adults' and the child's life. One four-year-old child we worked with had only two toys: a television and a video tape player. While in the home the clinician can play with the child. This provides modeling and helps to focus attention on the child's well-being.

In the case of the schoolage [sic] child or teenager, one can see if the home is structured for school studies and homework. Does the child have a private work space, adequate light, and school supplies? The skills of daily living can be observed. On one home visit we discovered why one recovering parent could not fall asleep in her own bedroom. The place was in chaos. It was clear that "organizing and self-care" skills had to include far more than just making therapy appointments on time.

Home visits help break through the social isolation the addict experiences. . . . Home visits can bring light into dark places.

We feel that home visiting with drug-abusing families of all social classes is valuable. Of course, they are time-consuming and require flexibility on the part of the clinician. In some neighborhoods such visits include a genuine element of physical danger. . . . Very often we ask family members to gather together family photograph albums and picture books to share with us. These are helpful in eliciting attitudes, beliefs, and feelings about the family unit and its individual members.

Some parents require continued home visiting to participate in treatment. . . . If a client misses a day, a staff member makes a home visit to help the client reenter the program as soon as possible. During these difficult days of recovery the babies and other children at home are at risk for abuse, neglect, and maltreatment. Thus, the home visit also ensures the well-being of the child.

[Levy and Rutter, 1992:207-209]

One major purpose of the home visit is to make observations that help to substantiate suspected substance abuse, to help assess the severity of substantiated substance abuse, or to help to identify relapse among recovering substance abusers. The attitude that the GAL volunteer should adopt is to assume substance abuse in the household. This may appear cynical and harsh but as the following writers show, it is a reasonable posture to take. Acoca and Barr (1989) in their discussion of the interrelationship between substance abuse and child maltreatment note:

> . . . Experience has shown that the presence of either one should be a red flag that the other may be there as well. Where there is child abuse there is a likelihood that addiction is operating to foster the abuse through weakened inhibitions. Likewise, where there is addiction there is the same likelihood of abusive behavior or some underlying need to block out the pain, such as providing the means for the victims of the abuse to cope.
>
> [Acoca and Barr, 1989:98]

In a like vein, Shotton, Beyer, and Acoca (1993) emphasize this point.

> Many mental health, substance abuse, social work and health professionals have come to agree on a unified approach to working with multi-problem families where alcohol and other drug abuse is a core issue. Critical to this approach is the understanding that professionals conducting the in-home family assessment, *should assume that where there is child neglect/abuse, there is drug or alcohol use and should actively seek to disprove it rather than vice versa.* This assumption is controversial among mental health and social work professionals who are concerned that they may alienate the family. *However, most substance abuse professionals believe that a respectfully conducted yet alcohol/drug focused assessment is actually less likely to alienate the family. Their experience is that family members are often relieved when chemical abuse, often a hidden problem, is brought into the open.*
>
> [Emphasis mine]
> [Schotton, Beyer, and Acoca, 1993:28]

While the GAL volunteer is not expected to conduct a full-scale, sophisticated substance abuse assessment such as might be done by a DSS caseworker or a SAS worker, they can make useful observations on their home visit. In addition, awareness of these issues can provide improved communication between the volunteer and the various service providers from whom they will elicit information on the case.

It should be noted that the information and guidelines given below are representative of a large but consistent literature on assessment factors. At the end of this chapter several references will be provided which will allow the reader to pursue these issues in greater detail. Chapters III and IV of this work also provide an accurate summary of salient factors to be considered in substance abuse and child maltreatment cases. The information in these two chapters is consistent with the literature review here and with the additional suggested readings.

In their chapter on *Applied Pharmacology*, Acoca and Barr (1989) provide "some tools" for in-home evaluation by Family Preservation therapists. They state that "Developing awareness of drug-related paraphernalia can help therapists make an initial assessment without being overly intrusive." (Acoca and Barr, 1989:53) The reader is reminded again that the GAL volunteer is not trained to be nor expected to act as a

Family Preservation therapist, a SAS therapist, or a DSS caseworker. However, they can benefit from the information used by these persons when they are in the situation of making a home visit.

Acoca and Barr describe some tools for in-home evaluation as follows:

During a visit to the home, make a visual survey of the contents and placement of objects. In particular, carefully inspect the bathroom and kitchen areas. These are the items to look for and inspect.

Drugs: They can be kept and hidden in anything - plastic bags, boxes of any kind and size, purses, pill vials, or substituted in over the counter medicine bottles, wrapped in tin foil, wax paper, balloons, condoms, stamps

Heating implements: lighters, matches, incense burners, sterno

Objects used as filters: cotton, socks, gauze, fine mesh, nylon stockings, paper, felt

Utensils used to dissolve: spoons, pots, pans, ashtrays, paper or plastic cups, glasses, bowls

Antiseptic products: hydrogen peroxide, rubbing alcohol, bleach, ammonia, other germicidal products that can be obtained commercially or from a health care institution (usually in unlabelled container)

Odors: Notice unfamiliar or distinctive smells

Laundry: Observe clothes for blood stains

Paraphernalia: Look for unusual shapes or utensils, razor blades, waterpipes

Read: Inspect all bottle labels looking for such ingredients as ethanol, isopropyl alcohol (isopropanol), essential oils (menthol, camphor, eucalyptus oil)

Visual Evaluation of Clients

Therapists need to identify the physical characteristics of drug abuse in their clients to determine the presence and/or degree of the substance abuse problem.

Substance abuse may be suspected when objective and careful visual examination of the following are observed:

General: General lack of hygienic appearance, grooming, sense of well-being or healthy facial glow. A person may look as if he/she has been staying up all night. Observe level of anxiety or passiveness, response to questions, and eye contact when engaged in conversation.

Face: Presence of puffiness, flushed appearance (not like a suntan), broken capillaries (small blood vessels around cheeks and nose)

Eyes: Dilated pupil or very small pupils, red eyes (can be disguised with use of Visine or similar eye drop products), roving eye movements, visual complaints, light sensitivity, unusual tearing

Nose: Rhinitis, runny nose, nasal salute, frequent sniffing (excuse may be allergy problems), frequent nose bleeds, puffy and red nose

Skin: Excessive sweating, abnormal skin turgor, pasty color or appearance, track marks, scars, bruises

Cardiovascular: Increased heart rate . . . , complaints of chest pain, frequent headaches (may indicate increased blood pressure).

Nails: Gray, blue or ashen color

Sexual activity: Decreased libido, impotence

[Acoca and Barr, 1989:53-55]

The reader is reminded that any of the above symptoms may be associated with conditions unrelated to substance abuse. Conversely, a substance abuser may exhibit few or none of these symptoms. In the remainder of their chapter on *Applied Pharmacology* Acoca and Barr (the chapter is written by Olga Woo, a pharmacologist) answer the following questions for six types of central nervous system stimulants and three types of central nervous system depressants - What are the drugs commonly being used and abused? How do they differ from one another? What are the street names of these drugs? How does the abuser use these drugs? (Methods of administration, paraphernalia used, different routes, onset and duration time responses are described.) How do these drugs affect the body and mind of the user? What are the extreme medical consequences of abuse of these drugs? (Overdose dangers, obstetrical problems, long-term and chronic effects, and withdrawal syndromes are provided.) [From Acoca and Barr, 1989:52-53]

Later in the Acoca and Barr work they present fourteen points or guidelines for assessing substance abuse in families. These guidelines follow here along with portions of the introductory material to the guidelines. This material was originally written for Family Preservation workers. Their chapter, in which this material occurs, is entitled, *Building on Family Preservation Skills in the Assessment of Substance Abuse.* Again, the GAL volunteer is not expected to function as a Family Preservation therapist but rather to benefit from the knowledge provided to them.

. . . A natural part of in-home assessment is an evaluation of whether or not it is safe to leave the child in the home during or after the intervention.

In the opinion of many specialists from the chemical dependency field, it is essential to make alcohol and drug evaluation an expected, explicit part of family assessment in order to determine the degree of substance abuse in the family and to assess the safety of the child. Within this chapter techniques for performing substance abuse related family evaluation and criteria for evaluating the safety of a child in a family where substance abuse is occurring will be discussed. (The risk assessment provided here was designed to provide informal guidelines rather than a formal risk assessment tool.)

The Family Preservation therapist's conceptual approach to the issue of substance abuse in families will in part determine the outcome of the assessment. If the therapist views substance abuse strictly as a behavior pattern, his limited objectives will probably reflect his belief that dealing with substance abuse is one among many goals, and not necessarily the primary goal. If, however, the therapist approaches substance abuse as a central organizing factor for both the using individual and the rest of the family, coping with that issue will be a *primary* objective. This does not mean that other problems and objectives are not important. It simply means that the therapist can deal with other issues more safely and effectively if substance abuse is addressed first.

Many Family Preservation therapists have been trained to enter the role of "personal scientist" while assessing families. This is a very useful approach for therapists first entering the family home. Home-based therapists are able to gather a great deal more information about substance abuse than office-bound therapists.

However, it is very important, given the prevalence of substance abuse and its role as a co-factor to child abuse and neglect, to enter the family *actively seeking evidence of the use of alcohol and/or drugs.* This perspective may be antithetical to the therapist's personal inclination and training. He may want to approach the family with an "open mind." Nevertheless, if he is not expecting and actively seeking signs of substance abuse, he may miss crucial information that he will need in order to evaluate the safety of the child and create effective limited objectives.

The following are guidelines for performing in-home family assessment where substance abuse may be a factor. Also included are sample interventions appropriate for the early phase of involvement with the family. These guidelines should be used in conjunction with other assessment techniques currently used by Family Preservation therapists.

NOTE: This information is provided so that GAL volunteers can better understand how the professional assesses and repsonds to substance abuse in the family.

Guidelines for Assessing Substance Abuse in Families

1. Assume that there is substance use and/or abuse in the family until it is proven otherwise.

2. Active listen [sic] for a long time (can be several hours). Let family members describe their problems as they perceive them.

3. Conduct a home evaluation, specifically targeting the presence of alcohol, drugs, drug paraphernalia, and physical evidence of drug use (i.e., blood on clothes, bloody cotton balls, etc.). Try to be unobtrusive. Ask for a home tour.

4. Do a visual, physical evaluation (i.e., pinpoint pupils may indicate amphetamine use, etc.)

5. Be straightforward about the fact that if the abuse, neglect or delinquency does not change for the better the child will be removed from the home.

6. Help family members prioritize their problems.

7. Understand that individuals who are abusing or dependent on substances usually deny, minimize or rationalize the problem. Also other family members will "protect" the using individual by assisting him/her in covering up the problem.

8. Use "I statements" to reflect to family members your concern about their drug use and the importance of dealing with the drug problem *first*. . . .

9. Begin to gather baseline data about family members' use of chemicals:

    - Ask about each person's health, nutrition, occupational status, school attendance and performance, legal issues, home environment, "religious community" (if it exists), family and peer relationships. Each of these areas, or "tracks," can be examined to determine:

        a. The degree of the chemical dependency problem.

        b. Potential areas of nurturance.

- Get a family history, including a drug history, from each person.

  a. One tactic is to ask each to describe his life story in terms of Christmas holidays, as these are often times when substances have been used excessively.

  b. Adolescents will sometimes agree to do "drug chart," [sic] a written record of their alcohol and drug use in the last year, with an adult who is not their parent.

- Identify areas of practical need (i.e., place to live, proper food, visits to the doctor, etc.)

- Ask appropriate family members if they've ever been to an AA, ALATEEN, NA, etc., meeting; "talk up" these meetings as a potential source of support for them; describe what happens at a meeting.

- Do a "walking tour" of the neighborhood to identify AA and ALATEEN meetings and other sources of community support.

- Use non-judgmental "I" statements to express concern about drinking and drug use: "I'm very concerned that you're drinking five glasses of wine every night."

- Don't push.

- Attend appropriate AA meetings with family members, go out for coffee afterwards and discuss what happened.

- Create concrete goals for each client *individually*.

- If you suspect or know that substance abuse is a major problem, reflect its importance in the treatment planning.

10. Begin family education about the effects of drugs on the body and mind. Talk about physical and mental signs of the various stages of substance abuse.

11. Begin to educate the family on how HIV infection *is and is not* spread. Focus on the link between specific behaviors and HIV infection.

12. Develop an awareness of the cultural identity of the family and how it affects family member's understanding of substance abuse.

13. As a way of helping family members assess their own substance use and abuse, teach them to track their alcohol/drug use. Ask them to record the *frequency* (how often) of their use, the duration of use

(how long has the individual been using and how long do the effects last when he uses currently) and the *intensity* (does the person have one or ten beers?). Ask them to do this over a three to five day period. Requesting that they record behavior for longer may not be realistic.

14. Instill hope. Explain that alcohol and drug dependent people can and do successfully stop using and that staying drug free is a learned skill which they can acquire. Give family members examples from your own experience or from stories in the media.

[Acoca and Barr, 1989:156-159]

The reader is reminded again that these are guidelines to assist in working with substance abusing families. Since these guidelines have been written for specially trained Family Preservation in-home therapists, some of the items may not apply for GALs. The volunteer should not tread into areas in which a therapist may be making a major effort since they may only succeed in undoing what has already been accomplished. This emphasizes the importance of the volunteer contacting the various professionals dealing with the family and getting a grasp of what is trying to be accomplished both in parts and as a whole. Given that the volunteer has an overview of an integrated approach to dealing with the substance abusing family, this affords an excellent opportunity to advocate for missing elements in the overall service delivery.

The more the GAL volunteer knows and understands of what the many other service providers can offer and are providing, the more likely their own efforts in the case will be effective. The better grasp the GAL volunteer has of substance abuse issues, substance abuse treatment issues, and resources to address these issues, the better they will be able to advocate for the children in substance abusing families.

Acoca and Barr next turn to what they term a "risk analysis."

The following questions are designed to help Family Preservation therapists determine whether or not the child can safely remain in the home during the course of the intervention. They can also be used to assess how safe the environment is for the therapist.

The risk analysis is only a framework. It is not intended to be a formal risk assessment tool. [Emphasis mine]

What kind of neighborhood is the home in?

- Is there safe transportation to the home?
- Is it a high crime neighborhood?
- Is the neighborhood safe at night?
- Is the entrance to the house well-lighted at night?

Are there weapons in the home?

- Where are they located?
- Does this family have a history of using weapons?
- Do children have access to weapons in the home?

Is there substance abuse in the family?

- If so, who is using?
- What is the degree of substance abuse (use, abuse, dependency)?
- What kinds of drugs are being used? (For example, P.C.P. can cause extreme and unpredictable violence. Its use creates a high potential for child abuse and also jeopardizes the safety of the therapist.)
- Are drugs being used intravenously? (If so, there is a very high risk of HIV infection, hepatitis, and other serious health problems.)
- Are street drugs being used? (Street drugs are often contaminated or overly potent and can cause allergic reactions or overdoses.)

Are any female family members using drugs?

- Which drugs and how are they administered? (Taking drugs during pregnancy can cause a miscarriage or serious damage to the baby. HIV infected mothers are very likely to pass the infection on to the baby.)
- Are any children in the home "cocaine babies?" (Babies whose mothers used cocaine while pregnant.) These children have a high incidence of irritability, sleep disorders, developmental delays and other problems. They are at highest risk for abuse because they can be extremely difficult to care for.

Does anyone in the household have or appear to have hepatitis or any other infectious diseases?

How do the children look physically?

- Observe skin tone, hair, weight, eyes, and fingernails to determine if their nutrition is adequate.

How do the adult family members look physically?

- Use the same guidelines outlined above.

What types of physical/sexual abuse or neglect have occurred in the family?

- What has been the duration of the abuse?
- Does the abuse occur when the family member is using alcohol and/or drugs?
- Does the abuse occur when the individual is *not* using?

If the therapist has evidence from a referral source or has learned through interaction with the family that there is a substance abuse problem and that it is linked to the child abuse, it is important to determine:

1. Whether the parent responsible for the abuse is willing to admit that he/she has a drug problem.

2. Whether anyone else in the family is willing to admit there is a substance abuse problem.

3. Whether the user or anyone else in the family is willing to seek help for the problem.

These last three questions are, in our opinion, crucial indicators of whether or not it is safe to maintain the child in the home during the intervention.

[Emphasis mine.]

For example, a family with a history of serious substance and child abuse where at least one member is willing to identify and seek help for the problem may be able to provide a safe environment. Conversely, a family with less serious substance abuse where there is complete denial about the problem and a refusal to seek help may pose a threat to the safety of the child.

[Acoca and Barr, 1989:159-161]

The Kansas City Metropolitan Drug Exposed Infants Task Force (1992) in their document entitled, *Guidelines for Identification, Reporting, Assessment & Management of Infants Endangered by Substance Abuse Exposure: A Multidisciplinary Approach*, provide some indicators of substance abuse which may be helpful to the GAL volunteer in their home visit.

Physical Signs:

1. Pupils are extremely dilated or constricted.
2. Track marks, abscesses, or edema are visible in upper or lower extremities.
3. Nasal mucosae are inflamed, chronic runny nose.
4. Patient is not well oriented.
5. Weight loss.
6. Loss of interest in physical appearance.
7. Frequent upper respiratory infections.
8. Appearance of pregnancy fails to coincide with stated gestational age.
9. Agitation or lethargy.

Emotional Signs:

1. Loss of interest in family, friends, sports, hobbies, or non-drug related activities.
2. Hearing voices when nobody has spoken.
3. Feeling depressed.
4. Repetitious, compulsive acts such as tapping of fingers or playing with hair.
5. Change of mood to be less patient, more nervous or angry. Rapid mood swings.
6. Loss of interest in food or sex.
7. Change in financial status, loss of job.

[The Kansas City Metropolitan Drug Exposed Infants Task Force, 1992:11]

The Kansas City Metropolitan Drug Exposed Infants Task Force, in their report, also provides an exhaustive addiction assessment form. It is a very thorough set of questions about substance abuse which covers both licit and illicit drugs. For the reader who wishes to see a well constructed and comprehensive set of questions about substance abuse, this particular form is highly recommended. (The Kansas City Metropolitan Drug Exposed Infants Task Force, 1992:12-13) The Task Force also has a page and a half section on when to order a drug screen. Although the focus is on prenatal, natal, and postnatal conditions, the information can be easily translated to other situations and older children. (The Kansas City Metropolitan Drug Exposed Infants Task Force, 1992:14-15)

Finally, Levy and Rutter (1992) provide a list of items to check on a home visit. They say, "As the reader knows, addicted clients can be quite manipulative, playing fast and loose with the truth in an attempt to disguise their true life-styles. Viewing a person's home and all his/her possessions (or lack thereof) provides a realistic portrait of his or her day-to-day reality." (Levy and Rutter, 1992:136) The following items are indicators of the child's environment and have direct implications for their safety and possible abuse and/or neglect as well as providing signals of the parent's substance abuse.

- Cleanliness of dwelling
- Adequacy of furnishings
- Level of nutritional food supplies
- Privacy for adults and children
- Drug paraphernalia and presence of alcohol
- Adequacy of clothing for adults and children
- Presence of toys and games
- Physical safety of dwelling

[Levy and Rutter, 1992:136]

There is a plethora of lists, indicators, and factors being used throughout the nation to aid in the assessment of substance abuse and child maltreatment cases. The material above is highly representative of things one needs to consider. It is intended that this material will provide direction and assistance to the GAL volunteer when they make their home visits. Additional materials are referenced below for those volunteers who desire to pursue these issues in more detail.

Resources to Guidelines for Working with Substance Abusing Families

There are many so-called risk assessment forms in existence (for example, most state child protective services utilize these forms in their investigations and case management). The state GAL office has collected twenty-one risk assessment forms from state DSS offices in the United States. It is striking to note that many states borrow heavily from forms developed in other states. Every form includes a question or item (or two) on substance abuse in the family. However, very few expand their inquiry to a more detailed consideration of substance abuse related factors. There is, as noted above, a strong relationship between parental substance abuse and child maltreatment. This means that many of the items on the risk assessment forms do bear indirectly on substance abuse issues. Therefore, a careful assessment will take all factors into consideration. In this document we have focused on indicators of substance abuse itself. However, related factors in risk assessments that are also relevant to substance abuse should not be ignored. References listed below include a reasonably representative sample of indicators for substance abuse and child maltreatment.

The reader is reminded that risk assessment forms are administered by professionally trained social workers who are specifically trained to use the assessment forms. In fact, it is common practice to withhold these forms from persons who have not gone through the training on their use. Many forms have a quantitative component where a derived single number has formidable implications for the family to which the number may be assigned. However pleased researchers may be with this quantification, social workers typically find a purely quantified approach wanting. Normally the caseworkers are permitted and often encouraged to give the factors, ratings, and the final number an interpretation based on their professional experience and judgment. If the number indicates one thing and their experiential intuition another, their judgment is often given priority in decisions about the case.

This is all to say that risk assessment materials are not to be taken lightly nor trifled with. However, they should not be viewed with undue wonder or awe. They are sincere attempts to bring together those factors which accurately identify troubled families and child maltreatment. As such the recurring components of these measures are worth noting and becoming familiar with. They will sensitize the GAL volunteer to characteristics and situations that are critical to recognize if they are to do their job fairly and effectively.

Suggested Material for Further Information

Acoca, Leslie and Joan Barr. ***Substance Abuse: A Training Manual for Working With Families***. New York: Edna McConnell Clark Foundation, 1989. [NOTES: The manual is available from the author, Leslie Acoca for $30. Ms. Leslie Acoca, P.O. Box 87, Woodacre, California 94973. Office phone (415) 488-0312. Home phone (415) 488-4647. Acoca does training from this manual and has updated some materials for the training although they are not yet available in the manual.]

Child Welfare League of America. ***Alcohol and Other Drugs: A Competency-based Training (ACT).*** [NOTES: This is a 36-hour curriculum consisting of two inter-related modules, ACT 1 and ACT 2. Eight specially developed videotapes are integrated into the two modules. There is an emphasis on prenatal substance abuse and its effects on the child as well as on drug exposed infants. For information contact Ms. Maureen Leighton, CWLA Training Director, Child Welfare League of America, 440 First Street, NW, Suite 310, Washington, D.C. 20001-2085 - (202) 638-2952.]

Collaborative Intervention with Young Families in Crisis: Child Abuse/Neglect and Substance Abuse. Chapel Hill, North Carolina: NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, NC Division of Social Services, Child Protective Services Unit, The School of Social Work at UNC-Chapel Hill, and Wake Area Health Education Center, 1992. [NOTES: This manual is part of a workshop developed for interagency training in working with substance abusing families in which there is child maltreatment. For further curriculum information contact Ms. Sarah Rous, UNC School of Social Work, Chapel Hill, North Carolina - (919) 962-0650 or Ms. Lane G. Cooke, Center for Aging Research and Educational Services, UNC School of Social Work, CB# 8065, 900 Airport Road, Chapel Hill, North Carolina 27599-8065 - (919) 962-3597.]

CSAP National Resource Center For the Prevention of Perinatal Abuse of Alcohol and Other Drugs, 9300 Lee Highway, Fairfax, Virginia 22031 - (800) 354-8824 or (703) 218-5701 (fax). [NOTES: It says perinatal abuse but they cover the waterfront on child maltreatment and substance abuse. This is no doubt the most complete repository of information on this topic anywhere. They have published literature, unpublished reports, program information, and information on resource persons to train, lecture, or consult. This is one government service that really works.]

