



Department of
**Mental Health &
Substance Abuse Services**



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**Substance Use Best Practice Tool
Guide**

APPENDIX C: Child Welfare

Division of Clinical Leadership in Collaboration with the
Division of Substance Abuse Services

Child Welfare

Substance use continues to be one of the most common reasons for involvement with the child welfare system. Parents and/or other caregivers who use/misuse substances can have a negative impact on the safety, permanence, and wellbeing of children and families (DHHS/ACF/CWIG, n.d.). Most studies indicate that parental/caregiver substance use is a contributing factor for between one third to two thirds of the children involved with CPS. Further, research has shown that children of parents/caregivers with substance use disorders (SUDs) are more than four times more likely to be neglected and nearly three times more likely to be abused than children of parents/caregivers without substance issues (DHHS/ACF, 2009). The Tennessee Department of Children's Services (TDCS) reports have indicated that nearly 50 percent of the young people in custody is the result of parent/caregiver substance (TDMHSAS, 2013).

A National Survey on Drug Use and Health (NSDUH) identified 8.3 million children living with a parent who was classified as having an alcohol or other substance use problem. To put this in perspective, this number represents approximately 11 percent of all the children in the United States and says that about three children in every classroom are going home to a parent who needs substance use treatment (Young & Hoffman, 2015).

There is renewed attention to the issue of substance use in child welfare because of the impact that increased use of heroin and opiates is having on the numbers of children entering foster care.

Governors of several states have spoken openly about the impact of substance use on their rising foster care numbers. In fact, the data show that the percentage of children being removed from the home and placed in foster care as a result of parental/caregiver substance use rose from 23 percent in 2004 to 31 percent in 2013. The percentage is likely an

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undercount since a number of children are removed for multiple reasons, e.g. (CWLA, 2015). Substance use disorders (SUDs) affect the way people live, including how they interact with others, function, and parent their children. Because SUDs impair priorities and judgment of parents/caregivers, parental discipline choices and child-rearing styles can be affected. SUDs also have negative effects on the consistency of supervision and care provided to children. The time and money parents/caregivers spend on using and/or seeking out substances may limit the resources available in the household to meet the children's basic needs. Moreover, families affected by substance use issues frequently experience many other kinds of problems, including mental illness, domestic violence, high levels of stress, and poverty—all of which are linked to child maltreatment (DHHS/ACF, 2009).

The children of parents/caregivers with SUDs and who are also in the child welfare system are more likely to exhibit intellectual, social, and physical problems than children of parents/caregivers without such issues. In addition, children from families affected by substance issues that have been abused and/or neglected are more likely to be placed in foster care and to remain there longer than maltreated children from families with no substance issues (DHHS/ACF, 2009).

Substance use becomes problematic and to the attention of child welfare when it contributes to the harm of children. Yet, distinguishing between “normal” and problematic alcohol use, e.g., can be

blurred and subject to interpretation, making identification difficult for caseworkers (DHHS/ACF, 2009). That is why caseworkers are using a wealth of strategies to prevent substance use/misuse while also improving outcomes for children and families (DHHS/ACF/CWIG, n.d.).

One first step is for child protection services (CPS) caseworkers to conduct an in-home examination of the individuals and environment in and around the home. The following indicators of SUDs should be checked by the caseworker:

- At least one parent/partner appears to be under the influence of a substance, admits to having a substance use disorder (SUD), or exhibits other signs of use/misuse or addiction (for example, needle marks)
- A child or other member of the family, including a partner, reports drug or alcohol use by a parent or kin in the home environment
- There is a scent of drugs or alcohol in the home environment
- Drug paraphernalia (for example, charred spoons, a large number of beer bottles or liquor, a syringe kit) are present in the home environment
- Substance use is included in the CPS report or call (DHHS/ACF, 2009).

This list can be used pre- or post-screening and might be incorporated into every home visit.