Geismar, Ludwig L. ***Family and Community Functioning: A Manual of Measurement for Social Work Practice and Policy***. Second edition. Metuchen, New Jersey: The Scarecrow Press, 1980. [NOTES: The development of this instrument began in the 1940's. It is comprehensive and impressive. For a basic reading of what one should consider when working with families, this is the work to review.]

Holder, Wayne and Michael Corey. ***Child Protective Services Risk Management: A Decision Making Handbook***. Charlotte, North Carolina: Action for Child Protection, 1993. [NOTES: This is proprietary information from ACTION for Child Protection in Charlotte, North Carolina. They were planning to adopt their CARF (Child at Risk Field) System for GALs. For more information contact Mr. Michael K. Corey, Associate Director, ACTION for Child Protection, 4724 Park Road, Suite C, Charlotte, North Carolina 28209 - (919) 529-1080.]

Kropenske, Vickie and Judy Howard. ***Protecting Children in Substance-Abusing Families***. Washington, D.C.: National Center on Child Abuse and Neglect, 1994. This volume just became available in June 1994. It is in NCCAN's User Manual Series and may be obtained from the Clearinghouse on Child Abuse and Neglect Information. It covers topics such as identifying substance abuse and the characterisitcs of parents at risk. There is an extensive section on family assessment. The volume concludes with a chapter on innovative approaches to intervention in parental substance abuse cases. [Clearinghouse on Child Abuse and Neglect Information, P.O. Box 1182, Washington, D.C. 20013-1182 - (800) 394-3366.]

Larsen, Judith and Robert M. Horowitz. ***Judicial Primer on Drug and Alcohol Issues in Family Cases***. Washington, D.C.: American Bar Association, 1991. [NOTES: This is a legalistic look at the issue. Appendix A has a *Family Checklist for Potential Drug and Alcohol Abuse*. The symptoms of dependence or abuse are taken from DSM-III-R. For information contact the American Bar Association, 541 N. Fairbanks Ct., Chicago, IL 60611 - (312)988-5000.]

Levy, Stephen Jay and Eileen Rutter. ***Children of Drug Abusers***. New York: Lexington Books, 1992. [NOTES: Dr. Levy is a psychologist who specializes in the treatment of addictive disorders. He has been the director of several leading drug abuse programs. He is currently in private practice. Ms. Rutter is a board certified diplomate in clinical social work. She is an administrative supervisor of New York Foundling Hospital, the largest child welfare agency on the East Coast, for which she has developed a treatment model that serves multiply dependent families. She also maintains a private practice. Dr. Levy and Ms. Rutter utilize their rich clinical experiences to write a very comprehensive book on the topic of parental substance abuse and child maltreatment.]

Magura, Stephen, Beth Silverman Moses, and Mary Ann Jones. ***Assessing Risk and Measuring Change in Families: The Family Risk Scales***. Washington, D.C.: Child Welfare League of America, 1987. [NOTES: This is a twenty-six item scale that measures risk to children in families brought to the attention of the child welfare service system. The items in this scale are reasonably exhaustive of the categories that one should consider in looking at substance abusing parents who also maltreat their children. The Family Risk Scale is fairly representative of risk assessment instruments.]

National Council of Juvenile and Family Court Judges. ***Protocol for Making Reasonable Efforts to Preserve Families in Drug-Related Dependency Cases.*** Reno, Nevada: National Council of Juvenile and Family Court Judges, 1992. [NOTES: A wide coverage of issues that does not specifically address the role of the GAL. However, the questions raised for juvenile and family court judges are relevant and useful for GALs. Of particular interest are the sections on *court proceedings checklist* and *court proceedings master checklist.* To obtain a copy or for information - National Council of Juvenile and Family Court Judges, PO Box 8970, Reno, Nevada 89509 - (702) 784-6012.]

North Carolina Division of Social Services. ***Family Risk Assessment: A Guide To Decision- Making in Child Protective Services.*** Raleigh, North Carolina: NC Division of Social Services, 1993. [NOTES: This is the risk assessment instrument adopted by North Carolina. Training is required for use of the instrument. For more information contact Ms. Jo Ann Lamb, Child Protective Services, Division of Social Services, Albemarle Building, 325 N. Salisbury Street, Raleigh, North Carolina 27603-5905 - (919) 733-2580.]

Raskin, Miriam S. and Dennis C. Daley. Assessment of addiction problems. In Raskin, M.S. and D.C. Daley (eds.). ***Treating the Chemically Dependent and their Families.*** Newbury Park, California: Sage Publications, 1991, 22-56. [NOTES: A most useful review of selected assessment approaches to addiction problems and the issues involved in making such assessments. For the very curious - recommended reading.]

Shotton, Alice C., Marty Beyer, and Leslie Acoca. ***Keeping Families Together: The Role of Mental Health and Substance Abuse Treatment Providers.*** San Francisco, California: Youth Law Center, 1993. [NOTES: The document is available from Youth Law Center, 114 Sansome Street, Suite 950, San Francisco, California 94104-3820. Phone (415) 543-3379.]

The Kansas City Metropolitan Drug Exposed Infants Task Force. ***Guidelines for Identification, Reporting, Assessment & Management of Infants Endangered by Substance Abuse Exposure: A Multidisciplinary Approach.*** Kansas City, Missouri: The Kansas City Metropolitan Drug Exposed Infants Task Force, 1992. [NOTES: While much of the material is focused on drug exposed newborns, many of the risk assessment and other assessment instruments are highly useful. For information contact Terry Jenkinson, Linkage Coordinator, Metropolitan Task Force on Drug Exposed Infants, Kansas City, Missouri - (816) 234-3670. Or for a copy of the report contact the CSAP National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs, 9300 Lee Highway, Fairfax, Virginia 22031 - (800) 354-8824.

Ward, Janet L. ***A Question of Balance: Decision Making for CASA/GALs.*** Seattle, Washington: National CASA Association, no date. [NOTES: This is a very useful volume for CASAs and GALs. In particular it contains *Decision Inventory Questionnaires* that raise relevant questions at the various stages of a case - shelter care/detention hearing; adjudicatory/dispositional hearing; subsequent review hearings; and termination parental rights hearings. For copies or more information, write National CASA Association, 2722 Eastlake Avenue East, Suite 220, Seattle, Washington 98102.]

VII. NOTEWORTHY PROGRAMS

In the search for information about strategies to utilize with substance abusing parents of children that are maltreated, a number of programs were identified which are having success or at least hold great promise. These programs are briefly discussed in this chapter. In considering what others are doing, one does not have to necessarily adopt their approach whole cloth. Concerns about resources and the applicability to local conditions often moderate the adoption of a given program. And sometimes one discovers improvements or modifications to programs that make them more efficient and effective. Perhaps some of the following programs will stimulate creativity that will make them adaptable and adoptable.

Michigan's Families First Program

Michigan's Families First Program is a Family Preservation program which follows the Homebuilders model (see Barthel, 1992). Three years after the implementation of the Families First Program, Blythe, Jiordano, and Kelly (1991) assessed its success.

> While Families First is a relatively new program without extensive evaluation, the initial data are positive. During the first 16 months of operation, Families First therapists in the Detroit area served 444 families. Of these, 246 families had at least one adult family member with a substance abuse problem, typically crack cocaine. Following those families up to a year after completion of service, at least 80% of the families remain intact, with parents caring safely for their children.
>
> Much of what we have learned in working with these families is counter to the beliefs of professionals and the lay population about parents who use drugs. Families First therapists have found that these parents are willing to choose help to decrease or discontinue their use, especially when facing possible removal of their children. While crack cocaine can have devastating effects on families, Families First therapists have found that it is as treatable as any drug problem, perhaps even more so. The key factor appears to be the manner in which a client's drug use is addressed. When approached respectfully with options, drug-using parents are motivated to seek help and are willing to change to make their lives and the lives of their children better.
>
> Although service providers have tended to focus on "the drug problem", Families First therapists found that drugs were much less of a problem than were systemic barriers. The lack of decent, affordable housing, poverty, inadequate social support networks, and limited education level, and/or job skills of the parents, and racial and general biases of the treatment system all work together to make it difficult for parents to make changes. Yet, Families First therapists have achieved promising results with their clients.
>
> [Blythe, Jiordano, and Kelly, 1991:13]

Families are referred to the Families First program when the DSS worker working with a case makes a decision to remove the child or children. Families First deals with families whose children are in imminent risk of removal and placement. It becomes a "last chance" for the parents. If the court authorizes the use of Families First and the program accepts the referral, the family is worked with intensively by a Families First therapist or team of therapists in the home. This intensive intervention is limited to six weeks. Beyond six weeks, referral to other agencies may be made and the case may continue as an open CPS (Child Protective Services) case. A case follow-up is done at three, six, and twelve months after termination.

When substance abuse is involved, the guidelines for appropriate referrals are as follows:

APPROPRIATE REFERRALS:
Referrals may be appropriate in substance abuse cases when:

1. A parent is available for treatment.
2. A parent is willing to get treatment for substance abuse problem.
3. There is no evidence of serious mental problems that would make treatment and cooperation impossible.
4. One or more of the children within a family is chemically dependent and the family is willing to work with FAMILIES FIRST worker to initiate treatment options for such children.
5. Parents have given birth to a drug addicted infant and are willing to get treatment for baby and themselves.
6. Families which need child care, transportation, or advocacy in selecting treatment option.

INAPPROPRIATE REFERRALS:

1. A parent is not available for treatment.
2. A parent is unwilling to get treatment for substance abuse problem.
3. A parent is found incoherent all of the time due to substance abuse.
4. Family members, including parents, fear being murdered by drug community and move constantly to avoid harm.
5. A parent wants child(ren) to be placed -- refuses to consider services or help that might enable child(ren) to remain in the home, even temporarily. Child(ren) are viewed as an imposition.

[Michigan Department of Social Services,
FAMILIES FIRST Guidelines, no date]

Following is a listing of the FAMILY FIRST values, beliefs and program characteristics (they are adapted from those of the Behavioral Science Institute [BSI] - Homebuilders program). They not only provide a better understanding of the FAMILY FIRST program but of the Family Preservation or Homebuilders program.

PROGRAM CHARACTERISTICS

- Focus on family strengths - not problems
- Limited to children at risk of imminent placement
- Immediate response (within 24 hours)
- Highly flexible scheduling (24-hour, 7-day/week availability)
- Small caseloads (2 families) per worker
- Intensive intervention (5-20 hours/week as needed)
- Services delivered in client's home and community
- Time-limited and brief (4-6 weeks)
- "Hard" and "soft" services delivered by a single worker with safety backup
- Ecological approach (works with family and community interaction)
- Goal-oriented, with "limited" objectives
- Flexible money
- Evaluation

VALUES AND BELIEFS

- Safety is our first concern
- Children need families
- We can't tell which families are hopeless
- Troubled families can change
- Clients are our colleagues
- We must respect our clients' values and beliefs
- It is our job to instill hope
- A crisis is an opportunity for change
- Inappropriate intervention can do harm

> A basic principle of the child welfare system in the United States is that every child is entitled to grow up in a permanent family. Inherent in this principle is the need to make all reasonable efforts to keep families together and to place children out of their homes *only* if their well-being cannot be protected within their families.
>
> [Michigan Department of Social Services,
> FAMILIES FIRST handout, no date]

Michigan's FAMILIES FIRST program claims success in dealing with their substance abusing families and their program has a good reputation nationally. However, the model they utilize - the Homebuilder or Family Preservation model - is one that has met with criticism. In a Washington Post article (Vobejda, 1994:32) Chicagoan Patrick Murphy, a Cook County public guardian (GAL), contends that the Family Preservation program allows children to stay home in the care of dangerous adults. He gave several examples of children who have died while in the care of the family preservation program. In addition, Vobejda notes that Murphy

> . . . also criticizes what he says is the flawed philosophy of the program. He argues that low-income families who take good care of their children are given little or no help from the government, while parents who have abused their children can get financial help and the services of a worker in their homes.
>
> "A program like family preservation . . . sends the wrong message out to 95 percent of the parents who are trying to do a good job under bleak circumstances, " Murphy says.
>
> [Vobejda, 1994:32]

Barth (1991) is critical of the short time period (4 to 6 weeks and in some programs up to six months) of the intervention.

> This brevity of service does not square with the fact that the resolution of drug-treatment is typically a year or two or with the fact that drug-exposed children create great demands on parents or with drug-users' limited capacity to parent. Whereas some parents have fallen from successful roles as parents and providers and largely need drug-rehabilitation, many drug-involved parents need habilitation and must -- for the first time -- become effective parents and providers. Until they do, their children are in double jeopardy.
>
> [Barth, 1991:3]

Dr. John Schuerman of the University of Chicago (Chapin Hall Center for Children) has been conducting an evaluation of the Illinois Department of Children and Family Services' (DCFS) Family First placement prevention program (a family preservation program). In his 1992 progress report he concurs with the point made by Barth when he reports:

> The program significantly reduces the length of time that cases are open in DCFS, with the exception of cases in which there are cocaine problems. In general, families with cocaine problems remain in DCFS longer than those without these problems, and cases with cocaine problems remain open longer after receiving Family First services than after regular DCFS services.
>
> [Schuerman, Rzepnicki, and Littell, 1992:ii]

Vobejda cites evaluation data reported for Michigan's Families First program.

> An evaluation conducted last year found that 24 percent of Families First children had been removed from their homes one year after entering the program, compared to 35 percent of children in a comparison group.
>
> [Vobejda, 1994:32]

In this particular article there was no description of the comparison group in Michigan. For the Schuerman study, cases were randomly assigned to one of two conditions - the Family First program or the regular DSS program. The treatment group was assigned to the Family First program and the control group (or comparision group) was assigned to the regular DSS program. The Michigan statistics are only fully comparable if their comparison group was also randomly assigned. Random assignment is considered an optimal and powerful experimental research design. It is conceivable that the evaluation design itself may have produced these differences between Michigan and Illinois.

Schuerman also reports that the Illinois Family First program "may have limited and short-lived success in helping families strengthen their informal support networks."

(Schuerman, Rzepnicki, and Littell, 1992:iii) In another article written by Schuerman, he concludes that the Family First (family preservation) program is not serving the intended group - families with children at "imminent risk of placement." (Schuerman, Rzepnicki, Littell, and Budde, 1992:193) He notes that caseworkers were not referring the children at risk intended for the program. He explains it this way:

> Workers have many good reasons for not referring seriously troubled families to these programs. Referring a case in which there is "imminent risk" obviously involves risk -- risks of harm to the child, and risks to the worker who may be held accountable if harm occurs. The workers may not be willing to take these risks. Workers may also doubt the ability of the family preservation agencies to handle difficult cases or to assess risk of future harm to children.
>
> [Schuerman, Rzepnicki, Littell, and Budde, 1992:197]

Perhaps the most striking finding about the Illinois Family First program is that it does not appear to be achieving a primary goal - reducing foster care placements. Schuerman reports that children in Family First were just as likely to end up in foster care as was the control group in his study. (Schuerman, Rzepnicki, and Littell, 1992:67)

One positive finding from the Schuerman evaluation is that:

> It appears that for the Chicago East sample, families may have experienced greater problem reduction in three out of nine domains as a result of Family First services and these improvements were relatively durable.
>
> [Schuerman, Rzepnicki, and Littell, 1992:iii]

The three domains to which he refers are physical child care, children's academic adjustment, and parental coping. (Schuerman, Rzepnicki, and Littell, 1992:82)

Other researchers have also been critical of the family preservation program model and implementation (see, for example, Rossi, 1992 and Wells and Biegel, 1991). One may well conclude from these research efforts and reported results that implementing family preservation programs nationwide may be premature based on research findings that put their effectiveness into doubt.

In sum, the concept of family preservation has many appealing features. For example, it is family oriented. It is delivered in the home. It coordinates assess to services in the community. It "empowers" the family. The essence of the program appears solid but the application apparently falls short in many places.

CONTACT INFORMATION

MICHIGAN'S FAMILIES FIRST -	Ms. Susan Kelly, Program Manager Michigan Department of Social Services Family Preservation Services Unit 235 South Grand Avenue, Suite 411 P.O. Box 30037 Lansing, Michigan 48909 (517) 373-0092
	Ms. Mary J. Jiordano Coordinator of Training FAMILIES FIRST [Same address as Susan Kelly]
HOMEBUILDERS -	Dr. Jill Kinney Substance Abuse Training Program Behavioral Sciences Institute - Homebuilders 34004 9th Avenue South, Suite 8 Federal Way, Washington 98003-6737 (206) 927-1550 [NOTE: Specifically ask about the Drug Affected Families Training Modules]

The SHIELDS Program

SHIELDS for Families, Inc. is a cluster of programs to address the issues of substance abusing parents. SHIELDS is an acronym standing for Sisters Helping Individuals toward Empowerment, Love, Development and Strength. Following is a brief description of the program.

> The SHIELDS for Families Project, Inc. is a private, non-profit organization which is comprised of twelve therapeutic non-residential programs which provide comprehensive, collaborative and community based services to families affected by substance abuse and/or child abuse who reside in South Central Los Angeles. SHIELDS primary goals are to: (1) reduce the incidence of drug and alcohol exposed infants; (2) increase the number of drug and alcohol abusing women seeking prenatal care and treatment; (3) increase retention rates in treatment and social services; (4) increase the number of families remaining intact in the community by decreasing the need for out of home placement and (5) strengthen families through the provision of comprehensive services. In order to increase the opportunities for successful outcomes, SHIELDS provides services utilizing center-based, "one stop shopping" model, in addition to home-based services. Currently, over twenty agencies provide on-site services to SHIELDS clients, including WIC, the State Department of Vocational Rehabilitation, and the Los Angeles County Department of Childrens' Services.
>
> All programs interact closely with the King/Drew Medical Center and all infants and children are followed in High Risk and Continuity Clinics. Programs are staffed by multi-disciplinary personnel with culture sensitivity to multi-problem families in need of habilitation and rehabilitation. Because families have varying levels of needs, SHIELDS programs provide for a continuum of care, with varying levels of intensity and services.
>
> [Program description from SHIELDS for Families, Inc., personal communication]

Following is a very brief description for sub-programs within SHIELDS. Further information may be obtained from the program (see contact information below).

> Project Support: Project Support is an Early Intervention program which offers case management, individual and group counseling, home visits and child care to recovering women and their drug-exposed infants and young children.
>
> The EDEN Center: EDEN is a comprehensive outpatient program that services women in recovery and their special needs children for 6-9 months. EDEN participants attend center based services four days a week and receive home based services a minimum of once per week. Services include individual, group and family counseling; parenting and

parent/child interaction classes; child care; child development, inclusive of developmental assessments and early intervention services; drug and alcohol, health, nutrition and AIDS education; and support groups.

The Genesis Family Day Treatment Program: Genesis is an intensive day treatment program for substance abusing pregnant and parenting women and their children 0-3 who reside in South Central Los Angeles. Services are provided six days a week, six hours a day, for an average of twelve months. Genesis utilizes a comprehensive, collaborative, "one-stop shopping" model for the provision of services. Currently over twenty agencies provide services on-site, and five agencies have staff co-located at the Genesis facility.

Heros and Sheros: The Heros and Sheros Program is a prevention and early intervention program for children (ages 6-14) whose parent(s) are enrolled in a drug treatment program, with a primary emphasis on serving the older children of families enrolled in existing SHIELDS programs. . . . activities are designed to help children therapeutically deal with issues relating to their parent's substance abuse and include individual and group counseling. Transportation to program services is provided.

GOOD NEWS: The GOOD NEWS Program is a comprehensive outpatient treatment program and Medical Unit that is on-site at the Imperial Courts Housing Project in South Central Los Angeles. . . . GOOD NEWS provides medical screenings and evaluations, as well as job readiness and job placement services. . . . GOOD NEWS is a collaborative program with the Imperial Courts Resident Council and the Los Angeles City Public Housing Authority. All program services are offered in Spanish and English.

Imperial Courts Beautification Project: This project was funded by the United States Department of Agriculture to help rebuild and reunify the Imperial Courts Housing Development following the Los Angeles riots. Residents of Imperial Courts are employed to plant vegetable gardens, trees and flower beds throughout the development. The ultimate goal of the program is to develop a Farmer's Market that can serve as a source of income and employment for residents.

South Central Case Management Connections: This program provides intensive case management services to substance abusing pregnant and parenting women and their children. Services include: family service plans, advocacy, information and referral, developmental assessments, and home and center based services. Families are followed for a minimum of three years and are contacted by their case manager a minimum of two times per month. Services are offered in Spanish and English.

SHIELDS' Outreach and Follow-Up Project: This program provides referral, outreach and follow-up services to drug exposed infants and

their mothers in order to ensure that children maintain continuity in their medical services. . . . Staff provide outreach services through letters, phone calls, and clinic visits to ensure children remain under medical care and to assist mothers in accessing health and treatment services.

SHIELDS' Medical Unit: The Medical Unit provides medical services to SHIELDS families in the Outreach and Follow-Up Project who are unable to access medical care during regular hospital clinic hours.

Compton Family Preservation Network: The Compton Family Preservation Network (CFPN) is a collaborative, community based program which works with high risk families referred by the Department of Children's Services. The CFPN is comprised of five agencies which co-locate staff in one site in order to provide intensive and comprehensive services to families enrolled in the program. Services are primarily in-home and include: counseling, teaching and demonstrating homemakers, parenting education and child care.

The ARK: The ARK Comprehensive and Child Development Program is designed to address the complex needs of pregnant and parenting women, and to address the socio-economic and psychological problems encountered which impair family functioning.

Family Intervention Program: The Family Intervention Program provides comprehensive case management and drug treatment services to families in collaboration with staff from the Department of Mental Health, Probation, Health Services, Children's Services and SHIELDS. Staff works as a team to meet families needs to eliminate the need for court intervention and out of home placement for children.

[Program description from SHIELDS for Families, Inc., personal communication]

The program staff and administration judges the program to be very successful in large part because they are in the community they serve and they work closely with that community. The community itself also provides other services and support. The SHIELDS program is there for the lifetime of the client if they need the program again after completing it.

CONTACT INFORMATION

SHIELDS for Families, Inc. - Ms. Kathryn S. Icenhower
Director of Administration
SHIELDS for Families, Inc.
P.O. Box 59313
Los Angeles, California 90059
(310) 603-8304

Children's Institute International

Los Angeles, California has yet another multifaceted program that addresses child maltreatment and parental substance abuse. It is the Children's Institute International (CII). Following are selected excerpts from materials sent by CII.

> In 1979, CII established one of the nation's first therapeutic day care centers for infants and toddlers at-risk of abuse and neglect.
>
> CII established an innovative facility for infant day care in 1976. This was expanded to a 24-hour emergency shelter and assessment center in 1984, and is a national model for the residential care of infants and toddlers. In 1988, again responding to another growing need in a critical area, CII expanded the capabilities of the shelter to serve medically fragile infants, many exposed prenatally to drugs.
>
> CII has pioneered many child abuse treatment methods, including SPARK (Support Program for Abuse Reactive Kids) in 1985 — the first of its kind to offer treatment for children ages 4-12 who molest other children; and CATS (Child Sexual Abuse Treatment Services) in 1986, offering specialized therapy for child sexual abuse victims and their families.
>
> CII is at the forefront of the family preservation movement — developing programs that focus on family reunification and improved family functioning. In effect since 1972, this program is cited as a model by the National Institute of Mental Health. Its success is documented by nationwide research which found that the re-injury rate for children in the CII program was one-tenth the national average.
>
> Project New Beginnings was established in 1987 as a demonstration program to meet the growing need for expanded services for drug-exposed infants, young children, and their parents. Essential to the program are treatments aimed at helping parents stay drug-free. Project New Beginnings makes it possible for a single agency to coordinate and deliver all the necessary multiple services to the children and their families.
>
> Partners in Foster Care, established in 1988, is another demonstration program unique in matching specially screened and trained foster parents to traumatized children, and providing these families with a 24-hour support network.
>
> CII's innovatively developed continuum of care provides a "one-stop" opportunity for troubled families and children to obtain the help needed to become productive, successful members of society.
>
> [Children's Institute International brochure, no date]

On November 1, 1993 CII put out a news release on a new program called PROJECT STABLE HOME. Following are excerpts from that release.

> With a major grant recently awarded by the Federal Abandoned Infants Assistance Program, Children's Institute International (CII) is once again at the forefront in addressing a critical need area -- the alarming increase in births of alcohol and drug exposed or HIV infected babies in LA County, and the increasing number of parents (often single mothers) in need of comprehensive community support systems to help them recover from chemical dependency and develop more effective parenting skills.
>
> . . . PROJECT STABLE HOME targets children prenatally substance exposed or HIV infected, who are at risk of abandonment.
>
> CII through PROJECT STABLE HOME creates and directs an inter-agency team to promote stable home environments with consistent primary caregivers for these children. The first priority is to deliver the necessary family preservation, parenting instruction and treatment services that will enable the children to safely remain with their biological parent(s). If this is not possible, then the next priority is to support placement with extended family members; the last option is for placement with specially trained foster parents. The Project's abandonment prevention services begin with high-risk populations before conception, intensify during pregnancy and the immediate post-partum period, and continue through the early formative years of these emotionally and medically vulnerable children. In addition to prenatal substance or HIV exposure, many are at risk of abandonment either by the birth mother or through a series of failed placements. The key focus is to reduce the number of losses and placements these children endure and to help build a stable home environment in which they can thrive.
>
> [Children's Institute International news release dated November 1, 1993]

CONTACT INFORMATION

Children's Institute International -	Ms. Mary M. Emmons Executive Director Children's Institute International 711 South New Hampshire Avenue Los Angeles, California 90005 (213) 385-5100

Step By Step

Step By Step is a regional, multiple agency program located in Wake County which addresses many of the same concerns of the California programs presented above albeit on a smaller scale. The Step By Step program "offers comprehensive health and treatment services to pregnant and postpartum women and their families impaired by alcohol, drugs, and related emotional problems." (Step By Step brochure, no date) This program is supported by the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

The point of entry for this program is the prenatal clinic of the Department of Health. When candidate mothers are identified they are encouraged to volunteer for the program. If they agree, they sign a contract to get into the program. They are covered by the services of the program prenatally with an eighteen months follow-up. They are provided clinical services and support services as follows:

CLINICAL SERVICES

- Medical care for pregnant and postpartum women, including HIV counseling and testing.
- Well-child care.
- Treatment for chemical dependency, including inpatient, outpatient and residential services.
- Psychological assessments.
- Child development assessments.
- Home visits by public health nurses.
- Nutritional counseling and WIC services.
- Individual counseling and support groups for victims of domestic violence and sexual assault.

SUPPORT SERVICES

- Community outreach.
- Care coordination for pregnant and parenting women and their children.
- Pre-treatment support groups.
- Family preservation services.

SUPPORT SERVICES [continued]

- Prepared childbirth, baby care and parenting classes for pregnant women and their partners.
- Individualized parenting services and parent support groups.
- Literacy programs and educational services.
- Extended care services and assistance with day care for children.
- Incentive programs.
- Assistance with Medicaid, AFDC, transportation and food stamps.

[Step By Step program brochure, no date]

CONTACT INFORMATION

STEP BY STEP -

Ms. Dorothy Cilenti
Program Coordinator
Wake County Department of Health
10 Sunnybrook Road
P.O. Box 14049
Raleigh, North Carolina 27620-4049
(919) 250-4635

Ms. Susan Schiewe
Program Supervisor
Step By Step
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(919) 250-1185

Comprehensive Child Development Program

This program is not specifically targeting substance abusing families in which there is child maltreatment. However, it can be seen as a prevention program, an early intervention program with results similar to other programs presented here. It has some common themes - single point of entry, multi-agency cooperation, and family focused. Following is a brief description of a North Carolina program called UPLIFT. It is our understanding that this is a federally funded program.

> The Comprehensive Child Development Program (CCDP), will provide intensive, comprehensive, integrated and continuous support services over a six-year period to 240 low-income families. To be eligible for enrollment in the program, families have to be at or below the poverty level, and either have an unborn child or a child under the age of one year. UPLIFT is one of thirty-four organizations nationally that has been funded for the research-oriented program.
>
> The overall objectives of the program are to provide services to children from birth to entrance into public school that will enhance their intellectual, social, emotional and physical development, and to provide needed support services to parents and other household family members that will enhance family stability and economic and social self sufficiency.
>
> In CCDP, all preschool children will be screened for health and developmental problems and will receive early childhood educational and nutritional services. Parents, and other family members, will receive health care (including prenatal care), parenting education, child care, transportation, education, vocational training, job placement and the all important peer support that has too often been missing from their lives.
>
> This grant will enable county health, mental health and social services departments and private non-profit agencies to unite in providing the kinds of early intervention services that can make a significant difference in the lives of young children and their families. The CCDP is designed to empower people by providing family members with more skills to deal with the stresses of daily life, and enhancing the already existing positive strengths of the family unit.
>
> [Program description received from UPLIFT, no date]

CONTACT INFORMATION

Comprehensive Child Development Program -	Ms. Carol D. Howard Project Manager UPLIFT, Inc. P.O. Box 222 Greensboro, North Carolina 27402 (910) 333-2222

Healthy Families America

This program model addresses the early identification of risk for child maltreatment. Within that context it also addresses substance abuse of parents as a critical factor in the risk for child maltreatment. Its parent program, Healthy Start in Hawaii, is comprehensive and highly successful.

> Healthy Families America is an effort to lay a nationwide foundation for a voluntary, neonatal, home visitation system. The effort was initiated in 1992 by the National Committee to Prevent Child Abuse in partnership with the Ronald McDonald Children's Charities. It is based on a model home visitor program developed by the Hawaii Family Stress Center in conjunction with Hawaii's Maternal and Child Health Division. New parents, most often the mother, are contacted prenatally or in the hospital at the time of their baby's birth and offered weekly home visits.
>
> [*North Carolina Cares*, a newsletter published by Prevent Child Abuse, the North Carolina chapter of Healthy Families America, Volume 16, No. 2, Fall 1993:4]

The origin of the Healthy Families America goes back to a program begun in Hawaii at the Hawaii Family Stress Center.

Overview

Hawaii's Healthy Start is a statewide home-visiting program designed to prevent child abuse and neglect by identifying high-risk families either before or immediately after the birth of a child, linking those families to health and social services, and providing family support and parenting education until the child begins school.

Population Served

Healthy Start focuses on vulnerable families with newborn infants who are at high risk of child abuse and neglect. By working closely with hospital maternity wards to screen pregnant women and newborns, the program identifies these vulnerable children either before or immediately after birth. Over half of all newborns in the state are screened.

"Early identification" workers review hospital records to determine which families live in the program's service area. The workers then examine case histories to identify parents who display certain risk factors, including

- environmental conditions, such as unemployment, poverty, or unstable housing;
- family conditions, such as single parenthood, lack of immediate family contacts, or marital discord; and
- personal conditions, such as substance abuse or psychiatric conditions.

Finally, parents who appear to be at risk are interviewed by trained staff. Staff talk with the parents about their current situation and childhood experiences, provide them with information on parenting and child development, and offer home visiting services. While the program is voluntary, 95 percent of the parents interviewed choose to participate.

Activities

Healthy Start's family support workers first contact mothers before they leave the hospital to schedule an initial home visit. These families often have very serious immediate needs, and family support workers are trained to assist them with such necessities as securing emergency food and housing assistance, completing application forms for health or social service programs, or resolving crises in family relationships. As they get to know their families better, family support workers offer parents emotional support, help them to cope with the stresses of parenthood, and promote emotional bonding and attachment between the parent and child. They also provide parents with information about their children's development and teach basic childrearing skills, such as how to develop eating and sleeping schedules for infants, or how to appropriately discipline toddlers.

Healthy Start links families to the full range of health and social services in their communities. All children in the program have access to health care services. Workers conduct developmental screening and assist with referrals for further testing and intervention. Workers follow up on immunizations and well care visits and encourage mothers to seek prenatal care for subsequent pregnancies. Healthy Start promotes school readiness by enrolling 4-year-olds in Head Start and is developing a new program for infants and toddlers based on the Parents as Teachers model. Family support workers help parents gain access to other services as well, such as child care, substance abuse treatment, or spouse abuse services.

To help families develop the ability to manage on their own, services become less intensive as parents gain the skills and resources they need. At first, all families receive home visits every week. The visits become less frequent as families grow more stable, autonomous, and responsive to children's needs. ***To ensure that improvements last, all families receive visits at least every three months until the child is five years old.***

[Emphasis added]

Evaluation

Evaluations of Healthy Start indicate that it is effective in identifying families at risk, preventing abuse and neglect among the families it serves, and improving the quality and stability of parent-child relationships. A study of the original demonstration project found that over three years, no instances of abuse and only four cases of neglect

were reported among 241 families served. No abuse was reported among 99.5 percent of the families identified by the initial hospital screening as not at risk. Clinical studies of some families in the program found that most had become more stable and had reduced their degree of risk for child abuse and neglect. More recent evaluations indicate that expansion of the program has not reduced its effectiveness: 1992 data shows no abuse or neglect in over 99 percent of the more than 2,000 families in the program.

Replication

The National Committee for Prevention of Child Abuse, in partnership with Ronald McDonald Children's Charities, has launched Healthy Families America to promote replication of the Healthy Start model nationwide. Currently 46 states are working to implement the model through demonstration projects or community organization efforts.

[Information packet provided by the Hawaii Family Stress Center, no date, personal communication]

CONTACT INFORMATION

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Healthy Families America -
Ms. Leslie Mitchel
Project Director
Healthy Families America
National Committee for Prevention of Child Abuse
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Chicago, Illinois 60604-4357
(312) 663-3520

Hampton Family Resource Project

According to Betsey Pratt of Healthy Start in Hawaii there are currently several successful programs on the "mainland" replicating the Healthy Start model. One program which Pratt highly recommended is the *Hampton Family Resource Project* in Virginia. The Family Resource Project consists of three separate programs - Healthy Start, Healthy Family, and Healthy Community. Healthy Start is the implementation of the Hawaii Healthy Start model. The point of entry for this program is through the Health Department's prenatal program. Of the three programs this is the only program directed solely to the poor in the community. The other programs are available to the entire community.

Healthy Family is a program that is designed to make the experience of raising children more enriching. Its services are offered to all families in the Hampton community. Following is a list of the various services it offers.

Young Family Centers - In conjunction with the local library there is a special section in the library with information for parents and families - books, cassette tapes and videos. This section of the library also has children's books and toys for the children to play with while their parents browse and read the library materials.

Parent Education Classes - These parenting classes are offered to all residents of the community at no cost.

"Healthy Stages" Newsletter - A series of newsletters has been developed which provide information on stages of development that all children go through to help parents anticipate what to expect. It covers the growth of the child from birth to age five. In addition to information about child development, the newsletter has information on age-appropriate activities, various community programs, health facts, immunization schedules, and the like.

Student Training on Pregnancy Prevention (S.T.O.P.P.) - This program helps teach teens and preteens about the responsibilities and realities of becoming parents. Trained counselors visit Family Life Education classes in grades 6 through 10. They share realistic information about the duties, costs and life changes involved in having a child.

Play Groups/Peer Support Groups - Parents are helped with organizing play groups, peer support groups and classes on special topics of interest by providing resources, meeting rooms, and information.

Hospital Resource Center - Information on program services, as well as schedules for classes and play groups, is located in the hospital lobby. (Note: The cooperating hospital for this community is Sentara Hampton General)

[Adapted from a brochure of the
Hampton Family Resource Project, no date]

The third component of the Hampton Family Resource Project is Healthy Community. This component of the program as of November 1993 had not yet been developed. Its intended purpose is to "encourage values and attitudes that support healthy child development."

> A community based local interdisciplinary task force, including representation from the public and private sectors, will be developed to address the needs of all children from the perinatal period to age five. This task force will be given the goal of identifying community-wide goals, objectives and strategies that address the problem. Activity will focus on promoting community understanding of the problem, improving service access and strengthening community collaboration.
>
> [Family Resource Project program description, 10/4/93]

Using the Healthy Start Hawaii model as a base, the Hampton Family Resource Project has extended a variety of services and education resources to the general population. This is a broad brush effort to focus on the needs of children and their parents. The program has engendered a multi-agency approach with strong connections to the private sector as a partner. It is truly a community effort and it seems to have fostered a sense of community as well.

CONTACT INFORMATION

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Ms. Louise Bartlett
Trainer of Trainers - Healthy Start
Hampton Family Resource Project
1320 LaSalle Avenue
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(804) 728-0725

CONTACT INFORMATION

Healthy Families America - Virginia

Ms. Barbara Rawn
Executive Director
Virginians for Child Abuse Prevention
224 East Broad Street, Suite 302
Richmond, Virginia 23219
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Healthy Families America - North Carolina

Ms. Jennifer Tolle
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Prevent Child Abuse, North Carolina
3344 Hillsborough Street, Suite 100D
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(919) 829-8009

START Program

The START (Steps to Accepting Recovery Treatment) program was developed by William A. Eddy (1992). Eddy, a clinical social worker, has a chemical dependency treatment background in both hospital and outpatient programs. He also has a law degree. Eddy has combined his law and social work degree to fashion a program that utilizes addiction treatment principles of simple steps and immediate consequences. For the information of the reader, a similar program is described by Finn and Newlyn (1993) in the National Institute of Justice's *Program Focus*.

The START program is a six months court-based intervention program. Each month the parent (substance abuser) and social worker set "attendance" and "learning" goals in three areas - drug treatment, counseling, and parenting instruction. The parent is encouraged to select a monthly plan that is their choosing within some minimum guidelines (Eddy [1992:13] notes that "In a program for abusive parents, researchers found that the parents had a greater investment in changing their behavior when setting their own goals."). The parent/social worker plan then becomes part of the court's order.

> This planning would focus on small, realistic tasks that fit the individual. For example, a parent without transportation might only be expected to attend one AA/NA meeting per week the first month. Setting up a therapy appointment and signing up for a parenting class might be the only requirements in the other two areas for the first month. Yet accomplishing those goals would build success. Another parent might be required to attend several meetings a week and to get on a treatment program waiting list.
>
> The Learning Goals would help the parent and those providing treatment services to focus narrowly and effectively on the same key issues.
>
> [Eddy, 1992:12]

In this planning approach, the court (through the social worker) would identify specific needs of each parent so that the most pressing needs could be dealt with first rather than deluging the parent with multiple orders. The focus should be on substance abuse recovery issues first. (Eddy, 1992:13)

> At the end of each month, the parent would turn in evidence of attendance in each area to the social worker, briefly describe some learning in each area, and set new goals for the following month. Reviewing the monthly results could enhance the parent's own awareness of strengths and desired improvements. By carrying the burden of achieving the goals, a parent would have a stronger role in taking initiative and fulfilling a responsibility. Observing his or her own success in small steps may increase the parent's self-esteem and confidence.

> This process also provides an opportunity for the parent to realistically evaluate and improve goal-setting. In briefly telling the social worker what was learned in the month, the parent may become more aware of personal issues. In setting goals for the next month, the parent may plan more realistically and feel a greater personal commitment.
>
> [Eddy, 1992:12-13]

At the end of each month the three goal areas are reviewed. For each success a positive consequence of $10 for each successful goal ($30 maximum per month) would result. For each failure, a negative consequence of one day in jail (a maximum of three days per month) would result - this would be based on contempt of court orders.

> The proposed START model of court orders and follow-up goes beyond simply ordering parents to participate in treatment activities. The court would require small steps each month to engage the parent in an active recovery process. Over several months, this approach is designed to get resistant parents to habits of participation and, ultimately, to accept recovery under their own motivation.
>
> While primarily maintained by the social worker, the START plan would be ordered and backed up by the court. After six or more months this approach would terminate, either because it successfully engaged the parent in treatment or it provided further evidence of the parent's limitations. This success-oriented model should increase the likelihood of recovery and positive reunification for otherwise "failed" families.
>
> [Eddy, 1992:12]

As of the date of this work, Eddy reports that a START program has not yet been established. (Personal communication) Although untested, the START model makes sense theoretically and appears to be very "doable."

CONTACT INFORMATION

START Program - Mr. William A. Eddy
160 Thorn Street, Suite 2
San Diego, California 92103-5691
(619) 291-9644

ON-TARGET PARENTING

This is a parenting program devised by William Eddy and Barbara St. Amant (1991). While the START program of Eddy has not been implemented, a sub-part of the START program, the On-Target Parenting method (the parenting instruction goal), has been adopted. One such program is in Newport News, Virginia (adjacent to the Hampton Family Resource Project). The Newport News CASA office began the On-Target Parenting program in conjunction with the substance abuse treatment program. Substance abusing parents are required to detox, to demonstrate that they want to be drug free, and to enter day treatment for substance abuse (which includes child care with a child development staff person to do a program for the children) in order to gain entry into the On-Target Parenting program. Another program in the Newport News/Hampton community called Project LINK provides transportation and child care (if needed) for persons involved in substance abuse treatment. Project LINK gets the parent(s) and their child(ren) to the day treatment center where they participate in a variety of programs, one of which is On-Target Parenting.

The On-Target Parenting program is done in Newport News at the substance abuse day treatment center. The model followed is Eddy and St. Amant's (1991) training manual for recovering parents. A small group of parents who qualify for the program are instructed by co-facilitators. One facilitator does training while the other facilitator observes the process to provide feedback and learning for future groups. The groups are closed in order to develop group cohesiveness which is believed to contribute to the success of the program. Confidentiality is a group ground rule which encourages candid group participation. The group runs for a period of ten weeks. In late November 1993 the first group was getting underway and no results were available at that time. However, the group co-facilitators were reporting that the program was being positively received, participation was good, information was being absorbed, and they were anticipating that parental behavior would change for the better.

In the manual there is a note to parenting instructors.

> The ON-TARGET PARENTING method is generally compatible with other methods of parenting instruction and is flexible enough to fit a wide range of parents. The manual is easy to use in a class format, using the exercises from each chapter as a basis of group discussion.
>
> We recommend using the first half of the available class sessions to cover the material presented in the manual, then using the second half of the sessions for group practice of problem situations using the PARENTING SUCCESS CARD. . . .
>
> Because of the negative feelings so many recovering parents have about their parenting, it is important for instructors to model the principles of positive LISTENING, NURTURING and TEACHING in the instruction of this method. Allow time for supportive group discussion as an important way of practicing the concepts and building confidence. And encourage a variety of suggestions for "on-target" responses to each problem

situation, to reinforce the idea that there is no one "right" way and that each parent already has a lot to offer.

[Eddy and St. Amant, 1991:xiii]

The diagrammatic representation of the On-Target Parenting program is a target or group of concentric circles the center of which is the child's developmental goals (for example, confidence in others, self, skills, and identity and the skills of self-awareness, self-discipline, and decision-making). The circles outside the child's developmental goals "bulls eye" are teaching, nurturing, listening, and protecting. Four arrows point away from the "target." These arrows represent four stressful emotions - guilt, anger, fear, helplessness. The parents are taught not to take their negative emotions out on the child.

> Even the best of parents have difficulty under stress. Rational thinking may disappear and emotional reactions take over. However, under stress our emotions have more to do with our own lives than with the child's behavior. Therefore, the target is a simple reminder when the going gets tough. You don' t have to be perfect. You don't have to give up. Just aim to be generally on-target.
>
> [Eddy and St. Amant, 1991:summary sheet]

When a child's behavior produces one or more stressful emotions, the parent is to "aim to be generally on-target" by invoking the four rational parenting actions - protecting, listening, nurturing, and teaching. In this way they avoid abusive responses to the child, model good parenting behavior for the child, and feed the child's developmental goals. In general, their own development is nourished which has a positive effect on their substance abuse treatment.

This appears to be a comprehensive and usable parenting curriculum. Eddy and St. Amant offer ON-TARGET PARENTING workshops, training, and consulting. For more information or a copy of the manual write to the address below or write William Eddy at the address in the Contact Information box above.

ON-TARGET PARENTING
P.O. Box 70059
San Diego, California 92167

CONTACT INFORMATION

Newport News ON-TARGET Program -	Ms. Phyllis Caswell Director, CASA 230-25th Street Newport News, Virginia 23607 (804) 247-8781

Summit House

Summit House in Greensboro, North Carolina is a community-based, non-secure, residential alternative to prison for mothers and pregnant women who have been convicted of non-violent crimes. For women in this residential program, most of the non-violent crimes for which they have been convicted are related to (directly or indirectly) their substance abuse - possession of drugs, trafficking in drugs, theft, shoplifting, writing bad checks, and so forth.

The capacity of Summit House is five women who have three or fewer children each. The waiting list for the program is quite long. The program staff addresses issues of substance abuse, parenting, education, developing job skills, and the like. They also provide support for the children in a variety of areas. Community programs are utilized as well during their stay in the program and as a source of reintegration into the community after leaving the program. For more information about the program, contact the persons listed below.

CONTACT INFORMATION

Summit House - Ms. Karen Chapel, Executive Director or
Ms. Barb Beutel, Program Director or
Ms. Rose Henry, Office Manager
Summit House
608 Summit Avenue, Suite 103
Greensboro, North Carolina 27405
(910) 275-9366

North Carolina Residential Treatment Programs for Perinatal Substance Abusing Women

At present there are six programs active in North Carolina. Each program has its own criteria for entry into the program. However, in general, substance abusing pregnant women and mothers with children can receive substance abuse treatment, along with their children, in these residential programs. Since the programs operate in somewhat different ways, the reader is urged to directly contact specific programs of interest. Mr. Ronald Osborne, Substance Abuse Services coordinates the perinatal project for the state.

CONTACT INFORMATION
NORTH CAROLINA PROGRAMS

Asheville, North Carolina -	Ms. Sherri Green Blue Ridge Area Program (704) 257-4485
Mecklenburg County -	Ms. Randi Gluderay Florence Crittenton Service Charlotte, North Carolina (704) 336-5024
Forsyth-Stokes Counties -	Ms. Mary Jo Lee Wish Winston-Salem, North Carolina (910) 725-7777
Chapel Hill, North Carolina -	Ms. Connie Renz Horizons (919) 966-9803
Raleigh, North Carolina -	Ms. Dorothy Cilenti Step By Step (919) 250-4635
Maxton, North Carolina -	Ms. Ann Clegg Robeson Health Care Corporation (910) 844-3066

CONTACT INFORMATION

North Carolina Division of MH/DD/SAS -

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Substance Abuse Services - DHR
325 N. Salisbury Street
Raleigh, NC 27603-5906
(919) 733-4671

Ms. Augusta D. Moore
Women's Services Consultant
Substance Abuse Services - DHR
(919) 733-0696

Concluding Comments

The programs described and referred to here represent those programs that were suggested by either GAL volunteers and staff, DSS and SAS interviewees, or various national sources contacted in the course of this project. Some programs were visited such as the Michigan Families First Program, the Hampton Family Resource Project, and the Newport News On-Target Parenting Program. For others, information was gleaned from face-to-face interviews with staff. And yet others provided information from telephone interviews, brochures, and program video tapes. In all, along with the resources found in Appendix A, the reader should have a rich base from which to pursue their interests.