Screening should consist of a simple, brief, set of questions that have been validated (DHHS/ACF, 2009). It should be noted that some Tennessee Department of Children's Services supervisors and team leaders have been trained in Screening, Brief Intervention, and Referral to Treatment (SBIRT), funded in part by two TDMHSAS-led grants—Building Strong Families in Rural Tennessee (BSF) and the Therapeutic Intervention, Education, and Skills (TIES) (E. Chappell, personal communication, October 31, 2014). Screening will help the caseworker determine whether a family member requires further evaluation for SUD. As with the in-home examination checklist, screening can become a standard component of the home visit or family assessments. General home visit safety tips, specific safety tips around substances, and screening tools are contained in the document, *Protecting Children in Families Affected by Substance Use Disorders*. The reference citation is provided in this section. Additionally, the document can be downloaded free of charge from <https://www.childwelfare.gov/pubs/usermanuals/substanceuse/substanceuse.pdf> (DHHS/ACF, 2009).

Screenings for SUDs should become a routine part of CPS investigations, case planning and monitoring, and risk and safety assessments. Evidence of SUDs are not always noticeable during the initial investigation and may not emerge until later during a caseworker's interaction with the case. However, the high prevalence of SUDs in families involved in the child welfare system suggests that CPS caseworkers should screen during all stages of a case. While not likely perceived as helpful by the family, screening for SUDs can help identify the likelihood that they exist. Sometimes SUDs are masked by other disorders and vice versa (DHHS/ACF, 2009).

Typically a call is placed to Child Protective Services (CPS) in the Tennessee Department of Children's Services (TDACS) when concerned individuals think a child is at risk of abuse and/or neglect due to substance use issues of the parent or other persons in the child's home environment. This call often results in a home visit by a CPS caseworker.

Caseworkers (and others) should refrain from labeling children who have been exposed prenatally to substances (DHHS/ACF, 2009).

Caseworkers (and others – anyone who will have contact with the children) should refrain from labeling children

who have been exposed prenatally to substances. For example, labeling a child as a “NAS baby” or “meth baby” can result in the child and/or others having lower expectations for academic and life achievements while ignoring other reasons for the social and physical problems the child may encounter (DHHS/ACF, 2009).

Today it is likely that child welfare workers will encounter an increase in the number of cases involving opioid misuse and dependence among pregnant and parenting women. This means that more families with babies will be coming to the attention of the child welfare system, as hospitals are reporting increases of infants born with neonatal abstinence syndrome (NAS). For such cases, a coordinated, multi-systemic approach that is grounded in early identification and intervention can assist both the child welfare and treatment systems in conducting comprehensive assessments as well as ensuring access to the range of services that will be needed by these families. Thus, *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders* has been developed and is available for download to assist child welfare workers in successfully setting collaborative planning and implementation of services in motion. This resource is available from https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf.

The Child Welfare Information Gateway (CWIG) Web site houses a wealth of information on substance use and its impact on children that may come to the attention of child welfare. Included among the information on the Web site are general resources for preventing substance use in children and families. In addition, there are prevention resources for targeted populations that address specific protective and risk factors associated with substance use. Resources on assessment, casework practice, treatment services, cross-system collaboration, and supports for families are also available (CWIG, n.d.).

Other resources for child welfare professionals can be found on the Children's Bureau Web site. (The Children's Bureau is an office of the Administration for Children and Families.) One such resource is the primer *Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Child Welfare Professionals* (Breshears, Yeh, & Young, 2009). This primer covers alcohol and other substance addiction, along with substance use treatment and recovery. Topics encompass treatment readiness and effectiveness, cross-system communication and collaboration, and contact information for other national resources (Children's Bureau, n.d.).

Finally, if the Family First Prevention Services Act of 2016 passes and is signed into law, child welfare would have financial and intervention resources for alternatives to foster care. Passage of this Act would reduce the cost and trauma of out of home placements of children whose parents have substance use problems. Title IV-E funds could be used for treating parents with substance use disorders by paying for residential substance abuse treatment or providing in-home and/or other services to keep families together. New Regional Partnership Grants would be created and existing

RPGs could be reauthorized. Tennessee currently has two RPGs: Helen Ross McNabb's New Beginning program and TDMHSAS' Therapeutic Intervention, Education, & Skills (TIES) project (ADAW, 2016).

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