Quite obviously the programs described above are not exhaustive for resources nationally or in North Carolina. But, they do provide information about the major cutting edge of useful programs to address the issues of parental substance abuse and child maltreatment. They also strongly suggest resources that, if they do not exist or are not readily available, should be vigorously advocated. The next and final chapter turns to advocacy issues.

VIII. ADVOCATING FOR THE CHILDREN OF SUBSTANCE ABUSERS

The children of substance abusers need all of the advocating and advocates they can get. They are very vulnerable and often this vulnerability is heightened by a strong focus on the substance abusing parent in isolation from the family unit (that is, the child). This focus on the substance abuser may ignore the needs of the child or may result in the child being removed from the home prematurely. While there are general guidelines for working with substance abusing families in the best interests of the child, there are no rigid rules or procedures (other than legal mandates which must be fulfilled) that can be followed in each and every case. The best advocacy tailors itself to the particular needs of a given case and utilizes all available resources while continually working for needed but unavailable resources.

This report has presented guidelines for working with the families of substance abusers in the best interests of the child. It has provided collective information from GAL volunteers and district administrators, child protective services and substance abuse professionals, other service providers, and mothers who were former substance abusers. The report has reviewed noteworthy and often innovative programs which are particularly well suited to the needs of substance abusing parents and their children. In all, many points for advocacy have been suggested. This chapter summarizes much of the prior chapters by touching on four areas in which GAL volunteers may advocate for the children of substance abusing parents. Those four areas are - Training and Information; Utilizing a Blended Approach; Services; and Political Concerns. Again, advocacy as presented here is not a specific procedure but a general process.

Training and Information

The best way a GAL can advocate for the child of a substance abusing parent is to carry out their responsibilities as a GAL as well as they can. Training and information will aid the GAL greatly in their work. While experience is a primary teacher of the GAL, good training and preparation can only enhance that experience.

Substance Abuse. Information about substance abuse and its impact on the family is vital to carrying out these responsibilities. The lack of knowledge of the GAL about substance abuse matters not only reduces the effectiveness of the volunteer but, as Levy and Rutter note, also may have a negative impact on the court itself.

> . . . Most family courts in America are understaffed and have overburdened calendars. Judges must adjudicate cases which, in rapidly advancing numbers, are the outgrowth of the drug epidemic in America. The judges themselves have received little or no training in drug abuse and must do the best they can without benefit of rational input. They are besieged by emotional appeals from addicted parents, biased attorneys, and harried social service agency workers. *Even where legal guardians are appointed to represent the rights and needs of the children, there exists an abysmal ignorance regarding the impact of addiction on family*

> *life and sensible strategies for effective intervention.* Yet these judges are expected, Solomon-like, to fashion fair responses to adults and children alike.
>
> [Emphasis mine]
> [Levy and Rutter, 1992:117]

The GAL volunteers could therefore benefit from training and information about substance abuse in general and its specific impacts on the family - especially children in the family. This training is best delivered by a substance abuse counselor or specialist who has had experience with cases in which there was child maltreatment. Even though the substance abuse counselor may have experience with cases in which they were aware of child maltreatment, providing training for GAL volunteers and perhaps joint training that includes DSS caseworkers will generate a deeper understanding of the philosophy, viewpoints, and experiences of GALs and DSS caseworkers and their need for specific knowledge about substance abuse. In short, the benefits should prove reciprocal for all involved and ultimately advantageous to the children whose parents are substance abusers.

As the above quote by Levy and Rutter notes, judges could also benefit from training about substance abuse and its impact on the children in the family of an abuser. In this way the judge could require more precise information about a particular case and evaluate that information in an informed manner. Again, while relevant training on substance abuse issues would probably be administered to homogeneous groups (that is, all judges, all DSS caseworkers, all GALs), the benefits from mixed training groups are potentially significant.

The training on substance abuse information for GAL volunteers should occur at two points - the initial GAL training and additional in-service training for GAL volunteers. In-service training would serve a two-fold purpose. First, new information relevant to advocates could be provided and some repetition of the initial training for refresher purposes would be beneficial. Secondly, the substance abuse trainer should get feedback about the usefulness of the information and the particular needs of the GAL volunteers for specific information. In other words, the in-service training would serve to finely hone the initial training agenda for the GAL volunteers.

GAL volunteer support groups would be a useful adjunct to the initial and in-service training. The support groups would focus on difficult issues such as child maltreatment cases in which there is substance abuse. The support group would provide new volunteers advocacy guidance on these difficult cases and it would give all volunteers an opportunity to identify their need for information in the in-service training as well as providing feedback to the initial GAL substance abuse training module.

Cultural/Class Competency. Another focus of training for the GAL volunteers is cultural and class competency. Competent training in this area is difficult to come by, but nevertheless important. Understanding social class differences (social scientists view social classes as types of subcultures) and cultural differences (that is, racial and ethnic differences) are very important to the job of the GAL volunteer. Shotton, Beyer, and Acoca (1993) describe what is meant by cultural and class competency. While they are specifically addressing these comments to mental health and substance abuse treatment providers, the contents of their remarks are useful for GAL volunteers as well.

> . . . The special forms of respect, trust, pride, shame and language within cultural and class groups must be appreciated . . . Intervention must start where the parent and child are. Home-based intervention is a must and should be based on the family's strengths. Culture and class are the family's reality and will be the context for efforts to keep the family together. Furthermore, home-based intervention facilitates the professional's assessment of the family's cultural community for informal sources of support.
>
> Cultural and class competency starts for professionals at three crucial points. First, it is best to not assume anything when going into a family's home - it is important to absorb the experience of the home rather than standing outside of it. Care should be taken to stop judgmental thoughts. The professional must stretch to observe the small caring interactions between parent and child. Second, if possible, the professional should go into the home with a team member of the family's culture and ask for feedback about what was missed and what resulted in unwarranted judgments. Third, professionals should focus treatment goals on ensuring the child's safety without undermining the uniqueness of the family and its community of support. This involves recognizing and incorporating into services alternative treatment approaches (such as healing ceremonies) and caregivers (such as ministers) from the family's culture.
>
> [Shotton, Beyer, and Acoca, 1993:34-35]

Volunteers need to be aware of their own class and cultural perspective. On the other hand one should not be seduced by "cultural relativity" in the extreme - that is, the notion that anything is acceptable because it is simply a feature (albeit a peculiar and objectionable feature) of a culture - hence what is peculiar is merely cultural and what is cultural is acceptable. We are not talking about such extremes of conduct such as incest, homicide, rape and the like. These are unacceptable behaviors not to be tolerated as merely a cultural aberration. Rather we are referring to behaviors which on the surface appear to be peculiar but in fact are alternate routes to very functional outcomes for the family. The volunteer secure in the knowledge of their own class and cultural perspective can then make an informed assessment of family members' behaviors without undue bias.

Least worst context. Shotton, Beyer, and Acoca (again writing for mental health professionals) discuss the anxiety of dealing with a child in a family which is not optimal for the child's development. The child advocate also needs to be aware of this perspective.

> Like judges, lawyers and child welfare workers, mental health professionals often find it difficult to work with children in barely adequate homes. Yet least worst choices are all that are available to support some neglecting and abusing families. Our wish to make them into "perfect families" that promote "optimal child development" is an antidote to the reality that we do little to prevent children's futures from being compromised by poverty and other problems. . . .
>
> When we build on a family's strengths, the best we may achieve is an adequate environment meeting the children's basic needs. Is it optimal? No. Is it better than the long-term consequences of removal? Almost always. Does it feel awful to be thinking "if only" all the time in these cases? Yes, but solving our discomfort by moving a child to a loving higher income foster family less compromised by stress is an unacceptable response to the least worst dilemma. In families where neglect/abuse and substance abuse has occurred, many of them will be the least worst placement for the child's long-term development.
>
> [Shotton, Beyer, and Acoca, 1993:14-15]

Shotton, Beyer, and Acoca also discuss the minimum standard of parenting for minimally adequate homes.

> . . . What must families do to permit adequate development of their children? Beyond providing regular meals, sleep, shelter and clothing, minimally adequate homes provide responsive caretaking, consistent, caring discipline, a stimulating (but not overstimulating) environment, and support for school competence. In addition, parents must not physically or sexually abuse their children.
>
> In families where substance abuse or incest exists, children also need adults to feel empathy, to communicate, to maintain boundaries, not to abuse power, and not to isolate the family. Supporting the family to find its own ways to meet these needs must be done in the context of recognizing the family's strengths and the child's attachment to the family. The ways that adult family members' needs obscure the children's needs must not be minimized, but care must also be taken to avoid imposing class/culture-biased definitions of family communication, power, and boundaries.
>
> Mental health professionals make a real contribution to keeping families together by clarifying the goal of "good enough parenting" and defining specifically these characteristics of minimal adequacy. . . . Mental health professionals are in a unique position to share with other service

> providers the findings of research. This can help them in their efforts to support minimally adequate homes and not remove children or delay reunification because of undesirable characteristics that do not put the child at risk.
>
> [Shotton, Beyer, and Acoca, 1993:33-34]

The GAL volunteer needs to be sensitized to the boundaries of the "least worst context" and the "minimally adequate" home. Initial training, experience, in-service training, and support groups can all contribute to mastering this approach and thereby gaining class and cultural competency. Through this, the volunteer will be advocating for the child in an efficient and effective way.

In sum, training, gleaning information, and sharing knowledge about the topics discussed above, will serve to make the GAL volunteer a more effective advocate.

A Blended Approach

The blended approach (Shotton, Beyer, and Acoca, 1993) is basically an appeal for interagency cooperation and the reduction of "turf" battles; a reduction in the duplication and fragmentation of services; and the coordination of a comprehensive delivery of needed services. In addressing this point, Barth says:

> The current "system," when it is working at its best protects the child of heavy drug users at home when possible. The first wave of services may involve a year or more of in-home follow-up services by the child welfare services system or public health services. These services could segue into a Family Services Plan under PL 99-457 which oversees the child's developmental care until age three. These services might then be supplemented by Head Start and the beginning of early childhood education that prepares children for school. If a child of a heavy drug user had this heavy array of services strung together, he or she would have a good chance of making good. At this time, no such system exists and the service cloth is full of holes.
>
> [Barth, 1991:18-19]

Although Barth is located at the University of California at Berkeley, he does not refer to the SHIELDS program in Los Angeles or the Healthy Start Program in Hawaii (for more information on these programs see the preceding chapter on "Noteworthy Programs."). Both of these programs are apparently successful efforts at making the service cloth whole. However, Barth is essentially correct that in most instances the children of substance abusers (and others suffering child maltreatment) do not experience a closely knit array of continuous services - the "blended" approach. The clarion call for a blended service approach is made by Shotton, Beyer, and Acoca. In their writing they do not specifically refer to the GAL advocacy role but it is clear that someone advocating for the appropriate mix of services belongs in the new partnership that Shotton, Beyer, and Acoca describe.

> A new partnership of mental health professionals, child welfare workers, substance abuse professionals, health professionals, staff from neighborhood organizations, and others is emerging. This partnership is creating a "blended" approach to services for children and families which integrates critical elements of each discipline. Blended services can be individually tailored to meet the needs of each family environment and therefore maximize the families' capacity to stay together.
>
> The blended approach challenges individuals within each discipline in a number of ways. They must acquire new skills from other disciplines, redefine roles and responsibilities, and develop an expanded first-hand knowledge of local community resources. They also must work collaboratively with others whose views and training may be substantially different or even contradictory to their own.
>
> Historically, these changes and expansions have created rifts between the various disciplines, particularly because most caregivers have been

> experiencing the dual stressors of higher caseloads and cases made more complex by increasing poverty and decreasing support services for children and families. It is precisely because children and families are experiencing greater stress and therefore presenting with more complex needs that individuals from all disciplines must transcend their boundaries and work as a team. Additionally, funding agencies are beginning to encourage interdisciplinary collaboration rather than competition. Teamwork provides a forum for exploring and overcoming differences in orientation and affords new opportunities for satisfaction since professionals who expand their skills are more likely to succeed in serving families and children.
>
> . . . a blended interdisciplinary approach, because it is likely to be more effective in protecting children's safety in the home, may help professionals see new ways to keep families together.
>
> [Shotton, Beyer, and Acoca, 1993:21-22]

Levy and Rutter (1992) propose a comprehensive multiservice center which would treat the substance abuse of the parent (in this case they are focusing on mothers with children) as a first priority. [Note: Levy and Rutter's description of the "soup-to-nuts" delivery system or multiservice center may be found in Chapter VI or in Levy and Rutter, 1992:132-133.] The service center would serve as a single point of entry. A comprehensive evaluation of the substance abuse and other problems would be done, and needs would be prioritized and addressed. Levy and Rutter described those other problems as "the melange of social, medical, psychological, nutritional, domicile, educational and vocational problems." They propose that "we should make reception of other services contingent upon active participation in drug-abuse treatment." Services and treatment would be a joint experience for the parent (mother) and their children. They go on to say, "The center will see to it that both parties' needs are being addressed. No longer will children be lost in the shuffle of 'adult only' concerns." (Levy and Rutter, 1992:132-133)

The Levy and Rutter model calls for a level of interagency cooperation that exists in rare instances but certainly not within the more formal structure implied by the concept of a comprehensive multiservice center. Certainly there are instances where multiple agencies share a common building and offer a single point of entry for a certain class of persons (for example, the homeless). However, moving from discrete or slightly overlapping services to fully integrated services coordinated by a single director or directorate is another matter. It is analogous to selecting a supreme commander to preside over planning and to set priorities and goals in a multi-national military undertaking. Such coordination is efficient and, barring a variety of serious squabbles, has proven effective in several instances since World War II. Perhaps social service agencies could take this important page from military history and improve on it in the battle against child maltreatment and parental substance abuse.

Much of the most recent literature addressing parental substance abuse and child maltreatment calls for a blended approach to assessment, setting priorities, and the delivery of services (see, for example, Kropenske and Howard, 1994; Child Welfare League of America, National Council of Juvenile and Family Court Judges, and Youth Law Center, 1993; Shotton, Beyer, and Acoca, 1993; Levy and Rutter, 1992; National Council of Juvenile and Family Court Judges, 1992; Barth, 1991.) Chapter VII on noteworthy programs indicates that some of the newer programs underway are making strong moves in this direction. However, the model proposed by Levy and Rutter has, to this writer's knowledge, not yet been accomplished.

Services

Levy and Rutter, as noted above, refer to a "melange of social, medical, psychological, nutritional, domicile, educational, and vocational problems" facing the substance abusing parent and their families (Levy and Rutter, 1992:132). The range or spectrum of services should be equal to addressing these problems. Quite obviously resources are not unlimited and available resources are often not allocated for this set of problems. Therefore, finding existing resources and gaining access to them is one task — while advocating for needed resources is the other important task for those dealing with child maltreatment and parental substance abuse issues.

The list of services required to adequately address child maltreatment and parental substance abuse is quite extensive. An exhaustive list would be a monumental task which is not attempted here. However, for different examples of such lists see - Crosse, S.B., E. Kaye, and A.C. Ratnofsky, 1994:3-40; Office of Guardian ad Litem Services, 1993:A-6; Child Welfare League of America, National Council of Juvenile and Family Court Judges, and Youth Law Center, 1993:Appendix U - see especially the State of Indiana materials; and Children's Defense Fund, 1992:67-69.

A Children' Defense Fund document presents a pyramid of services based on the premise that "As family needs grow in intensity, so do services to meet those needs." (Children's Defense Fund, 1992:68) It goes on to note that "When communities are able to offer a pyramid of assistance that matches the pyramid of family needs, problems are likely to be solved or alleviated at earlier stages, when they are easier and less costly to address." (Children's Defense Fund, 1992:68, 69) The ability to offer needed services on demand is, especially in the case of substance abusing parents, critical for the well-being of the children in the family.

The short list of services which families in the Comprehensive Child Development Program (see Chapter VII) have identified, in the order of their importance, is - housing, transportation, child care, and jobs (personal communication with program staff). This might be considered a basic list of services needed. For substance abusing parents in day treatment, two services - transportation and child care - appear to be critical to facilitating their success in treatment. In the Hampton/Newport News area of Virginia there is project LINK which provides these services and supports and supplements other existing services (see Chapter VII).

Accessing services is difficult for anyone (service provider or client) not fully familiar with what services are available. In order to facilitate access to services, GAL volunteers may consider advocating for a current resource directory of services covering both their county and, in some instances, the state. In a document by the Child Welfare League of America, National Council of Juvenile and Family Court Judges, and Youth Law Center (1993) a list developed by Elizabeth Cole of essential information for a resource directory is given.

- Name, address, phone and fax numbers for agency and all of its branches

- Hours when service is provided by agency and branches, including how to reach staff after hours, on weekends, and on holidays

- Names and phone numbers of:
  -- intake staff
  -- key administrative staff
  -- executive director

- Listing and description of services offered by the agency

- Eligibility criteria for all offered services

- Description of application process, including what documentation is needed

- Cost of service and availability of fee waiver, reduction, or financial assistance

- Qualities of services
  -- your opinions based on experience and evaluation
  -- how responsive, relevant, and effective they have been

[Child Welfare League of America, National Council of Juvenile and Family Court Judges, and Youth Law Center, 1993:196]

In the same document, Cole elaborates on the "qualities of services" item found in the resource directory information list.

1.	AVAILABILITY	Does the type of service the client needs exist within a specific agency?
2.	ADEQUACY	Can the organization supply the service in a sufficient amount to meet the client's needs?
3.	APPROPRIATENESS	Does the existing service meet the specific needs of this client? Is it suitable? A good fit?
4.	ACCEPTABILITY	Does the proffered service meet the client's preferences?
5.	ACCESSIBILITY	How easily can the client obtain services from this agency? Is the service geographically, financially, psychologically, socio-culturally, temporally, and physically accessible?

[Child Welfare League of America, National Council of Juvenile and Family Court Judges, and Youth Law Center, 1993:197]

A 1991 conference sponsored by the National Committee for the Prevention of Child Abuse (Jones, Mitchel, and Ackatz, 1991) made recommendations for services and service delivery.

> There are a variety of formats in which services can be offered to substance-abusing adults to prevent child abuse. A comprehensive set of services in a given community should address the more immediate facets of the substance abuse problem (e.g., a detoxification unit) and the underlying causes of the abuse (e.g., family history of abuse). . .
>
> All of these services need to be:
>
> - culturally competent and culturally appropriate; . .
> - sensitive to individuals with impairments of any sort, e.g., accessible to individuals in wheelchairs;
> - family focused, e.g., work with all members of the family;
> - sensitive to the need for parents to participate actively in the development of their own treatment plan according to their time frames, the stage of progression of their addiction, and readiness levels;
> - affordable, non-punitive, and user-friendly, e.g., include transportation when necessary and accommodate those who are orthopedically impaired;
> - focused on the strengths in the individual and geared toward helping the individual build competencies that will foster self-esteem;
> - community-based and helpful in strengthening the community;
> - sensitive to the possibility of parental history of victimization or domestic violence, which may be the driving factors of their substance abuse;
> - long term and include follow-up during the critical time after the person has stopped abusing substances; and
> - structured so as to protect the physical safety of the service providers in neighborhoods with active drug trade.
>
> While professional training is essential to the delivery of some services, it is equally important to make available support and services from a parent's peers, family, friends, and neighborhoods [sic]. These are the people in their environment, not the environment set up for them during services.

> Obviously, funding to pay for the variety of services needed in any community is essential and should be sought from a variety of sources at the local, state, and federal levels.
>
> [Jones, Mitchel, and Ackatz, 1991:2]

Jones, Mitchel, and Ackatz report a variety of ways in which services can optimally engage and retain parents. Following is a subset of that total list which is particularly relevant for substance abusing parents.

1. Services need to be "user-friendly," providing child care and transportation to other agencies for different services, or bringing outreach workers from other agencies to the client's primary site of care to provide comprehensive care at one site.

2. Service strategies must be tailored to intervene in all cultures. Often, the population in need is reluctant to seek prenatal care and may not be familiar with the health care system. To engage parents in service, programs must work within clients' cultural beliefs.

3. Professionals working with this population must be educated in both substance abuse and child abuse. They must be aware of their role in attracting parents to services.

4. Services must be targeted to all socioeconomic groups. Substance abuse is a universal problem.

5. Services need to be affordable.

6. Programs should provide services during evenings and weekends to accommodate clients' schedules.

7. Child/respite care for clients attempting to obtain medical care or supportive services needs to be provided.

[Jones, Mitchel, and Ackatz, 1991:10]

The information gleaned from the many field interviews reported in Chapters IV and V and supported by the literature cited throughout the report, focus on some additional services that would benefit substance abusing parents and their children.

- **Drug assessment** - If parental substance abuse is to be the prime focus in substance abuse/child maltreatment cases, a thorough drug assessment is needed along with a clear plan for drug treatment.

- **Treatment on demand** - Often a substance abusing parent is ready for treatment but there are no available treatment slots open. When the treatment slot opens, the parent is, for a variety of reasons, not willing to enter treatment. Since motivation to receive treatment is a large factor in the success of the treatment, treatment on demand is highly desirable.

- **Family-centered treatment** - While the parent is the substance abuser, the substance abuse affects the entire family - especially the children. The family needs to be considered as a unit and provided with whatever treatment forms are needed to stabilize the family and to make it a more functional unit.

- **Residential care for substance abusing parent (usually the mother) and children** - Single mothers may be reluctant to enter residential treatment if they have to give up their children temporarily. Residential treatment for mothers and children maintains the family-centered focus of treatment and encourages mothers to take advantage of treatment. Residential treatment can address parenting issues in a real time way. The children's development can be monitored and any special services needed by them can be delivered.

- **Halfway house for reintegration** - For substance abusers, their old environment is fraught with memories and temptations for renewed substance abuse. A halfway house can facilitate their reintegration into the community and maximize the chances for their continued sobriety. Contacts with needed community services can be assisted through the halfway house which could be staffed with representatives of various relevant agencies.

- **In-home services** - These services can be either be a follow-up from the residential care and halfway house or can occur during day treatment for substance abuse if residential care is not an option. In-home services following the model established by Homebuilders or Family Preservation is appropriate. In the beginning the intervention should be intensive and gradually tail off into a less intensive provision of services. A major difference from the traditional model of intensive intervention is, these services should be offered over a period of several years (perhaps five or six years) rather than six weeks to six months.

- **Follow-up** - Relapse prevention can be provided as part of the in-home services. The children, as part of the treatment received in residential care or whatever treatment they may receive, will have learned the signs of relapse and thereby become partners with the recovering parent in identifying relapse so that additional treatment may be started. In addition, the in-home service team should have a recovery mentor who will help the recovering parent and also deal with relapse issues.

- **Therapeutic foster care** - If the child, for whatever reason, needs to be removed from the home and can not be safely placed with a relative, there should be foster care available with specially trained foster parents who can offer therapeutic care.

Services and service delivery are critical for adequately addressing the problems of substance abusing parents and child maltreatment. An ideal model of services has been drawn. It is unlikely that such a systemic response is available anywhere but that does not lessen the need for these services. The GAL volunteer may have to pick and choose in advocating for these services. The ultimate goal is to have all these services available and functional in an integrated system of service delivery - that is, the blended approach.

A final word on services - the assumption underlying this discussion is that these services will be well conceived and well delivered. Poor services are potentially very harmful. Poorly trained service providers, uncommitted service providers, and inadequate service models all conspire to make the service recipients and others cynical and uncooperative. With so much at stake we must guide our efforts with the maxim, "if something is worth doing, it is worth doing right."

Political Concerns

Levy and Rutter write:

> Children can not vote, they do not have the funds to influence society, they are impotent with regard to the control of their own destiny. The societal problem of drug abuse must be managed in new ways to save the children, lest they become overwhelming burdens on society during their childhood and far into their adult years.
>
> [Levy and Rutter, 1992:128]

Children are vulnerable and politically powerless - they require advocates to help them grow and reach their full potential. The programs and services required to assist the maltreated children of substance abusing parents are approved and funded by politicians. Politicians are, in most cases, short-term office holders attempting to deal with long-term societal problems. They tend to sponsor programs which are popular with the public and which will have quick positive outcomes thereby providing themselves a basis for re-election. Long-term programs which may take a generation or longer to show positive results are an anathema to politicians.

Advocating for programs whose outcomes are unproven and uncertain while vying for limited resources to fund those programs is an extremely difficult task. Nevertheless, bit by bit the policymakers and politicians must be made aware of the issues and the most probable solutions to those issues. If the best of programs are put forth on a limited pilot basis and given a fair chance, their demonstrated successful impacts will influence those who control society's resources to support such programs. Ultimately programs that work save money for society. That is a politically viable position to take.

Lisbeth Schorr (1989) in her book, *Within Our Reach: Breaking the Cycle of Disadvantage* addresses issues related to the poor and disadvantaged in our society. What she has to say rings true for the maltreated children of substance abusers - just substitute "children of substance abusers" for "disadvantaged," since these terms may be considered interchangeable for the purpose of this discussion.

> It lies within our reach, before the end of the twentieth century, to change the futures of disadvantaged children. The children who today are at risk of growing into unskilled, uneducated adults, unable to help their children to realize the American dream can, instead, become productive participants in a twenty-first-century America whose aspirations they will share. The cycle of disadvantage that has appeared so intractable can be broken.
>
> . . .

The search for better solutions is gaining momentum. Administrators, politicians, professionals, business leaders, and citizens are reexamining outmoded practices and boundaries. Cities and states, often with the support of private funds, are taking unprecedented, if tentative, steps toward a fundamental restructuring of services.

. . .

. . . everyone concerned — voter and elected official, volunteer and bureaucrat, front-line worker and policy analyst — must recognize that investing in the futures of disadvantaged children means investing in first-class services.

When I reviewed the findings contained in this book for the U.S. House Select Committee on Children, Youth, and Families, the chairman, George Miller of California, remarked, "What you found is what this Committee found, and what we keep finding over and over again: when it comes to services for kids and families in poverty, where it is done in first-class fashion, it succeeds beyond our wildest dreams. And everywhere we've tried to do it on the cheap, everywhere we've tried to cut a corner, we end up spending money with no appreciable results."

There is no better summary of my findings. The common elements of successful programs — comprehensiveness, intensiveness, family and community orientation, and staff with time and skills to develop relationships of respect and collaboration — add up to first-class services.

Do today's political and budgetary imperatives make a major new commitment to improve the futures of America's most disadvantaged children seem illusory? Do the costs of first-class programs, in dollars and professional resources, preclude elected officials from allocating substantial funds to meet the needs of such a powerless constituency?

Not if enlightened realism prevails. All Americans will benefit from the provision of first-class services to children and families living in adversity. All Americans are burdened by the high cost of *not* making the required investment. Reaching out to the hard-to-reach and helping the hard-to-help are not idle sentiment, but a practical response to an urgent American problem.

. . .

Knowing now that effective social interventions *can* reduce the number of children hurt by cruel beginnings and simultaneously promote the national welfare, we must be certain that these newly available tools are put to work. We have the knowledge we need. We know how to organize health programs, family supports, child care, and early education to

strengthen families and to prevent casualties in the transition from childhood to adulthood. We know how to intervene to reduce the rotten outcomes of adolescence and to help break the cycle that reaches into succeeding generations. Unshackled from the myth that nothing works, we can assure that children without hope today will have a real chance to become the contributing citizens of tomorrow.

[Schorr, 1989:291-294]

Summation

There it is. The relationship between child maltreatment and substance abuse by parents — empirical studies and reports by practitioners and GAL personnel report the same general patterns. Guidelines are suggested for working with the families of substance abusers - how to identify parental substance abuse and strategies for intervention. Ongoing programs that are new, unique, and apparently successful are reviewed. Finally, four major areas for advocacy are presented - training and information; interagency cooperation (the blended approach); general services, the evaluation of services, and services specific to substance abusing parents and their children; and political advocacy for a powerless constituency. Many paths of advocacy for the maltreated children of substance abusers have been traced in this report. Choose the path that suits your program needs, your individual abilities and energies. Let the results of those advocacy efforts be in the best interests of the children.

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APPENDIX A

RESOURCES

FOR

CHILD ABUSE AND NEGLECT ISSUES

ACTION FOR CHILD PROTECTION
4724 Park Road, Suite C
Charlotte, North Carolina 28209
(704) 529-1080

AMERICAN PUBLIC WELFARE ASSOCIATION
(*Affiliate*: National Association of Public Child Welfare Administrators)
810 First Street, NE, Suite 500
Washington, DC 20002-4205
(202) 682-0100

BEHAVIORAL SCIENCES INSTITUTE/HOMEBUILDERS
34004 9th Avenue, South
Federal Way, Washington 98003
(202) 927-1550

CENTER FOR CHILD PROTECTION & FAMILY SUPPORT, INC.
714 G Street, SE
Washington, DC 20003
(202) 544-3144

CENTER FOR CHILDREN AND LAW
American Bar Association
1800 M Street, NW
Washington, DC 20036
(202) 331-2250

CENTER FOR THE STUDY OF FAMILY POLICY
Hunter College, Room 1209 East Building
695 Park Avenue
New York, New York 10021
(212) 772-4256

CHILD WELFARE LEAGUE OF AMERICA
440 First Street, NW, Suite 310
Washington, DC 20001-2085
(202) 638-2952

CHILDREN'S DEFENSE FUND
26 E Street, NW
Washington, DC 20001
(202) 628-8787

CLEARINGHOUSE ON CHILD ABUSE AND NEGLECT INFORMATION
P.O. Box 1182
Washington, DC 20013-1182
(800) 394-3366

CSAP NATIONAL RESOURCE CENTER
For the Prevention of Perinatal Abuse of Alcohol and Other Drugs
9300 Lee Highway
Fairfax, Virginia 22031
(800) 354-8824

EDNA McCONNELL CLARK FOUNDATION
250 Park Avenue
New York, New York 10177-0026
(212) 551-9100

FAMILY PRESERVATION CLEARINGHOUSE
The Center for the Study of Social Policy
1250 Eye Street, NW, Suite 503
Washington, DC 20005
(202) 371-1565

NATIONAL CASA ASSOCIATION
2722 Eastlake Avenue East, Suite 220
Seattle, Washington 98102
(206) 328-8588

NATIONAL COMMITTEE FOR PREVENTION OF CHILD ABUSE
332 S. Michigan Avenue, Suite 1600
Chicago, Illinois 60604-4357
(312) 663-3520

THE NATIONAL COUNCIL ON CRIME AND DELINQUENCY
685 Market Street, Suite 620
San Francisco, California 94105
(415) 896-6223

NATIONAL CENTER ON CHILD ABUSE AND NEGLECT
Clearinghouse on Child Abuse and Neglect Information
P.O. Box 1182
Washington, DC 20013-1182
(800) 394-3366

NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES
P.O. Box 8970
Reno, Nevada 89509
(702) 784-6012

NATIONAL CRIMINAL JUSTICE REFERENCE CENTER
NATIONAL INSTITUE OF JUSTICE
Box 6000
Rockville, Maryland 20850
(800) 851-3420

Other **NCJRS** Clearinghouses for specialized information needs

Juvenile Justice Clearinghouse (800) 638-8736
Justice Statistics Clearinghouse (800) 732-3277
National Victims Resource Center (800) 627-6872
Bureau of Justice Assistance Clearinghouse (800) 851-3420

NATIONAL RESOURCE CENTER ON CHILD SEXUAL ABUSE
107 Lincoln Street
Huntsville, Alabama 35801
(205) 534-6868

NATIONAL RESOURCE CENTER ON FAMILY BASED SERVICES
The University of Iowa School of Social Work
112 North Hall
Iowa City, Iowa 52242-1223
(319) 335-2200

YOUTH LAW CENTER
114 Sansome Street, Suite 950
San Francisco, California 94104-3820
(415) 543-3379

APPENDIX B

GUARDIAN AD LITEM VOLUNTEER

AND

STAFF INTERVIEWS

[NOTE: This appendix reports the complete data from interviews with GAL volunteers and GAL staff. The full responses to open-ended questions are placed here because they were too lengthy to include in the body of the report. Chapter V provides this information, but only in summary form. Answers to the closed-ended questions that were reported in Chapter V are repeated here in order to place the open-ended responses in context.]

GAL PROGRAM AND FIELD EXPERIENCE

An interview guide [see Appendix C] was developed based on information from the interviews reported in Chapter IV and from conversations with GAL staff. Next, arrangements were made to actually interview GAL volunteers and staff who supervise them in the field. At each site selected for interviewing, the district administrator (or a support staff person if the administrator was unavailable) and a volunteer were interviewed.

A convenience sample of the state was constructed by contacting the district administrators statewide and asking them to participate in the data collection. Each district administrator was asked to recommend GAL volunteers and cases with the following attributes:

- GAL volunteers with moderate to extensive experience with substance cases.
- Type of substance: Where alcohol is the major drug abused; where the major drug abused is other than alcohol; polydrug abuse.
- A case in its beginning phase where substance abuse is suspected but not yet substantiated.
- A case in its middle phase where substance abuse is established and efforts are or have been underway to remedy that abuse.
- A case in its final phase where substance abuse has been established and efforts to remedy the abuse have failed.

[NOTE: These are general guidelines. Cases that "generally" fit these categories were selected with no particular effort to perfectly match the conditions noted above.]

Thirty of the thirty-three GAL district programs responded. Twenty-one of the thirty district programs were selected for interviews based on the general guidelines listed immediately above. The distribution of the selected districts on these three guideline variables is as follows:

[NOTE: In one district the selected volunteer became ill and was not available for an interview. The interviewer's time frame did not permit scheduling a substitute volunteer. In another district the volunteer was unable to meet with the interviewer on the date set. In this case a GAL attorney was substituted for the volunteer. The volunteer interview guide, however, was not used with the GAL attorney . As a result the totals are 19 rather than 21.]

Experience of volunteer

Very experienced	12	(63%)
Moderate experience	2	(11%)
Very little experience	5	(26%)

Type of substance

Alcohol	10	(53%)
Alcohol & marijuana	1	(5%)
Alcohol & cocaine	2	(11%)
Crack/cocaine	5	(26%)
Polydrug abuse	1	(5%)

Case phase

Beginning	2	(11%)
Middle	10	(53%)
Final	7	(36%)

As is easily seen, most of the volunteers (63%) interviewed were very experienced. Alcohol alone was involved in cases 53% of the time and alcohol combined with other substances appeared in cases 69% of the time. Cocaine ran a second place (26%) as the type of substance involved in a case, but cocaine appeared in 37% of the cases which included use in combination with alcohol. Although somewhat higher proportions appear here (probably due to the small sample size) than the proportion of substances reported in GAL 1993 statewide survey (see Table 7, Office of Guardian ad Litem Services, 1993:10) the general distribution pattern of substances associated with GAL cases is the same. This similar pattern is remarkable particularly in the light of persons familiar with the cases reporting that they are often unsure of just what drugs are actually involved in a particular case (the denial and secretiveness of the abuser makes precise knowledge of the drugs abuse extremely difficult sometimes). However, the general consistency of these reports of proportional use should give the reader confidence in the overall pattern of use that repeatedly emerges.

Finally, most (53%) of the cases were in their middle phase with another 36% of the cases reported drawing to a close. Overall, very experienced volunteers were reporting on cases that were well underway so that they could comment on them with some confidence. Also, recall that the district administrator or a support staff person was interviewed and often commented on the volunteer's case along with other cases that illustrated the general conclusions they drew in their interviews.

The distribution of the programs that participated in the interviews by section of the state is as follows:

Eastern region -	5 programs
Piedmont region -	8 programs
Western region -	8 programs

This represents a reasonably balanced coverage of GAL programs throughout the state. There were some scheduling difficulties compounded by time and travel constraints which limited the interviewer from responding to all of the thirty programs that volunteered cases for the study.

Following are the reported responses of both GAL volunteers and GAL staff. The GAL volunteer responses are reported for both closed-ended and open-ended questions. Staff responses only involved open-ended questions.

A. *GAL Volunteers*

These are the responses for the nineteen GAL volunteers interviewed. The interview guide is found in Appendix C. Not every question from the guide will be summarized. The reader can refer to the guide to identify those questions which are not reported here. The first portion of the interviewing instrument asks about the characteristics of the household. For simplicity the data are summarized over all of the nineteen interview cases. There are too few cases to permit breaking the data into multiple sub-categories or cross-classifications. This summarization, as presented, will give the reader a sufficient overview of the type of cases seen by GAL volunteers that are substance abuse related.

Characteristics of the Household

Location of the household:

Rural	- 4
Small town	- 8
Big or medium city	- 6
Suburban	- 1

Neighborhood economic characteristics:

Wealthy	- 0
Middle class	- 4
Poor	- 15

Neighborhood physical characteristics:

[NOTE: Due to instrument revision there are two cases with missing data for this question.]

Orderly	- 9
Chaotic	- 6
Don't know	- 2

Clean	- 9
Dirty	- 7
Don't know	- 1

Neighborhood safety:

Very safe	- 1
Fairly safe	- 8
Unsafe	- 9
Don't know	- 1

Is substance abuse (buying, selling, using) a problem for this neighborhood?:

Yes	- 14
No	- 5

Cases reported are fairly evenly spread between rural, small town, and city (big or medium) areas. Small towns and cities are the predominant areas from which this sample of cases is taken. A majority of reported cases involve persons coming from neighborhoods judged to be poor. In three of the four instances in which the volunteer reported the neighborhood to be middle class, they qualified.that response to "lower middle class." It will be recalled that these cases are highly filtered - they have gone through DSS and a variety of community agencies and programs and DSS has finally petitioned the court to take custody of the children. This does not necessarily imply that substance abuse and child maltreatment cases are strictly a lower class phenomena. Perhaps the resources of persons in other social classes permit them alternative solutions which do not put them at risk for intervention by the court and the GAL program. On the other hand, perhaps substance abuse creates a "drift" to a lower socioeconomic environment. What is known, however, is that the preponderance of GAL substance abusing child maltreatment cases reported in this sample consist of persons living in neighborhoods that are characterized by the GAL volunteers as being poor.

The 15 poor neighborhoods are seen as being orderly and clean about as often as they were seen as being chaotic and dirty. Also, neighborhoods were viewed as being fairly safe or very safe as often as they were viewed as being unsafe. The perceived characteristics of order, cleanliness and safety are evenly distributed and thereby fail to show a pattern for substance abuse-related child maltreatment cases. However, substance abuse is reported to be a problem in nearly two out of three neighborhoods. Not surprisingly, child maltreatment cases involving substance abuse appear to occur most often in neighborhood environments in which substance abuse and its related activities (buying, selling, and/or using) are a problem for that neighborhood.

A sub-analysis of the neighborhood variables orderly/chaotic, clean/dirty, safe/unsafe, and drug problem/no problem was done to see if a particular pattern between these variables emerged. As the data below demonstrate, there is a compelling pattern.

			Drugs	
Orderly and Clean	8	Safe -	Yes - 2	No - 4
		Unsafe -	Yes - 2	No - 0
Chaotic and Dirty	6	Safe -	Yes - 0	No - 0
		Unsafe -	Yes - 6	No - 0
Orderly and Dirty	1	Safe -	Yes - 0	No - 1
		Unsafe -	Yes - 0	No - 0

Missing data cases - 4 [NOTE: If a case was incomplete for any of the four variables above, it was ruled a missing data case]

When the neighborhood is considered chaotic and dirty it is also seen as unsafe and having a drug problem. Three-quarters of the neighborhoods described as orderly and clean are seen as safe although it is reported that one-third of these "safe" neighborhoods have a drug problem. One-fourth of the neighborhoods reported as orderly and clean are viewed as unsafe with a drug problem.

It is interesting to note that all of the middle or lower middle class neighborhoods are viewed as orderly and clean as well as safe. Only one of those orderly, clean, and safe middle class neighborhoods was reported to have a drug problem. However, in general, if a neighborhood has a substance abuse problem (buying, selling, and\or using), it is seen as an unsafe environment.

The household composition of the cases reported had an average of 3.7 persons (this excluded one atypical household in which ten persons were listed in the household - the number of persons listed in the other households ranged from six to two). Dividing the total number of persons (again, excluding the atypical household) by the total number of reported bedrooms produced a 1.65 persons per bedroom. In those cases where there was information on the sleeping arrangements, children most often had their own bedroom or shared a bedroom with a sibling. There were two cases, however, in which the sleeping arrangements were unusual. In one case a nine-year old female slept with her mother and father and sexual abuse was alleged. In the other case a thirteen year old female slept with her father in a one bedroom camper. Sexual abuse was also an issue in this case.

Persons in household:

Mother alone	- 8
Mother and boyfriend	- 5
Mother and father	- 2
Mother and stepfather	- 1
Mother and parents	- 1
Father alone	- 1
Father and stepmother	- 1

Single mothers are the most frequently occurring category. Mothers with live-in boyfriends are the second most frequently occurring category. Often the stability of the relationship with the boyfriend is unsteady and the children experience multiple, serial boyfriends living with the mother. In all but two cases, the mother is in the picture for the children. In the other two cases the father is the parent with the responsibility for the children.

Following are some additional characteristics of the above categories. Approximately two thirds of the parents in these cases are in their thirties. The other third consists of two mothers with boyfriends in their early twenties and one in her early forties; and two single mothers are in their mid-forties while one is in her late twenties.

HOUSEHOLD COMPOSITION
Comparisions of Characteristics

	Household Composition:	Mother Alone	Mother w/ Boyfriend	Mother w/ Parents	Mother & Father (or stepparent)	Father Alone
Characteristics	**Category of Characteristic**					
Number of Children	One	4		1	1	1
	Two	1	1		2	
	Three	3	1			
	Four		3			
	Six				1	
Race	Black	2	4			
	White	5	1	1	4	1
	Native American	1				
Job Stability	Stable	3	1		4	1
	Unstable	4	4	1		
	Don't Know	1				
Education: Grade Completed	6th Grade			1		
	8th Grade	1				
	10th Grade	3	3		1	
	11th Grade		1		1	
	12th Grade	2	1		1	
	Don't Know	2			1	1
Persons Abusing Drugs	Mother	8	2			
	Father				1	1
	Mother & Father				3	
	Mother & Boyfriend		3			
	Mother & Mother's Father			1		
Types of Drugs:	Alcohol	5		1		
	Cocaine				1	
	Crack		2			
	Prescription drugs				1	
	Alcohol & Cocaine		1	1		
	Alcohol & Crack	1				
	Alcohol & Marijuana	1			1	1
	Alcohol, Coc., & Marij.		1			
	Alcohol, Coc., Crack & Marij.		1			
	Alcohol, Crack, Heroin, Coc. & Marij.	1				

The reader is cautioned at this point to not use these small non-random sample distributions to make generalizations. The distributions are presented as information for the reader to get a sense of the characteristics of the families involved in the cases which were selected for their substance abuse traits for this phase of the study. These data, in large part, support and are supported by the results of the statewide survey (Office of Guardian ad Litem Services, 1993). However, these data also may suggest to GAL policymakers a need for further exploration and verification of patterns of interest observed in these data.

In the next section of the interview the GAL volunteers were asked how they would characterize the household on six criteria. This is followed by questions about the family's support network or lack thereof.

Household Characteristics:

Orderly	12	Sufficient food	12
Chaotic	5	Little or no food	5
Clean	13	Sufficient furniture	14
Dirty	4	Little or no furniture	3
Safe physical environment	13	Toys for children	11
Unsafe physical environment	4	Few or no toys	6

[NOTE: There were two don't know responses for this question series. Therefore, the total number of responses is 17 rather than 19.]

The reader can surmise from the distribution above that most households in this group of cases were orderly, clean, safe, and had food, furniture, and toys. Of the five cases that were characterized as chaotic, four of the five also had other negatives - dirty, unsafe, little or no food, little or no furniture, and few or no toys. Two of the chaotic cases were negative on five and six factors while two cases were negative on two factors. What these four cases have in common is that cocaine or crack cocaine was the substance being abused. The fifth case, involving alcohol and marihuana, was seen as chaotic but the other five factors were all positive.

Twelve cases were seen as having orderly households. Of these, seven involved alcohol as the drug of choice. Only one of the seven even had one negative - an unsafe physical environment in which the father abused the children and the stepmother when using alcohol. In all other cases where alcohol was the substance abused, the households were positive on all six factors. The household in which prescription drugs were abused was also positive on all six factors. This accounts for eight of the twelve cases.

The remaining four cases of the twelve cases that had orderly households showed another pattern. These four cases involved cocaine or crack cocaine (three of the four had cocaine and alcohol combined). In three of these four "orderly" households containing a cocaine or crack abusing mother and/or boyfriend, at least one of the other five factors was negative. Only the remaining fourth case had all six factors positive and in this case the mother and boyfriend abused cocaine, alcohol, and marihuana.

The pattern that emerges from these seventeen cases is one of cocaine or crack cocaine being more disruptive than alcohol to the family and household as measured by the six factors above. In general, alcohol alone does not appear to compromise the household on these six factors. But alcohol in combination with cocaine or crack cocaine does appear to produce negatives for the six factors. The main effect appears to be the use of cocaine or crack cocaine. As DSS investigators indicated, food, furniture, and toys are often sold to support this very addictive drug habit. The focus on obtaining the drug can easily lead to neglect of the children and the household - hence the chaotic, dirty, and unsafe environment.

Characteristics of Family Supports Networks by Types of Substance Abuse

	Abuse of:	Alcohol	Alcohol/ Marijuana	Alcohol/ Cocaine	Prescription Drugs	Cocaine/ Crack	Cocaine/ Crack/ Marijauna/ Alcohol
Strength of Support Network	Strong	1				1	2
	Moderate	2	1			2	
	Weak	3		4	1		
	None-isolated		2				
Who is in Support Network	Extended Family	4	1	3	1	3	2
	Friends	3	1	1		1	1
	Neighbors	1	1	1		1	
	Others	2		2	1	2	

[NOTE: For the question, "Who is the support network?" respondents gave multiple responses so that the total number of responses may exceed the number of cases. In the support network "others" category, DSS and the GAL volunteer had four mentions; church and therapist/group therapy/mental health had three mentions.]

Case Information

Ten of the nineteen cases involve cocaine or crack cocaine (three of these nine have combined alcohol and cocaine or crack cocaine abuse) substance abuse. Nine of these ten cases are neglect cases (four of the nine are neglect and dependency cases). The tenth case involves neglect, dependency, and sexual abuse.

An additional eight of the nineteen cases involve alcohol abuse, and another involves prescription drug abuse. These account for the nine remaining cases. Four of the eight alcohol abuse cases are neglect cases and a fifth alcohol abuse case is neglect and dependency. The remaining four cases (three alcohol abuse cases and one prescription drug abuse case) are abuse cases - three sexual abuse cases and a physical abuse case (specifically, one physical abuse, one sexual abuse (the prescription drug case), one sexual abuse and neglect, and one sexual abuse, neglect, and dependency case).

It would appear, based on these nineteen cases, that cocaine principally results in neglect while alcohol abuse (and perhaps prescription drug abuse) has a higher likelihood of resulting in sexual and/or physical abuse. Again, the numbers are small and caution must be exercised in interpretation of the data. However, to the extent that these data are accurate reports of the type of child maltreatment, the above pattern is a reasonably strong one. Several volunteers indicated that when sexual abuse cannot be substantiated and neglect can, the case is often pressed forward on the neglect issue.

***How did this (abuse, neglect, dependency) come to the attention of DSS? Who filed a complaint?*:**

Family
- Father 3
- Stepmother 1
- Grandmother 1
- Cousin 1

School
- Counselor 2
- Truancy 2

Police
- Violence in home 1
- Investigation ouside home 1

DSS Monitoring 2

Other
- Boyfriend 1
- Neighbor 1
- Anonymous 1

Don't know 2

***Has this family had any prior complaints filed?*:**

Yes - 14
No - 5

***How many prior complaints?*:**

One - 1
Two - 2
Three - 1
Six - 3
Many - 2
Don't know - 5

Seventy-four percent of the nineteen cases had prior complaints about child maltreatment. The GAL volunteers were uncertain about how many prior complaints there were in five of the fourteen cases where there were prior complaints. For the remainder, the number of priors ranged from one to many prior complaints.

The major source of complaints came from family members (or quasi-family members such as boyfriends) and the school. The police also made complaints as the result of investigations and being summoned to a crime committed in the home (a mother stabbed a "guy" in her home). DSS in carrying out their normal monitoring function discovered situations that warranted action being taken. The reported sources are rounded out by a neighbor reporting and an anonymous report being made.

It appears then that the children are best protected if they are not in isolation but can be monitored by family and extended family and by the school. Children who are isolated, very young, and/or not in school are more at risk for having no one to advocate for them when they are the recipients of maltreatment. It also appears that troublesome families are not a secret to DSS and other community agencies. It would seem that with the many prior complaints made to DSS about many of these families, that being able to substantiate the complaints is a major barrier to positive action to protect or remove the child from harm.

Dealing With Substance Abuse Cases

Beginning with this series of questions, the interview instrument utilizes predominantly open-ended questions. A given respondent may provide more than one answer to a given question. Therefore, a tally of responses which add up to a specified number of respondents is not appropriate. Instead, categories of responses are given in the order of their frequency of mention - from most frequently mentioned to least frequently mentioned.

How do substance abuse cases differ from non-substance abuse cases you see?:

Extremely difficult cases

- Substance abuse cases are hopeless - well, maybe that's too strong. But most substance abusers stay substance abusers - it's rare that they don't.
- It is less hopeful that the substance abuser will change and the substance abuser is less likely to cooperate. This is especially true when crack cocaine is used. Addiction is so severe and motivation of the substance abusing parent is different from other cases.
- Things rarely change in substance abuse cases - in other cases they do change. Cocaine users "really just don't give a happy damn." They meet their substance abuse needs at any cost. Treatment - use - treatment - use - treatment --- they seem to cycle through this endlessly.
- Substance abuse cases do differ. About fifty percent will not quit the substance abuse to get their children back. Non-substance abuse case parents are easier to work with - there are fewer problems like refusing to go to mental health or parenting classes.
- These kinds of people are in heavy denial.
- Substance abuse cases are extremely difficult to work with - they lie to me and to themselves. It's very frustrating, they are a slave to a drug combined with other problems such as poor parenting. It doesn't matter what you do - they relapse. We can go through the motions but it won't work.
- The substance abuser thinks more of themselves than anyone else (like the child).
- Substance abuse cases are not going to be resolved. The problem is with the stability of the parent. Cocaine is impossible to beat.
- These cases are more frustrating - it's harder to find a permanent plan for them because relatives are often involved in drugs as well.

How do substance abuse cases differ from non-substance abuse cases you see?: (continued)

Extremely difficult cases (continued)

No one knows quite what to do in these cases. How do you assess what danger the child is in because of the substance abusing parent - this is much more difficult. For example, when the parent abuses alcohol and gets into the "system," the system holds them much more accountable than it does other parents.

You spend more time than usual on the case. You have to monitor the substance abuser and keep a close eye on them. They tend to tell a good story but they mislead you.

Non-substance abusing parents get on a better track - they try harder than substance abusing parents.

Non-substance abusing parents are more in control than the substance abusing parent. The non-substance abusing parent used bad judgment. The substance abusing parent is addicted.

When alcohol is involved all reason is gone, you are unable to protect the child. It is harder to deal with because you can't reason with an alcoholic. You can't influence them.

In cases where there are no drugs involved it is more straightforward. You can identify the "problem" and deal with it.

Risk of violence

Substance abuse leads to violence - alcohol and cocaine.

There is violence in substance abuse (alcohol and cocaine).

Alcohol abuse progresses to violence.

Drugs other than alcohol are dangerous and possibly lead to violence.

There is a risk to volunteers - if the substance abuser is under the influence, there may be a risk to the volunteer.

Child abuse

There is more abuse (physical and sexual) in substance abuse cases.

These kinds of people (substance abusers) are in heavy denial about their drugs and sexual abuse.

Child neglect

Crack leads to total neglect.

Substance abuse cases usually involve neglect rather than abuse except for alcohol were there is more abuse.

When you get a "new" substance abuse case, what is the first thing you do because it is a substance abuse case?:

[NOTE: The responses split 60/40 with most persons saying that they did the same for substance abuse cases as they do for non-substance abuse cases. But even some of those who said they did the same for all cases had suggestions about how substance abuse cases might be addressed. Following are those suggestions and the responses of those who treat or would treat substance abuse cases differently.]

Thing(s) that *are done* in a new substance abuse child maltreatment case

- Assess the substance abuser's desire for treatment (in-patient treatment provides an optimal chance for change). Check if the treatment was tried. Check if the treatment is available when the person is ready to be treated (sometimes persons are ready and the treatment isn't available). Ideally the substance abuser would be provided a longer period of care and more services and supports. Also a person should be available to monitor their aftercare.
- Talk directly with the mother (substance abusing parent) first. If the mother says - I'm not going to use drugs and I want my children back - that is one sign of a substance abuse problem.
- Since the substance abuse records are not open, I talk to DSS to find out about the home dynamics. I also talk with a recovering alcoholic to get insight into those substance cases where alcohol is a problem.
- The child should be out of that environment immediately - the child is in danger. The exception is for marihuana or alcohol use - not abuse.
- I'm a bit more concerned for my personal safety. I don't want to walk in on a drunken brawl.

Things that *should be done* in a new substance abuse child maltreatment case

- In every case look for drugs to explain abuse and neglect. It explains things about forty percent of the time.
- I want to test every parent for substance abuse when there is child maltreatment. So a substance abuse assessment. Do unannounced screens. Follow-up the substance abusing parent on all the recommendations of the substance abuse assessment.
- On all cases (but this is a higher priority for substance abuse cases - you have a damaged child) get the child evaluated (psychological) to determine the impact of the maltreatment (and substance abuse) on the little person. Evaluate what services are needed. Stabilize the youngster.

What is the first issue you address? Is it the immediate safety of the child(ren), the risk of future abuse or neglect, or something else? Why that first? How do you do that?:

[NOTE: This questions series had seventeen of the nineteen respondents saying that they addressed the immediate safety of the child. Two respondents said they addressed the risk of future abuse or neglect first because they either assumed the social workers have seen to the safety of the child and/or the child is out of the home and therefore assumed to be safe. They assessed the risk of future abuse or neglect by interviewing professionals connected with the case and others connected with the case (e.g., family), made home visits, and checked various records (criminal, hospital, and substance abuse records when possible). Following then are the responses of those addressing the safety issue first.]

Address the immediate safety of the child first - how do you do that?

If the child is in the home it is important to go out and see what is going on. It is difficult to assess infants - they are not in contact with the outside world, they are isolated.

A minimal measure of safety is - is someone available to protect the child? See that there are no obvious safety hazards.

Check the house thoroughly and ask questions of the neighbors.

Check their placement. Interview relatives and neighbors.

Do interviews with DSS, relatives, day care workers, medical workers, mental health workers, TASC (Treatment Alternatives to Street Crime) worker, and probation officer. The DSS workers brief us.

Investigate where they stay and who has responsibility for them.

Make home visits.

Go see the child and see their environment and the people around them.

Visit the child.

Go and talk to all parties involved - DSS, parents, etc.

Get background from DSS - interview child, parents and gather other information.

Go visit the family and interview the children (if possible). And, make sure that I will be safe visiting.

Visit the children were they are and check on them.

Random visits in school and at the home. The school is the best place to check.

Look for stability in the home before reunification.

As the reader can see from the repetition of the answers, making visits to the child's environment is very important. If the child is in the home or in placement, the home where the child currently resides or may be reunited is visited. If the child is in placement (foster care, with a relative, or elsewhere) it is still important to visit the child to check on their safety and to gather information from the child about their home situation. The family of the substance abusing parent may have their own substance abuse problems. Foster care placements may have their own hazards leading to child maltreatment. In addition to visiting, information from a large number of persons involved in the case from professionals to relatives, friends, and neighbors is also important to gather.

The Best Interests of the Child

What does "in the best interests of the child" mean to you?:

Safe environment (primary concern)

- A clean, safe environment which is drug-free (drugs do not equal safety). Their safety. What is best for them so they can have a normal life. Safe. To be in consistent environment where they are loved and nurtured.
- To provide the best physical safety, mental and emotional well-being you can.
- Safety and a nurturing environment.
- Safety and well-being - fed, loved, nourished, etc.
- The best environment for the child to be safe and to grow up to be the best person they can be.
- Immediate safety and future safety. Their social development - what can be done to help the child to be a productive citizen.
- A safe environment. An environment where the child is thriving.
- To be safe, feel secure, be loved, and be happy.
- Provide the safest, most nurturing environment that is possible under the circumstances.

A beneficial environment (primary concern)

- As stable and happy a childhood as possible with an eye to the future for a productive life.
- Whatever is most likely to produce the best overall outcome for the child.
- Provide the child a healthy environment to have their needs (emotional and physical) met. Help them to be healthy and productive adults.
- A nurturing, long term, supporting environment.
- What will benefit the child the best for the rest of their lives.

Return to family

- What's in the best interest of the child is to be returned to his family. This could be the extended family.
- A basic premise is that children are best with their biological family <u>if</u> everything else is in place (i.e., providing a healthy environment in which to grow).
- It does not mean reunification necessarily.

Not necessarily what the child wants

- Not always what the child wants.
- It does not mean making the child happy.

When asked what the 'best interests of the child" means to them, volunteers responded with two major themes. One group emphasized safe and nurturing environment. The other group of volunteers emphasized an environment which produced a positive outcome - that is, the child could become a healthy and productive adult. A few volunteers mentioned the reunification issue which has as its basic premise that children are best served by being in their biological families. Some noted that the extended family could also serve the best interests of the child. They were careful to note, however, that the family unit (whether the parental or extended family) needed to provide a healthy environment to activate this premise.

Finally, volunteers commented that what the child wanted was not necessarily in their best interests. The volunteers were not in the business of making the child happy in the short-range if it had long range-negative implications for their well-being.

Under what conditions is it in the "best interests of the child" to keep the family together when there is substance abuse in that family?:

Parent(s) get treatment

- If risk to the child is minimal. If parents agree to and carry out substance abuse treatment.
- If there is ongoing treatment - residential and then non-residential treatment with follow-up.
- According to the thoughts of drug counselors - if they are making progress in treatment.
- If the substance abuser is in treatment and making progress.
- Parent is seeking help and making improvements.
- When the substance abuser is abstaining and getting help.
- If the parent is demonstrating they are trying to deal with their problem. Even at that, the child needs protection.
- If parents make an effort - try to work with them and get the children back.
- If children participate with their mother in rehabilitation.

Alcohol abuse may be different

- A lot of children live in alcoholic families and are OK. The family has the resources to care for the children. Some substance abusers do not neglect children because they make arrangements to care for the children.
- If the parent is able to function as a parent. Alcoholic parents do raise children.
- If there is hope it will be resolved. With alcohol abuse you have a shot or with short term substance abuse - that is, they have been using a short while.

Under what conditions is it in the "best interests of the child" to keep the family together when there is substance abuse in that family?: (continued)

Other

If the substance abuser is able to work. If the substance abuse can be addressed - treatment doesn't seem to work.

One of the parents is at least in control or someone in a support network is available to care for the children.

Almost always substance abuse is not as dangerous to the child as sexual and physical abuse.

How is the child being taken care of? Are basic needs being met? Is life ongoing in the home?

Age of the child is a factor. Leave in the home if they are 15 to 17 years old. If the child is younger than 15 - take them out of the home. This applies to neglect only. If there is abuse - take the child out of the home. However, if there is a non-substance abusing parent in the home who can protect the child, keep the child in the home.

Take the child(ren) out of the home

Do not have a child there if there is substance abuse.

Get the kids out until the substance abuse stops or keep them in if the parent actively seeks treatment.

Under what conditions is it in the "best interests of the child" not to keep the family together when there is substance abuse in that family?:

Parent will not accept help for substance abuse

If the substance abuser will not accept help for substance abuse.

If the parent(s) do not agree to substance abuse treatment or do not carry out their agreement to get substance abuse treatment.

If treatment is not sought by the substance abuser.

When parent does not seek help and make improvements.

No effort, no progress

The parent shows no effort time after time.

If they are not doing anything - not showing responsibility.

When the parent isn't trying.

The parent makes no progress (The respondent refers to a case in which the mother is arrested three times after leaving prison.)

When you tried and tried to help and nothing changes.

Under what conditions is it in the "best interests of the child" not to keep the family together when there is substance abuse in that family?: (continued)

Continued use of drugs

If they are still using.

When parents continue using drugs.

You cannot deal with someone under the influence of a substance. Therefore, you do not have an adult who can be responsible for children.

When parents are out of control and can't maintain sobriety for any significant amount of time.

Child's safety is threatened

When the child's safety is threatened. The parent is out of control and there is no one in a support network.

If the parent is allowing poor decision-making to not protect the child.

When the child is not protected they are being neglected. Where there is no security, stability, or hope.

If the children are going to be neglected or abused.

Failure to parent

Constant failure of mother to mother.

Is the substance abuser functional in the family as a parent? Are there "normal" family activities?

Violence

If there is violence in front of the children.

If there is or could be violence occurring from selling drugs.

Substance Abuse Cases and DSS

In substance abuse cases, do you usually agree or disagree with DSS's assessment of the situation?:

Agree

Thirteen of the nineteen respondents said they usually agreed with DSS's assessment of the situation. One volunteer commented, "There is no optimum solution." Although overall most volunteers agreed in general, many of them had specific points of disagreement. These points are noted below.

Disagree

[NOTE: Often these points of disagreement are couched in a recognition of DSS limitations. DSS has limited county financial resources which sometimes do not allow them to act in the best interest of the child.]

Reunification

- DSS wants to return children too soon - we are more cautious.
- DSS want to put children back in the home too soon.
- They want to return the child too soon.
- We disagree whether to return the children to home - we don't want them to go back and DSS does.
- DSS expects parents to be squeaky clean. They have no tolerance for any substance abuse of the parents. They want them to jump through many hoops before reunification.
- DSS want to return children too quickly or not soon enough.

Placement

- DSS looks for the most expeditious placement rather than for the best placement.
- We disagree with DSS on placement but the problem is that there are so few foster families in the county that the children have to be moved out of the county. An ideal solution to this would be a residential group home for foster care and treatment care.
- We disagree on the appropriateness of placements.
- DSS doesn't remove the child soon enough - they don't have enough foster care options so they delay removal decisions.
- We disagree with the amount of time children are allowed to float around in foster care.
- We disagree with DSS moving children into foster care too much.

In substance abuse cases, do you usually agree or disagree with DSS's assessment of the situation?: (continued)

Permancy

When is enough, enough? We want to move to permancy earlier than DSS.

Other

There is dissatisfaction with DSS services not provided.
Sometimes DSS doesn't do their research thoroughly.
We often disagree with DSS's assessment of the future safety of the child.

Substance Abuse and Child Maltreatment

What drug or drugs are most often associated with a child being physically abused? Why is that?:

Alcohol - 13 responses

Inhibitions are lowered and violence comes out.
Parents drink with children around and may lose temper.
Dad beats mom who then beats the kid.
Alcohol brings it (physical abuse) out.
You lose inhibitions and self control. These are not nice people to begin with and alcohol gives them false courage to go a step further.
The depressant stage of alcohol produces anger.
It produces violence.
People under the influence don't behave rationally. They lose their temper and make bad decisions.
People, when using, are enabled to do violent things.
There is a greater tendency to lose control and one's temper.
Don't know why - 3 responses.

Alcohol and cocaine - 1 response

People are usually more irrational and out of touch when on cocaine. When alcohol is involved, parents shoot at each other.

Cocaine, crack cocaine - 4 responses

It messes up their head. If they are high on the drug and the child bothers them, they may be violent.
They use too much and are up all night. In the mornings they want to sleep all day - they get nasty.
Don't know why - 2 responses

No drug - 1 response

The cases we had of physical abuse were not associated with drugs.

What drug or drugs are most often associated with a child being sexually abused? Why is that?:

Alcohol - 10 responses

Releases inhibitions - 6 mentions.
Father prostitutes daughter for alcohol. Being so drunk he is not in control of the situation and can't protect the child.
There is neglect of child while the parent is drinking.
Don't know - 2 mentions.

What drug or drugs are most often associated with a child being <u>sexually</u> abused? Why is that?: (continued)

<u>Alcohol and marihuana - 1 response</u>

Don't know - 1 mention

<u>Alcohol and crack - 1 response</u>

Increases sexual drive and lowers inhibitions.

<u>Cocaine - 1 response</u>

Don't know - 1 mention

<u>No drug - 2 responses</u>

<u>Don't know - 4 responses</u>

What drug or drugs are most often associated with a child being <u>neglected</u>? Why is that?:

<u>Cocaine/crack cocaine - 8 responses</u>

Loyalties and commitments are not in place. There is no balance or steadiness to life - crack is your master!

Expensive + highly addictive = cocaine. They spend money (AFDC, food stamps, and kids' social security money) to buy drugs and neglect children.

The important thing is to get money to make a buy.

Parents don't care - they only care about using money to buy crack.

Crack draws the user into their own world.

Parents leave children alone and use money for drugs.

Don't know - 2 mentions.

<u>Crack and heroin - 1 response</u>

Drugs are the focal point for the person to the exclusion of the children.

<u>Cocaine and alcohol - 3 responses</u>

They sell everything to buy drugs. The house is filthy.

Absorbs the parent. Children are neglected while the parent is getting the drug and the effects of the drug.

Money gets spent on other things than the children. The parent is not focused on the children but on the drugs.

What drug or drugs are most often associated with a child being neglected? Why is that?: (continued)

Alcohol - 3 responses

Because of the inability to do what needs to be done.
Parent neglects the children while drinking.
Because of the inability of the parent to function, the child is neglected.

All drugs - 2 responses

Don't know - 2 mentions.

Don't know - 2 responses

What drug or drugs are most often associated with a child being unsafe? Why is that?:

All drugs - 6 responses

It takes some sense to keep someone safe
Don't know - 5 mentions.

Cocaine, crack cocaine - 5 responses

Cocaine is a drug associated with violence.
There is an absence of the parent to play the protector role.
Children are left alone.
They leave children alone in a dangerous environment.
If the person doesn't get crack on time, they will do anything - they are tense, etc. They will hit, kill, or sell children sexually for money.

Alcohol - 3 responses

The child is unsafe because of neglect. Parents drive under the influence with children in the car.
With alcohol abuse there is a greater tendency to lose control - have a temper.
Don't know - 1 mention.

Heroin or cocaine - 1 response

When the parent is on these they take the child along with them but not when they are on alcohol.

Alcohol and cocaine - 1 response

It's most alcohol abuse when the child is unsafe

What drug or drugs are most often associated with a child being unsafe? Why is that?: (continued)

Alcohol, cocaine, marihuana, and prescription drugs - 1 response
Not explained - 1 mention

Don't know - 2 responses

How do each of the following factors relate to how you view and work with a substance abuse case?:

Age of the children in the family

The younger the child the more unsafe they are - 5 and under.
Younger children are at risk. Older children can fight their way out.
Preschool children are less able to care for themselves and they are less able to know it's their parent's problem.
Younger children are the most vulnerable - they can't run away or tell someone.
Preschoolers are most at risk and more vulnerable.
Preschool is the age at which the child is in the most danger.
Young children vs. adolescents - can they get help if they need it? Young children are less able to do this.
A caution sign for infants to children five years old - they don't understand what's going on.
Younger children are more at risk. Adolescents can take care of themselves.
The younger, the more they need to be protected.
Remove the younger child from the situation. The older child has better defenses.
The older child can participate but the younger child can't understand the problem to be helped.
The older the better for protecting one's self.
The preverbal child is isolated, the preschool child should be monitored, the school-age child can be monitored by the school. The older the child, the less risk there is.
For neglect - take the child out of the home if younger than fifteen. If abuse - take the child out regardless of age.
Parents train little ones what to say. School age children - you can check on the child better and they are more verbal than younger children.

You can't interview a very small child, you have to rely on observations.

The older the child, the more I consider their viewpoint.

Don't' know.

How do each of the following factors relate to how you view and work with a substance abuse case? *(continued)*

Availability or non-availability of caretakers other than the substance abusing caretaker

If there is an appropriate caregiver in the home, keep the child in the home.

There should be a responsible adult to protect the child.

If the caretaker is a non-substance abuser and able to protect the child.

A non-substance abusing caretaker is desirable.

You need to have another adult to protect the child.

The stability of the caretaker is important - they need to be strong enough to protect the child and not let the substance abuser run over them.

It's real important to have a responsible caretaker in the home to supervise.

It makes a big difference - you need a responsible adult in the home to keep the kids in the home.

A single person with no support system is a worst possible case. The children need someone who can give them protection.

If there is another responsible adult (someone who can protect the children) in the home, you can keep the child in the home - maybe.

You want at least one responsible adult in control.

You need a responsible adult in the household.

If a parent is in the home to protect the child physically and emotionally then OK.

Even if there is a caretaker, it's rare they will take up the slack. You need to go outside the home for a caretaker.

It doesn't make a difference - they just leave - don't bother with caretakers.

Family support is very important.

Don't know - 3 responses

How do each of the following factors relate to how you view and work with a substance abuse case?: *(continued)*

Type of substance being abused

Alcohol and cocaine/crack cocaine - 7 responses

For crack or alcohol, the parent shouldn't be allowed near the child until they go through treatment and have six months of sobriety.

Coke produces violence and alcohol produces verbal abuse.

Alcohol and crack are the only two drugs I know. If crack is involved, get the kids out of the house.

A parent on alcohol is more volatile and dangerous to the child. Cocaine leads to neglect.

Alcohol is about as bad as cocaine.

Alcohol isn't seen as severe as crack or cocaine.

With alcohol there is more hope. With cocaine or crack there is little or no hope.

Any drug - 6 responses

If the parent is under the influence of any drug that is a problem.

All drugs are bad.

All drugs are a problem.

Drugs or alcohol, it doesn't matter.

Alcohol varies but we are scared of all other drug use.

All drugs are of concern.

Cocaine, crack cocaine - 3 responses

Crack is worse than some other drugs.

Cocaine is a major concern.

One needs to do more intensive work with crack.

Alcohol - 1 response

Alcohol causes the most abuse of any kind of drug.

Don't know - 2 responses

How do each of the following factors relate to how you view and work with a substance abuse case?: *(continued)*

Type of drug-related activity: user; seller

Seller - 11 responses

If selling - get the parent out of the house or the child out of the house.

It's a very dangerous situation.

With selling there are a whole lot of unsafe people coming to the house.

Selling - I'm more concerned with people coming to the house buying. These strangers are a risk for the children.

Most moms are only users but if they deal, violence is a concern.

If selling - get the child away because of the caliber of people coming to buy.

Sellers attract more dangerous persons.

With sellers more violent contacts are being made.

When selling the wrong kind of people are coming by to buy.

Selling indicates a lack of money which may lead to stealing.

It's worse if selling. They (mother) may sell themselves and/or their children.

The seller is a problem - people coming around the children and shootings.

User - 1 response

The child is more threatened by someone using cocaine because of the things they would do to get the drug.

No difference - 3 responses

There is no difference for users and sellers - none of these people should be around the child.

No difference - both are a concern.

Both are of equally troublesome.

Don't know - 4 responses

How do each of the following factors relate to how you view and work with a substance abuse case?: *(continued)*

Particular family strengths/resources

[NOTE: Since respondents made multiple mentions, the number of mentions will not necessarily sum to nineteen.]

Support system

- Strong family support without enabling. The extended family provides a safety net for the child.
- If the extended family lends support.
- Usually there is an extended family member who is willing to help.
- The stability of the extended family and as a support group. Is the family committed to working together?
- Is there a family network? Are there relative with which to place children?
- Responsible and supportive family members.
- The aunt is the only strong person and she has the child.
- We look for a support system.
- Family support and friends support.
- Is there extended family support?

Relationship with child

- What is the relationship between the parent and the child?
- What are their priorities in life? Where are the children in that?
- Look for love and concern as strengths.
- How much does the parent know about the child? Is the child afraid? That's a good indicator.
- Ability to persevere as a parent.

Stability

- We are looking for some kind of stability - income stability, work, and/or a place to live.
- Are they employed? Do they have a job that's important to them?
- Is there a stable job and/or a stable home (i.e., they don't move a lot).
- Work history.

Willingness to change

- Willingness to admit their substance abuse and to work on it.
- Whether the parent is willing to go get help.
- Look for some sincere commitment of the parent to change.

Compliance

- Is the parent following the judge's orders?

How do each of the following factors relate to how you view and work with a substance abuse case?: *(continued)*

Particular family strengths/resources *(continued)*

Strengths as an indicator

Sometimes the strengths seduce me into thinking that the substance abuser stands a better chance than they do.

We assess whether there are enough strengths - that's our job.

In-home resources

Can they get in-home resources when the mother is in treatment?

Strengths ≠ substance abuse

I can't find any strengths if they are using drugs.

Don't know - 1 response

Can a child stay in a family in which there is substance abuse or must the child be removed?

[NOTE: For this question there are seventeen respondents. This question was not included in an earlier version of the interview guide.]

Stay - 12 responses

It's possible the child can stay if there is a responsible adult in the home.

They can stay - if there is ongoing therapy and close supervision. Or they can return if there has been successful treatment and abstinence for several months.

They could stay with safeguards in place.

They can stay under close monitoring - it's possible.

They can stay if the child's basic needs are being met and the substance abuser is functional as a parent.

If there is another stable parent in the household it might be possible.

Children should be removed only if they are neglected or abused. Substance abuse takes place in the middle or upper class families and their children aren't taken.

They can stay is there are appropriate caregivers and the child is not in danger. The parent should be in treatment and trying to solve their addiction.

Yes. There needs to be someone around with some sense to protect the children and to nurture them.

Yes, the children can stay. The substance abuser has to be willing to get treatment and be getting it. The physical safety of the child must be insured.

Can a child stay in a family in which there is substance abuse or must the child be removed? *(continued)*

Stay - 12 responses *(continued)*

It depends on the willingness of the parents to accept help and to help themselves and on their support network.

Sometimes they can stay but that is probably rare.

Remove - 5 responses

The child must be removed immediately. They are at risk emotionally and physically.

They should be removed because a substance abuser's home is not a safe place.

Remove the child and reunite when the substance abuser shows progress and has six months of sobriety.

It depends on whether the substance abuser is seeking treatment. Until treatment is sought - remove the child.

Children want to stay but it is best to remove them.

Can a child be reunited with their family if the parent is not drug-free or must the parent be drug-free before they are reunited?:

Drug-free for reunification - 15 responses

Legally it is almost impossible to reunite if the substance abuser continues to abuse.

The parent should be drug-free. 3 months drug-free and continued treatment.

It's best that the parent be drug-free for 90 days.

Needs to be drug-free for 3 to 6 months minimum.

They should be drug-free - 6 months sobriety. If they are reunited the children need to go through support treatment to deal with potential relapse.

They should be drug-free for 6 months.

Reunite if they show progress and have 6 months of sobriety.

We prefer they be drug free for 6 months.

They must be drug-free for one year.

They have to be drug-free.

Have to be drug-free.

The parent should not be using for reunification.

Yes, they should be drug-free so they can focus on caring for their children.

Yes, otherwise it's too dangerous for the child.

If you take the child out of the home for safety reasons, then stay with the game plan. Don't return the child until the parent is drug-free.

Can a child be reunited with their family if the parent is not drug-free or must the parent be drug-free before they are reunited?: (continued)

Not necessarily drug-free for reunification - 4 responses

If the parent shows positive steps and there is monitoring.

They could be reunited with adequate adult supervision in the household.

It varies from case to case - how much do they drink? can they stop? what happens when they drink?

If the substance abuser is functional in the family as a parent and there is no potential for violence (e.g., selling drugs).

Community Resources

What kinds of resources are available for working with substance abusing cases?:

[NOTE: Since each respondent listed several resources, what follows is a simple tally of how often a particular resource was mentioned. More resources than we mentioned may be available - these were the ones that came to mind during the interview.]

AA - 10
Mental health - 9
Mental health (substance abuse services) - 8
Residential drug treatment - 8
Substance abuse counseling - 7
NA (Narcotics Anonymous) -5
Parenting classes - 5
DSS - 5
In-patient drug treatment - 4
In-Home Family Preservation Program - 3
Al-Anon - 2
TASC (Treatment Alternatives to Street Crime) -2
Alcohol counseling - 1
Infant - Child Development Services -1
Family Services - 1
Health Department - 1
Detox Center - 1

What kinds of resources are not available that are needed to work with substance abusing cases?:

Treatment for mother with children along

Treatment situation where mother and child are together.
Residential treatment for mother and children. [3 mentions]
Day treatment program that mothers and children who are too young for school could participate in.
Non-residential treatment program oriented to mothers with babies.

Treatment programs

Residential treatment program.
County facilities for in-patient treatment but be able to go to work during the day.
A 28 day drug treatment program locally.
Higher quality Mental Health counseling .
Substance abuse treatment centers in housing projects (that would take care of transportation and child care problems).

What kinds of resources are not available that are needed to work with substance abusing cases?: *(continued)*

Community services

A good interface to access services for families.

I want a list of services available with a description of what they do and for whom.

Facilities for battered women and their children.

Resources for children in GAL cases

Residential group home for foster care and treatment care.

A mentor program for all GAL children (like Big Brother/Big Sister).

Children in substance abuser homes have no one to help with homework and no quiet place to work.

Drug testing

Drug testing (Mental Health takes the client's word) [2 mentions]

Cooperation with other agencies

Closer cooperation and sharing information between DSS/MH/GAL - it's not that they can't - they don't. For example, I would like to attend permanency planning meetings.

Community education

More community education about child abuse.

GAL continuing education

Continuing education for GAL volunteers

Ideal Solutions

In your opinion, what kind of program would be an "ideal" program to address the issue of a substance abusing parent/caretaker?:
[NOTE: Some respondents gave more than one response.]

Residential treatment - mother and children

- A residential facility for moms and young kids.
- Send whole family (mother and children) to residential treatment center.
- Residential treatment long term for mother and kids.
- County based residential treatment with children that teaches parenting, job skills, etc. with a transition house for a follow-up program.
- A residential treatment program with a focus on prenatal women and women with infants which would include vocational training.

Day treatment - mother and children

- A day treatment program that mothers and children (who are too young for school) could participate in.
- Day treatment that takes women and their infants

Treatment modalities

- Put the substance abuser in a facility that would provide therapy for the drug problem; provide assistance with job finding; and ease the person back into society. Have a family therapist at the facility also.
- Use a reality approach to alcohol treatment. Don't soft soap the consequences of their abuse.
- 29 days is not enough - keep in drug treatment programs longer, say six months.
- There should be treatment on demand and more money for treatment.

Support groups

- Develop support groups for children and their parents so that they do not get so isolated. Also provide respite care.
- Keep the substance abuser from their friends. Get them out of their environment and move them somewhere else.

No one program will do

- There is not one organized program that can intervene successfully.
- It takes a lot of components - residential program, follow-up, and AA (for alcohol problem).
- There isn't an "ideal" program.

Don't know - 5 responses

In your opinion, how can the GAL program best advocate for the children of a substance abusing parent or caretaker?:

Dealing with cases

Be honest with the parent - "Look, you have a choice, help yourself or the consequence is you will lose your child." The parent is mad at DSS so the GAL volunteer has a competitive edge.

By insisting that parents get treatment and deciding when it won't work. Then terminate parental rights (TPR).

Use a "tough love" approach. The best thing to do is to be tough. Take the child and tell the substance abuser to get cleaned up and maybe the child will be returned.

More GAL volunteers need to get more involved. They need to understand the substance abuser better. They should escort the substance abuser to programs to see their reactions at meetings. In this way you can often see a "fake." You can better assess their involvement and their willingness to recover.

I check on my cases a lot (two times a week). Weekends are a good time since there is more drug use then or the first of the month when they get their AFDC check.

The more information I get, the better I can advocate for the children.

Have more programs available for parents and children.

We need proper treatment for substance abusers and their family. If there is not good treatment, there is very little that can be done for the child.

The child has a right to be safe (from verbal or physical abuse or neglect). In substance abuse situations this will happen. The GAL volunteer needs to protect the child.

By making sure that the children don't stay in the environment that produce their parent's problem. It cycles through generations.

Do what we do already. Ask over and over, "What is in the best interest of the child?"

Creating awareness

Make school more aware - for example, fetal alcohol syndrome

Make people aware of substance abuse and child abuse. Then there will be more people to recognize it and report it.

GALs

Have a GAL volunteer association which would be a support group for volunteers.

We need more volunteers. There are cases without volunteers.

In your opinion, how can the GAL program best advocate for the children of a substance abusing parent or caretaker?: (continued)

Strategies

Look at the overall "big picture." We usually work at the grass roots level, one-on-one.

In advocating we should recommend something practical and reasonable. Make certain that the safety nets are in place.

Advocate on a broader political level (county commissioners, state legislators) for increased resources.

No special advocacy is needed - treat all cases the same.

B. GAL District Administrators

The preceding section details the responses of the GAL volunteers who were interviewed about specific substance abuse/child maltreatment cases and the general issues involved in such cases. In this section interviews with district administrators are summarized (in two cases, a support staff person was interviewed in lieu of a district administrator). Interviews with the district administrators also utilized the interview guide developed for the GAL volunteer interviews. The first section on case-specific information was skipped and the interview began with the generic questions about substance abuse/child maltreatment issues (see Appendix C for the instrument - questioning began with the last question on page four of the instrument). Since the district administrators have knowledge of all their cases, their views and experience are expected to be more broad and comprehensive than the those of individual volunteers. These interviews were intended to tap their overall experience with substance abuse/child maltreatment cases within given districts.

It was noted in the beginning of this chapter that twenty-one district programs were selected for interviewing. Volunteer interviews were missing in two districts so that a total of nineteen interviews were reported. In this section the two missing districts are returned to the total since interviews were done with the district administrators in those programs. However, three districts will not be represented from the total twenty-one for the district administrator interviews. In two districts the staff person was the GAL advocate. That is, the staff took on cases as would a volunteer. These interviews were counted as volunteer interviews. In another case, the district administrator and the staff person, acting as GAL advocate, were interviewed together and their collective interview was assigned to the volunteer section. Therefore, the total number of interviews considered in the district administrator interviews is eighteen. Following are the summary responses of those eighteen GAL district administrator interviews.

Substance Abuse Cases

How do substance abuse cases differ from non-substance cases you see?:

[NOTE: One response is missing, there are a total of seventeen responses.]

Difficulties

- Substance abuse cases, especially crack, are more frustrating than non-substance abusing cases. Parents are totally resistant - they think they don't need help and they resist help. Mental health can't get through to them.
- Substance abuse cases complicate everything. How long do you deal with substance abusers before know if that issue is resolved?
- Substance abuse cases are harder to deal with. Addiction is the most difficult part. Substance abusers are real hard to rehabilitate. These cases are harder to resolve or it may never happen.
- Substance abuse cases are more frustrating and go on longer.
- These cases are twice as hard to get at - there are multiple problems. Other cases are more straightforward.
- In substance abuse cases there are a great deal more frustrations. There is more interaction between volunteer and mental health personnel and treatment personnel.
- There is an easier measuring of progress and success in other cases than in substance abuse cases. You are less certain about when you can let go of the kids - when are they safe?
- Substance abuse cases have parents whose primary goal is to get drugs. Other cases are not as all-consuming. Because of the drug addiction you can't reason with the substance abusing person and substance abusing persons don't keep their promises. Cocaine destroys the motherly instinct.
- Substance abuse cases make things more difficult for reunification because parents are required to get their substance abuse under control (this isn't required of substance abusing families of say, the middle class). We dangle the children to encourage the parent to get sober - it doesn't always work.
- In substance abuse cases there is a whole other level of problems and issues to deal with. What do you attack first? You need to address both doing something for the children and the substance abuse at once. Sometimes treatment is not available.
- Non-substance abuse cases have a better chance to be resolved. We don't have a lot of resources to address substance abuse issues. The prognosis for substance abuse is not usually good.

How do substance abuse cases differ from non-substance cases you see?: (continued)

Difficulties (continued)

Non-drug cases are easier to deal with. In non-substance abuse cases one can address the issues of job training and the like to make things better. In drug cases the parent's judgment is impaired. They don't have a job and they don't have enough money. They are nervous and irritable. They party and leave the kids for long periods of time. They can't care for children. Things don't get better without intervention in drug cases - but in non-drug cases things can get better on their own.

Substance abuse cases are a batch of problems - unemployment or irregular employment; housing problems; they don't qualify for certain services (e.g., they are evicted from public housing for drug use); their criminal record disqualifies them for certain services (e.g., public housing); getting treatment may be difficult - insurance hardly covers it, it's too expensive and it takes too long; and the parent's self-worth is too low - they feel unworthy to be a parent and an outcome is that they consent to things easily that leads to TPR. Questionable practice: In substance abuse cases the social worker leaves children in the home so the parent can get substance abuse treatment (AFDC and Medicaid - SSI - Medicaid will pay 100% for the substance abuse treatment). Most of the time the child has been removed from the home when the GAL volunteer gets involved. The child may not want to go back home because the child is fearful of the parent - the parent blames the child for their loss of income (e.g., AFDC) and for getting caught for substance abuse.

Safety of children and volunteers

When alcohol and crack cocaine are involved the user is "whacked out" and allows strangers access to the kids. With crack cocaine the mother prostitutes children to get money for drugs. With alcohol the drug user sexually abuses the children and/or physically abuses them. Crack cocaine users leave children alone for long period of time. They sometimes lock the children in the home. The children are filthy and not fed. There is no food in the house, no electricity, the children need medical treatment, and the like. Crack cocaine users trade food stamps and AFDC money for drugs. Crack cocaine users homes are sparse on furniture and on toys.

Substance abusers forget they have children when they are under the influence of the drug.

How do substance abuse cases differ from non-substance cases you see?: (continued)

Safety of children and volunteers (continued)

In drug cases there is a safety factor for the volunteer. The substance abuser lives in a drug/crime infested neighborhood. They often have the attitude - "I'll kill anyone who takes my kids!" Drug using mothers are harder to find - relative and friends protect them.

The drugs they use make for volatile situations. Users are unpredictable and they tend to be violent. They threaten caseworkers and GAL volunteers. They actually kidnap children.

The Best Interests of the Child

What does "in the best interests of the child" mean to you?:

Needs and nurturing

- Puts the child's needs (physically, psychologically, and educationally) first.
- Have a plan that addresses the emotional, health, and security needs of the child.
- Is the parent able to meet the needs of the child? Do parents have the needs of the child at heart?
- Putting the child's interests above the parents.
- Put aside the needs of the parents. Do what is best for the child on an individual basis (this varies from child to child).
- That the emotional, physical, and mental needs of the child are being met in the warmest nurturing environment possible.
- To provide an environment in which there is nurturing, protection, and the child can thrive to reach its potential.
- That the child has an opportunity to participate in society (health, education, etc.). There is a balance between emotional and physical factors.
- Every child deserves a place to grow up - permanence - a sense of belonging.

Safety

- Do what needs to be done to make the child safe and sound.
- See that the child is safe, has a permanent situation (that is, is not moved around a lot), and is nurtured. But, the child doesn't have to be happy.
- What will protect the child? What services does the child need?
- Every child is entitled to a safe, loving and nurturing environment.
- You want the child to be safe. Advocate for services for the child to be the best human being they can be.
- That the child will not be neglected and/or abused again.

To be with family

- Remembering the child should be with their parents (although in some cases this is not the best for the child). DSS should empower families so they can solve their problems and keep the family intact.
- To be with their family. But, if the family is not complete (that is, they do not have the ability to parent the child) take them out of the family. This may not be what the child thinks is in their best interest.

Problematic

- This is not very often obtainable. Consider how to damage the child the least. It's a difficult issue - theory and reality are at odds.

Under what conditions is it in the "best interests of the child" to keep the family together when there is substance abuse in that family?:

[NOTE: There is missing data for one respondent.]

Responsible adult caregiver in household

The child can stay in the home if there is another adult to protect the child from the substance abuser.

If there is an other caregiver to care for the children.

Have a non-substance abusing caretaker in the home so that children's basic needs are met.

There needs to be a responsible adult in the home. If one or both parents are abusing substances, an option is to have a family member or someone come in to protect the child. Or, put the child in daycare until the non-substance abusing responsible parent come home from work.

Keep the family together if there is someone to care for the child when the drug using parent is out of it.

Need to provide for care of the child by supervision by a responsible adult.

Safety of the child

If the child is safe and their needs are met. It is best to keep the children in the family when possible.

Keep the child in the family when it is safe.

Keep the children in the family if there is no severe risk to the child - this preclude infants. If one parent is not a substance abuser and not codependent. The minimum we can accept is that the substance abuser agrees to get treatment.

If the children are in no immediate danger - every family should be kept together as long as the substance abuser is willing to get help and to follow through with a treatment plan. Keep the child in the family if at all possible.

The child could stay in the home if - the child is not in danger (this runs the gamut from people coming and going - the possibility of violence to neglect - where the parent can't care for the child); the substance abusing parent gets treatment; someone moves in to care for the children (a support system); if the child is not too young to fend for themselves - the older child can fend for themselves while the younger child can not.

Under what conditions is it in the "best interests of the child" to keep the family together when there is substance abuse in that family?: (continued)

Age of child

The age of the child is important. For a teen it is possible that the substance abuse won't affect them.

In keeping a family together with a substance abuser in the family, you must consider the age of the child [NOTE: nothing more was specified]. Other support systems that could be put in place need to be used. The parent's level of involvement in drugs needs to be determined.

Parent gets treatment

If the substance abusing parent gets treatment, the child might stay.

Other

Keep the family together if there is any possibility that the substance abusing parent(s) can be fixed. Using drugs is not a reason to remove the child. Using drugs does not equal neglect. For example, a mother who uses drugs but keeps her children well fed, clothed and gets them to school on time [This is, admittedly, an unusual case.]

Keep the family together. Removal of the child may be more detrimental than leaving the child there. When substance abuse is not a primary concern of the parent and when the child's needs are met, the child can stay. I have friends who have alcoholics in their family and removing those children would have been detrimental.

Under no conditions

Substance abuse is dysfunctional. It is not in the best interests of the child to stay in the family. It sets children up to get into the cycle of substance abuse. It takes the child's childhood when they take the parenting role for their dysfunctional parent.

Under what conditions is it in the "best interests of the child" not to keep the family together when there is substance abuse in that family?:

Parental substance abuse continues

Do not keep the family together is the parent refuses to give up their substance abuse. There is a need to see if the child is safe.

If the substance abuse continues, take the child.

Remove the children when the substance is the primary focus of the parent to the exclusion of the child.

Do not keep the child in the family if the substance abuse is at a point that there is no treatment (the parent either refuses or doesn't begin); the substance abuser denies the problem; they are out of control; the substance abusing parent can't provide for the safety of the child.

If the substance abusing parent hasn't been sober, hasn't been in treatment, or hasn't established sobriety after treatment. Unless the parent is in treatment and has a year of sobriety (determined by random drug screens) and is committed by their behavior to continue treatment - DSS should take physical custody of the child.

Do not keep the family together if the parents refuse to take appropriate action. If there is no support network, take the child.

Child in danger

Take the child from the family when the child is at risk for harm.

Take the child when there is a high risk level - imminent danger.

Remove the child from the family when the child isn't safe.

Take the children out if there is fighting and violence - if there is severe risk to the child. Also remove if the parent refuses treatment.

If the children are in immediate danger and if there is chronic neglect of children who are vulnerable and getting into trouble.

Take the child out of the home if there is substantial risk of injury or neglect.

When the parent or family puts the child in danger (DWI, etc.) and doesn't provide for the physical and emotional (nurturing) needs of the child - remove the child.

Caretaker/support system missing

Remove the child if there is no non-substance abusing caretaker in the home. Also if the child's basic needs are not being met.

If there is no other caregiver (than the substance abusing parent) to care for the children.

If there is no support system and the parent is deeply involved in drugs.

Under what conditions is it in the "best interests of the child" not to keep the family together when there is substance abuse in that family?: (continued)

Other

Substance abuse is dysfunctional and not in the best interests of the child. It sets up the children to get in that cycle of substance abuse and it takes the child's childhood. If there is substance abuse, remove the child.

Time limitations on a case: If the mother doesn't care for the children and isn't going to do anything about her substance abuse - give her six months and then TPR. If the mother cares but she is not getting better very rapidly - she is doing something but not enough - give her one year. If the mother is trying - give her longer than a year.

Substance Abuse Cases and DSS

In substance abuse cases, do you usually agree or disagree with DSS's assessment of the situation?:

Agree - two responses

Agree most of the time but disagree on certain issues

Disagree on the kind of treatment - DSS wants one time per week treatment and we want residential treatment for the substance abuser. GAL wants to remove the child before DSS. DSS want to reunify earlier than GAL.

We disagree on placement - it's usually the wrong family member they want to place the child with. Reunification - GAL wants to return the kids home sooner but it's easier for DSS to leave them in foster care.

DSS doesn't look for extended family hard enough to make placements.

DSS sometimes wants to return the children too soon. They do this probably because there is no place to put the children - no foster home for them.

We mostly disagree with the timing of when the child is returned to the home. If foster care isn't going well, DSS wants to return the child to the home - if things are going OK they keep them in the foster home.

We disagree on the placement of children. They need to assign children to foster care - DSS doesn't because they have no openings. For those in foster care, they are able to place them with relatives but they won't. If they did the latter, it would make the former more possible.

DSS is too quick to try to place children in foster care - they need to exhaust alternatives - they don't look for alternative placements to keep the children in the family.

Our point of disagreement is the timing of the returning children. DSS will give the parents more leeway than GAL. Substance abuse takes a long time to deal with but not several years as DSS does.

We have good rapport with DSS. On reunification - DSS wants to return the child too early. On placements - DSS wants to place the child in extended family who are worse off than the child's family. They fail to get the whole story. Why? High caseloads and GAL staff can find out things DSS can't. This is because they have access to records DSS doesn't and GAL volunteers are seen as the "good guys" who don't want to take the child but get the child back. Parents therefore cooperate more readily and provide information to the GAL volunteer.

We have a sense of urgency for a permanent plan but DSS moves too slowly. It is in the best interest of the child to resolve this problem quickly.

In substance abuse cases, do you usually agree or disagree with DSS's assessment of the situation?: [Continued]

Varies

It varies with the severity of the substance abuse - the less severe the substance abuse, the more disagreement (this refers to alcohol only - we agree on crack). DSS does not focus on what harm substance abuse does to the child. GAL says yes and DSS says no to treatment for children which will provide the child with coping skills.

It depends on the social worker and how they view substance abuse. DSS holds the substance abusing parent to unusually high standards. For example, a mother has her children taken. The mother stops using crack but still uses some marihuana or beer but is taking care of business. The social worker says don't return but we think it is probably OK.

Disagree

The GALs uncover more than is alleged in the petition done by DSS. We disagree on foster care placements. We disagree on the number of chance the parents should have - DSS give too many chances.

DSS wants the child to stay in the home or to return home when GAL is of the opinion that the home is not safe for the child. Having the children stay in the home helps the DSS caseload - they don't have to transport the child. One needs to understand why DSS does what they do.

DSS wants to reunite at all costs. DSS is not an advocate for the child - they are advocates for the parent and the family.

DSS doesn't look carefully enough at extended family placements (the apple doesn't fall very far from the tree). The family may not be appropriate.

Substance Abuse and Child Maltreatment

***What drug or drugs are most often associated with a child being physically abused?*:**

[NOTE: Beginning with this question there are missing data for one interview thereby reducing the total number of interviews to seventeen.]

Alcohol - 10 responses

Alcohol and cocaine - 4 responses

Cocaine - 1 response

All drugs - 1 response
Crack, alcohol, prescription drugs.

Don't know - 1 response

***What drug or drugs are most often associated with a child being sexually abused?*:**

Alcohol - 11 responses

Alcohol and cocaine - 3 responses

No drugs - 1 response

Don't know - 2 responses

***What drug or drugs are most often associated with a child being neglected?*:**

Alcohol, cocaine, and crack cocaine - 10 responses

Crack - 4 responses

Alcohol - 2 responses

Don't know - 1 response

What drug or drugs are most often associated with a child being unsafe?:

All drugs - 6 mentions

Crack cocaine, cocaine - 3 mentions

Alcohol, cocaine, and crack cocaine - 3 mentions

Alcohol - 2 mentions

Missing data - 3 responses

How do each of the following factors relate to how you view and work with a substance abuse case?:

[NOTE: There are fourteen responses with data for this series.]

Age of the children in the family

The younger the child, the greater the risk.
The younger the child, the more danger to their safety - others can't see and talk to them.
The younger the greater risk for neglect.
The younger the child the more vulnerable they are.
For young children there are physical risks and for older children, emotional risks.
If the child is too young to get help on their own they have to be placed.

It is important to know whether the child can take care of their self and this varies from child to child.
Less than four years of age, the child is bound to get hurt. From ages five to eight they can take care of themselves.

The infant is non-verbal and can't be interviewed. You can get a lot of information for four or five year olds - the "honesty age."
For infants it's a safety issue. They are at an age when they are unable to care for their self and the parent may go off and leave them alone.

For the infant there are physical needs only. Pre-school there is a period of learning and they begin to understand the family behavior. School age there are other problems.
The school system gives good feedback. Preschool the daycare gives good feedback. Infants to school age are at risk.
For preschool children, if the addiction is long standing, take the child out of the home.

How do each of the following factors relate to how you view and work with a substance abuse case?: (continued)

When alcohol is involved the kids are older and they can do more to survive longer. When cocaine is involved the kids are younger and at risk.

Availability or non-availability of caretakers other than substance abusing caretaker

Another adult to care for the children is important.
Another adult to nurture and keep the children safe is needed.
You need a responsible adult.
Someone who could support is important.

If they can protect the children - usually they can't or there wouldn't have been a petition. For example, the father works and the mother drinks. The kids suffer. Resolution - daycare for the kids and the father protects them when he is home.
Caretaker availability makes a big difference - you need it.

For example, if the grandmother is in the home - if the court tells the grandmother to care for the children then it's OK. The caretaker can intervene more effectively if they are mandated to do so by the court.
Have a grandparent or the like to be the responsible caretaker. Get the substance abuser out of the home - they create chaos.
Use grandparents a lot - children go to grandparents.

Whether there is another non-substance abusing caretaker can mean the difference in the removal of the child.

No response - 3 respondents.

Type of substance being abused

Crack users disappear and leave children alone at home. Alcohol is usually consumed at home. The parent may pass out but otherwise they do not go out to drink and leave the children.
Crack cocaine users have the criminal element around them and also have a lengthy criminal record (B&E and assault, for example). With alcohol there is a higher risk factor - they drink days on end and do not feed or cloth the children (they neglect them).
With crack there is outrageous neglect and with alcohol there is a milder form of neglect.
If cocaine or alcohol - something needs to be done quickly.

How do each of the following factors relate to how you view and work with a substance abuse case?: (continued)

Type of substance being abused (continued)

Alcohol and other drugs are two different addictions. You can reason with the alcoholic and they need support. With other drugs there is constant maintenance of the drug, the user need to leave their environment, and the craving is easily triggered.

Crack users go under so fast.

The type of substance doesn't make a difference. It's the same for all. Address the treatment plan.

Anything that cause the parent to not function is a problem.

There is no difference - all drugs are troublesome.

It's not the type of substance but the use of the substance - how it is used and with what result.

Don't know - 2 responses.

No response - 2 respondents.

Type of drug-related activity: user; seller

Selling is another complicating layer - the number of people going into home is a risk to the children.

When a parent is dealing they are taking children along or the dealers come to the house. How the users get the drug puts the children at risk.

Generally there is selling to get money to use. If they are selling everyone comes to the home to buy and puts the children at risk.

If the parent is a seller they put their children at physical risk - the kind of people who come to the home may sexually abuse the children.

Selling is very dangerous with people coming into the home.

Selling brings the criminal element into the home.

Selling is dangerous.

With selling, violence is not very far away.

People they sell to put the children at risk. There is violence related to selling.

With selling there is the threat of violence.

If there is drug selling remove the children from the home.

Don't know, we've had not cases associated with dealing - 3 responses.

How do each of the following factors relate to how you view and work with a substance abuse case?: (continued)

Particular family strengths/resources

Is there an extended family and are they a supportive extended family?

Look to other family members (extended family) for support.

Strong grandparents are often helpful. Look for strengths to utilize - usually in the extended family.

If one parent is dependent on the other parent then find extended family to care for the child - provide respite care.

The family support system is a major strength.

Look to outside support systems, how long the parent has been on drugs, the functioning level of the family, and how committed the substance abuser is to getting off drugs - look to their actions.

Families around here stick together - there is lots of support.

Always look for strengths. The basic assumption is that children do best in their biological families. Look to empower parents to take care of themselves and their children.

Find family resources that will not allow the substance abuser to interrupt their family life. If you can do this, you are lucky.

See how the family interacts. Do they love the child? What is the motivation to work on the problem?

Sufficient care resources for the children can offset substance abuse problems.

No response - 3 respondents.

Can a child stay in a family in which there is substance abuse or must the child be removed?:

[NOTE: There are seventeen respondents for this question and those following]

Safety

They can stay in the home if it is safe.

The child can stay in the family - just provide for their safety and remove the substance abuser or help the substance abuser.

The child could stay in the home if the child is not in danger and if someone moves in to care for the child.

Keep the child in the family if the child is safe and their needs are met.

Can a child stay in a family in which there is substance abuse or must the child be removed?: (continued)

Responsible adult in household

The child can stay if another responsible adult is present to keep the child safe.

Keep the child in the family if there is a non-substance abusing caretaker in the home and the child's basic needs are met.

If there is a caregiver other than the substance abuser in the home to care for the children, they can stay in the family.

If there is another adult to protect the child from the substance abuser they can stay in the home.

The child can stay in the family if there is a responsible adult who can care for the child - someone to take up the slack. Middle class folks function with a parent who is drug dependent (usually alcohol). They have the resources to cope.

Yes, they can stay in the home. Fine families who have alcoholics raise children - the spouse covers it up.

Willingness of parent to get treatment

The family can be kept together as long as the substance abuser is willing to get help and if the child is in no immediate danger.

The substance abuser must be in treatment and committed to continuing that treatment and the child's care must be provided for through the supervision of a responsible adult.

When the substance abuse is not the primary concern of the parent and the child's needs are met.

If the parent works to give up their substance abuse.

Other

The child doesn't necessarily have to be removed when there is substance abuse - but substance abuse is dysfunctional and if there isn't physical harm there may be emotional harm or neglect.

The child can stay in the family if they meet a "minimum sufficient level " (this is a DSS concept).

If substance abuse - remove

If a parent is a substance abuser - take the child out of the home!

Can a child be reunited with their family if the parent is not drug-free or must the parent be drug-free before they are reunited?:

Must be drug-free

They must be drug-free for three months minimum.

They need to prove themselves. They should be drug-free six months (as tested by periodic drug testing) before being reunited. This is not too much to ask.

They must have a year of sobriety with random screens during this time.

It is OK to reunite if the substance abuser is drug-free.

Drug-free? What's that? The last five urines are clear? OK to reunite but, the substance abuser must complete the treatment plan.

In order to reunite do random screens to verify that the substance abuser is not using drugs. Also, make certain the home is safe for the child's return.

When you get into the system you have to meet a higher standard. DSS prior to the petition has a lower standard. The court, after the petition, has a higher standard - the court will not allow reunification until the parent is drug-free for a certain number of months.

For reunification we require them to be drug-free. We hold them to higher standards than we need to.

Safety

The focus of the reunification is what the child needs to safely return home.

Reunite if the drug use is not harmful to the children. Otherwise, don't.

Other - reunite

They can be reunited. The parent may mature and get their life together. They should have a commitment to not use substances.

If substance abuse - do not reunite

If the parent is still a substance abuser, do not reunite.

If the substance abuser is still actively using substances do not reunite. Also you need to provide for the safety of the child and to have a plan. How long do we need to be inlvolved in their lives? How long does one have to be drug-free to trust returning the child?

Do not reunite if the parent refuses to give up substance abuse.

No reunification if treatment is refused or not started and the parent continues to deny their drug problem.

Other - do not reunite

If DSS's "minimum sufficient level" is not met, do not reunite.

No response - 1 respondent.

Community Resources

What kinds of resources are not available that are needed to work with substance abusing cases?:

[NOTE: For the remaining questions here and below there are sixteen respondents for whom data are available. In this particular question, multiple resources are mentioned. They are organized to indicate the frequency of their mention and therefore will not sum to the total number of respondents.]

Residential treatment for parent which allows children to accompany parent

Residential treatment for mother (parent) and children.

More treatment programs where the mother and children are together. Mothers would be less hesitant to go into treatment. The mother has to make the choice to put the child into foster care during her treatment. This type of treatment program would facilitate the parent wanting and getting treatment.

A place where young mothers could get residential treatment with their children with them.

Halfway house where parent and children can be.

Substance abuse treatment

Beef up substance abuse programs.

Fewer delays and no waiting list for substance abuse treatment.

More drug treatment facilities.

More treatment facilities in the county or more local.

Foster care

More foster care.

More foster homes.

Foster homes for families - so we would not have to separate siblings.

Therapeutic foster homes.

Children of substance abusers counseling

Counseling for children of substance abusers.

Programs for children of substance abusers.

Facility to treat psychologically damaged children.

Parenting classes

More effective parenting classes.

More effective parenting classes and a way to monitor effectiveness.

Parenting classes.

What kinds of resources are not available that are needed to work with substance abusing cases?: (continued)

Transportation

Good transportation to treatment facilities.

A transportation system - need to move children and adults for visitation.

In-patient treatment

In-patient treatment - 2 mentions

More 28-day programs

Treatment follow-up

Better follow-up care after treatment.

Halfway house that is local (follow-up on 28-day program).

Support system - a recovery mentor (one who helps with the recovery process) who could provide respite care.

Support system for crack mothers.

Medicaid

Medicaid beds that last longer than they do.

Therapist for specialized cases (e.g., sex abuse) that will accept medicaid.

Therapy types

Family support center - all in one place where the parent gets treatment and the children could also get support.

Family therapy - treatment for the whole family.

Family therapist.

Family therapist to help parents understand what is happening to their children.

Sex offender therapist for adults.

Sex abuse treatment. Specialized therapy - group sessions.

Battered spouse treatment.

DSS

More DSS workers

DSS facilities for visitation are not good - they should be more pleasant for the children.

What kinds of resources are not available that are needed to work with substance abusing cases?: (continued)

Other

More drug assessment

More intensive outpatient treatment - longer follow-up, more frequent drug screens, and meet the group or individual daily instead of once a week.

More money for better services - you get what you pay for and that's a problem.

A Child Center - a child decorated center for all evaluation services for children. Currently children go to Chapel Hill for sex abuse evaluation - let the adults go to the children.

An emergency home - quick response to situations and short term stay.

No waiting list for children at mental health.

More in-home services like Family Preservation.

Ideal Solutions

In your opinion, what kind of program would be an "ideal" program to address the issue of a substance abusing parent/caretaker?:

Family approach

- Be comprehensive - address all the needs of the family not just the substance abuser's needs. This means children's needs too.
- A family treatment plan. Provide services to everyone. Address substance abuse first and then other issues such as education (GED) and job training.
- Provide in-home therapy and move to family therapy.
- Treat the substance abuser and the entire family.

Accessible services

- Make services accessible of clients. More in-home Family Preservation. Provide services at night, not just during the day. The "system" is not user friendly. The system shuts down on weekends - you can't transport children for visitation on Saturday or Sunday. The bureaucracy stands in the way of treatment, especially mental health.
- Fit the needs of the family instead of vice-versa.
- There is a need for intensive intervention. Family Preservation offers intensive services to families which could be useful in substance abuse cases.

Halfway house for substance abusers post-treatment

- Ideally have a 28-day program and a halfway house. The halfway house would be monitored residential treatment for the mother and child. The mother would learn parenting skills; receive DSS services - job training and vocational rehabilitation, help with employment and housing; and get drug treatment. There would be services for the children too. A DSS worker would be on staff at the halfway house.
- It would be ideal to have a drug halfway house. A place to go after residential drug treatment.
- Follow-up after drug treatment which provides motivation to continue to stay clean.

Regional or local center for coordinated substance abuse treatment services

- A regional center or local center - have all treatment in one place so folks don't run from hither to yon.
- Have a treatment center in the county and coordinate treatment in one single place.

In your opinion, what kind of program would be an "ideal" program to address the issue of a substance abusing parent/caretaker?: (continued)

Visitations

- Make visitations productive. Have supervised visitations (a meaningful visit) where there is instruction (parenting, etc.) and close in-home supervision.
- DSS visitation facilities - have a DSS visitation room that is child friendly and parent friendly.

Other

- It would be great to have a place where young mothers with children could get residential treatment.
- Have in-patient treatment at the local hospital.
- Drug treatment gender equality. At present women get Medicaid and men get nothing and stay addicted.
- A multi-faceted approach - put money on the front end to stop the "cause" of substance abuse. Good education programs might have an input.

In your opinion, how can the GAL program best advocate for the children of a substance abusing parent(s) or caretaker(s)?:

Get parents back on track

- In the best interests of the child, help the parent to get their act together.
- Push for services that can be offered to families - get the parent back to the level where the children are not at risk.
- The best way to advocate is to get the parent's help. The frustration is that many parents don't want to help.

See that child is safe

- The best advocacy is to make such the child is not at risk for harm.
- See that the child is safe in their environment

Political path

- Don't be so politically isolated. Advocate with the legislature and have it filter down to local programs.
- Advocate through legislative action and community service. But we are limited by our mandate from GAL.

In your opinion, how can the GAL program best advocate for the children of a substance abusing parent(s) or caretaker(s)?: (continued)

Be objective

The best advocacy is - know the facts; come to a conclusion based on the facts; advocate for the child.

Don't let middle class, white values and attitudes about substances get in the way of advocating for the child.

Advocate by assessing the severity of the problem early on and addressing the family's needs.

Maintain child-parent contact when possible

Keep the bond with the parent by visitations when possible.

Make certain that the child is not indiscriminately removed from their family.

The court

Educate judges better about substance abuse.

Advocate to make the court recognize that it is not just getting the substance abuser squared away, but it needs to address the child's issues as well.

Support services

Advocate for support services. Advocate for the availability of professionals when needed but not when convenient.

Address the drug problem

Become part of a coalition (community service providers or the general public) to do something about the drug problem.

APPENDIX C

INTERVIEW GUIDE

INTENSIVE SUBSTANCE ABUSE

CASE ADVOCACY PROJECT

Total # Cases_____ # Drug Cases _____
District _____ Location _____
Case # _____

INTENSIVE SUBSTANCE ABUSE CASE ADVOCACY PROJECT

NORTH CAROLINA GUARDIAN AD LITEM PROGRAM

INTERVIEW GUIDE

CHARACTERISTICS OF THE HOUSEHOLD

Location of the household:

❑ Rural ❑ Small town ❑ Big or medium city ❑ Suburban

Neighborhood economic characteristics: ❑ Wealthy ❑ Middle class ❑ Poor

Neighborhood physical characteristics: ❑ Orderly ❑ Chaotic

❑ Clean ❑ Dirty

Neighborhood safety characteristics: ❑ Very safe ❑ Fairly safe ❑ Unsafe

Comments: _____

_____

Is substance abuse (buying, selling, using) a problem for this neighborhood?

❑ Yes [How so?_____]

❑ No

Where is the child now? ❑ In parent's household

❑ Elsewhere [Where? _____]

Parent's household composition:

Number of persons in household ____ Number of rooms in dwelling _____

Number of bedrooms _____ Sleeping arrangements _____

CHARACTERISTICS OF THE HOUSEHOLD [CONTINUED]

Relationship to Head of Household	Gender	Age	Race	Marital Status	Job Type	Job Stability	Educ.
Head of household							

Who is involved in drugs in this household?

Who_____ Type of involvement: ❑ Use ❑ Sell ❑ Other Drug(s):_____ ❑ Suspected ❑ Known

Who_____ Type of involvement: ❑ Use ❑ Sell ❑ Other Drug(s):_____ ❑ Suspected ❑ Known

Who_____ Type of involvement: ❑ Use ❑ Sell ❑ Other Drug(s):_____ ❑ Suspected ❑ Known

Who_____ Type of involvement: ❑ Use ❑ Sell ❑ Other Drug(s):_____ ❑ Suspected ❑ Known

How would you characterize the household?

- ❑ orderly
- ❑ chaotic

- ❑ clean
- ❑ dirty

- ❑ safe physical environment
- ❑ unsafe physical environment

- ❑ sufficient food
- ❑ little or no food

- ❑ sufficient furniture
- ❑ little or no furniture

- ❑ toys for children
- ❑ few or no toys

What kind of support network does this family have?

- ❑ strong
- ❑ moderate
- ❑ weak
- ❑ none - isolated

Who is in this support network?

- ❑ extended family
- ❑ friends
- ❑ neighbors
- ❑ others _____

CASE INFORMATION

Is this case an abuse and or neglect case? Or something else?

- ❑ abuse
- ❑ neglect
- ❑ dependency
- ❑ other _____

Which children in the family are "officially" involved in the case?

_____

_____

_____

How did this (abuse, neglect, dependency) come to the attention of DSS? Who filed a complaint?

_____

_____

_____

Has this family had any prior complaints filed?

- ❑ No
- ❑ Yes - How many prior complaints? _____

Were any of these prior complaints substantiated by DSS?

- ❑ Don't know
- ❑ No
- ❑ Yes - How many were substantiated? _____

PROCESS ANALYSIS

Please give a quick outline of the case from the time that you were assigned to the case until now.

How do substance abuse cases differ from non-substance abuse cases you see?

PROCESS ANALYSIS [CONTINUED]

When you get a "new" substance abuse case, what is the first thing you do <u>because</u> it is a <u>substance abuse case</u>?

What is the first issue you address? Is it . . .

- ❑ immediate safety of the child(ren)
- ❑ risk of future abuse or neglect
- ❑ something else _____

Why that first? _____

_____

How do you do that? _____

_____

BEST INTERESTS OF THE CHILD [BIC]

What does "in the best interests of the child" mean to you? _____

_____

_____

_____

_____

_____

BEST INTERESTS OF THE CHILD [CONTINUED]

Under what conditions is it in the "best interests of the child" to keep the family together when there is substance abuse in that family?

Under what conditions is it in the "best interests of the child" not to keep the family together when there is substance abuse in that family?

In substance abuse cases, do you usually agree or disagree with DSS's assessment of the situation?

- ❑ Agree
- ❑ Varies - How is that? _____
- ❑ Disagree - What are the points of difference when you disagree with DSS?

SUBSTANCE ABUSE ISSUE

What drug or drugs are most often associated with a child being physically abused? Why is that?

What drug or drugs are most often associated with a child being sexually abused? Why is that?

What drug or drugs are most often associated with a child being neglected? Why is that?

What drug or drugs are most often associated with a child being unsafe? Why is that?

SUBSTANCE ABUSE ISSUES [CONTINUED]

How do each of the following factors relate to how you view and work with a substance abuse case?

Age of the children in the family_____

Availability or non-availability of caretakers other than substance abusing caretaker

_____

Type of substance being abused _____

_____

Type of drug-related activity: user; seller _____

_____

Particular family strengths/resources _____

_____

Other [?] _____

_____

Can a child stay in a family in which there is substance abuse or must the child be removed? How is that?

_____

_____

_____

_____

Can a child be reunited with their family if the parent is not drug-free or must the parent be drug-free before they are reunited? How is that?

_____

_____

_____

_____

COMMUNITY RESOURCES

What kinds of resources are available for working with substance abusing cases? Are they local or elsewhere?

What kinds of resources are not available that are needed to work with substance abusing cases?

IDEAL SOLUTIONS

If you could only change one thing about this case, what would it be?

In your opinion, what kind of program would be an "ideal" program to address the issue of a substance abusing parent/caretaker?

In your opinion, how can the GAL program best advocate for the children of a substance abusing parent(s) or caretaker(s)?